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PROGRAMME BUDGET 2010–2011 **MID-TERM REVIEW**

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TABLE OF CONTENTS

INTRODUCTION	IV
OVERVIEW OF ORGANIZATION-WIDE EXPECTED RESULTS	IV
ACHIEVEMENTS BY STRATEGIC OBJECTIVE (SO)	VI
OVERVIEW OF BUDGET IMPLEMENTATION BY THE END OF 2010	XIV
PROGRAMMATIC AND BUDGET ADJUSTMENTS MADE ON THE BASIS OF THE MID-TERM REVIEW	XVIII
IDENTIFICATION OF PRIORITY RESULTS	XVIII
IDENTIFICATION OF SPECIFIC PLANS TO ACHIEVE EFFICIENCIES AND COST REDUCTIONS	XIX
IDENTIFICATION OF SPECIFIC ACTIVITIES AND RESULTS THAT WILL BE REDUCED OR NO LONGER DELIVERED	XIX
SO1 Communicable diseases	1
SO2 HIV/AIDS, Tuberculosis and Malaria	17
SO3 Chronic noncommunicable conditions	28
SO4 Child, adolescent, maternal, sexual and reproductive health, and ageing	37
SO5 Emergencies and disasters	48
SO6 Risk factors for health	58
SO7 Social and economic determinants of health	67
SO8 Healthier environment	76
SO9 Nutrition and food safety	87
SO10 Health systems and services	96
SO11 Medical products and technologies	113
SO12 WHO leadership, governance and partnerships	119
SO13 Enabling and support functions	128

INTRODUCTION

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 technical and financial implementation.¹

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.

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.

OVERVIEW OF ORGANIZATION-WIDE EXPECTED RESULTS

Table 1 shows the progress made in achieving the Organization-wide expected results by strategic objective. 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.

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

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.

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 decision it takes during the second half of the biennium in response to the financial situation. ■

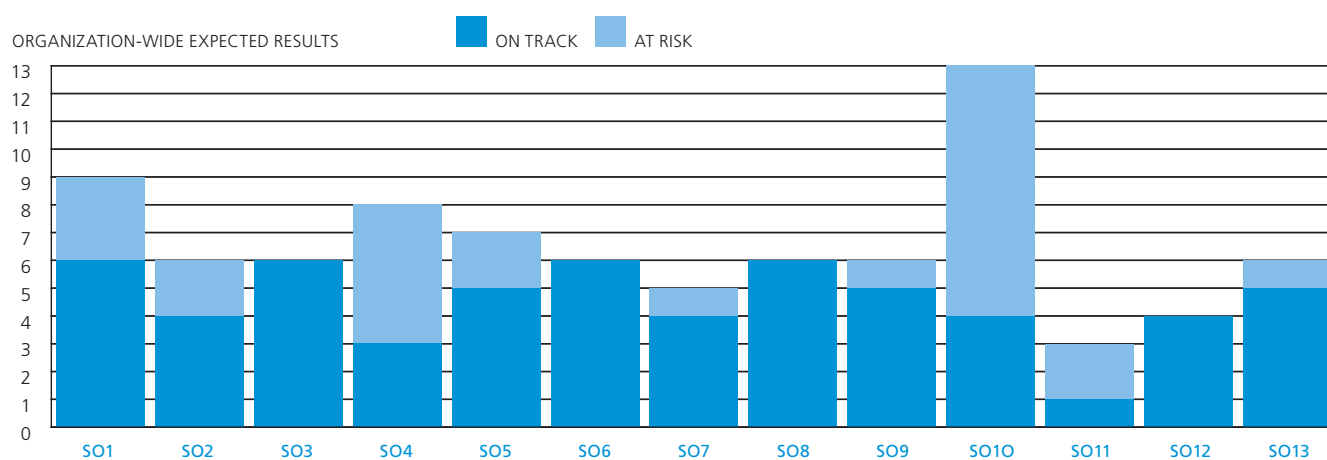
Organization-wide expected results that are “in trouble” may be cut back or postponed until the next biennium. Particular attention has been focused on the reasons why progress is not on track and the actions required to minimize the risk to full achievement of expected results by the end of 2011.

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”. ■

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.

STRATEGIC OBJECTIVE	ORGANIZATION-WIDE EXPECTED RESULTS			TOTAL
	ON TRACK	AT RISK	IN TROUBLE	
SO1 Communicable diseases	6	3	0	9
SO2 HIV/AIDS, Tuberculosis and Malaria	4	2	0	6
SO3 Chronic noncommunicable conditions	6	0	0	6
SO4 Child, adolescent, maternal, sexual and reproductive health, and ageing	3	5	0	8
SO5 Emergencies and disasters	5	2	0	7
SO6 Risk factors for health	6	0	0	6
SO7 Social and economic determinants of health	4	1	0	5
SO8 Healthier environment	6	0	0	6
SO9 Nutrition and food safety	5	1	0	6
SO10 Health systems and services	4	9	0	13
SO11 Medical products and technologies	1	2	0	3
SO12 WHO leadership, governance and partnerships	4	0	0	4
SO13 Enabling and support functions	5	1	0	6
TOTAL	59	26	0	85



ACHIEVEMENTS BY STRATEGIC OBJECTIVE

STRATEGIC OBJECTIVE 1

TO REDUCE THE HEALTH, SOCIAL AND ECONOMIC BURDEN OF COMMUNICABLE DISEASES

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.³ 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.

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 Cape 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.

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. Efforts to enhance WHO's management of public health risks under the International Health Regulation (2005) will require closer collaboration across the three levels of the Organization. Enhanced resource mobilization efforts are planned at every level. ■

³ 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

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.

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

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 global 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.

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

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.

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

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.

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

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 Reponse 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 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 mega-countries had undertaken Global Adult Tobacco Surveys and 160 had completed Global Youth Tobacco Surveys.

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 adopted the Global strategy to reduce the harmful use of alcohol (resolution WHA63.13) and endorsed 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. ■

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

A regional strategy to address key determinants of health in the African Region was endorsed*. Technical assistance for implementation of social determinants of health and equity-focused health was provided to 18 countries in three regions. Evidence on implementation of social determinants of health 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 Western 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 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.

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. ■

* Resolution AFR/RC60/R1

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

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 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.

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 the development of national 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

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, a Regional Strategy and Plan of Action has been approved by the Eastern Mediterranean Regional Committee and a strategy and plan of action for the reduction of chronic malnutrition has been approved by the Directing Council of the Region of the Americas. 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.

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

Staff of 25 high-priority 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 HINARI access to research in health programme 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 Safety was implemented in six countries in the African Region and the International Classification for Patient Safety was developed.

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 co-ordination of health system research (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

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 for 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.

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 anti-counterfeit medicine programme, 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 several resolutions on the subject.⁴ ■

⁴ Resolutions WHA 58.27 and WHA 60.16

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

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 Expert Working Group on Research and Development Financing and Coordination, and the meetings of the International Health Regulations Review Committee.

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.

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 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.

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

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 at 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.⁵ A global resource mobilization strategy was endorsed by the Global Policy Group.

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.

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. ■

⁵ document A64/6.

OVERVIEW OF BUDGET IMPLEMENTATION BY THE END OF 2010

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%.

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.

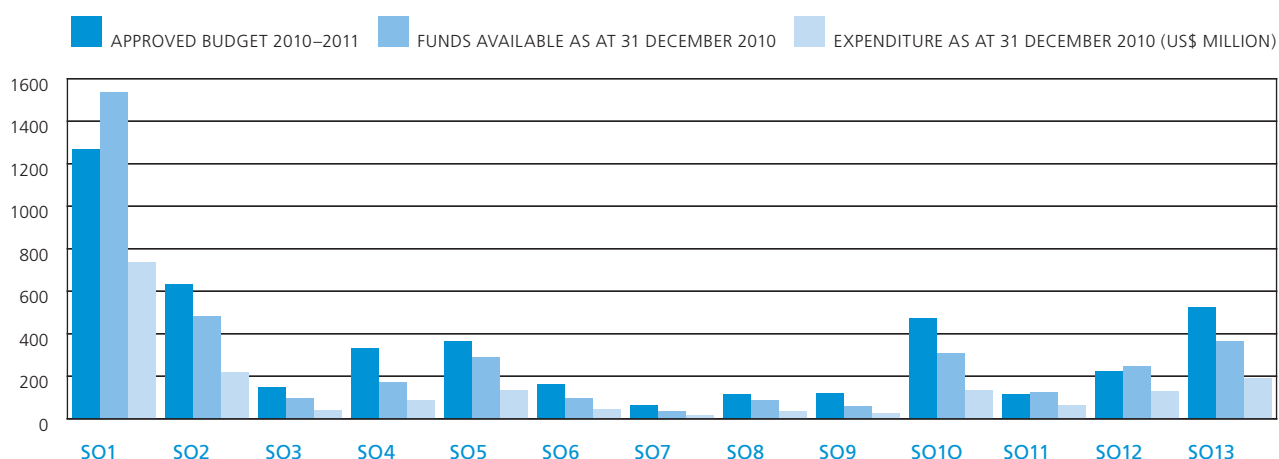
The following tables show how the Programme budget 2010–2011 has been implemented to 31 December 2010 by strategic objective, budget segment and major office. ■

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

STRATEGIC OBJECTIVE		APPROVED PROGRAMME BUDGET 2010–2011	FUNDS AVAILABLE AS AT 31 DECEMBER 2010 ^a			FUNDS AVAILABLE AS % OF APPROVED BUDGET	EXPENDITURE AS AT 31 DECEMBER 2010	EXPENDITURE AS % OF APPROVED BUDGET	EXPENDITURE AS % OF FUNDS AVAILABLE
			AC	VC	TOTAL				
US\$ million									
SO1	Communicable diseases	1268	73	1462	1535	121%	737	58%	48%
SO2	HIV/AIDS, tuberculosis and malaria	634	40	440	480	76%	217	34%	45%
SO3	Chronic noncommunicable conditions	146	37	61	98	67%	40	28%	41%
SO4	Child, adolescent, maternal, sexual and reproductive health, and ageing	333	46	124	170	51%	88	27%	52%
SO5	Emergencies and disasters	364	15	276	291	80%	136	37%	47%
SO6	Risk factors for health	162	31	64	95	59%	44	27%	47%
SO7	Social and economic determinants of health	63	15	20	35	56%	16	25%	45%
SO8	Healthier environment	114	30	55	85	74%	37	33%	44%
SO9	Nutrition and food safety	120	18	39	58	48%	27	23%	48%
SO10	Health systems and services	474	124	183	307	65%	136	29%	44%
SO11	Medical products and technologies	115	26	99	125	109%	65	56%	52%
SO12	WHO leadership, governance and partnerships	223	190	55	246	110%	129	58%	52%
SO13^b	Enabling and support functions	524	279	85	364	69%	189	36%	52%
NOT YET DISTRIBUTED TO SOs				29	29				
TOTAL		4540	925	2993	3918	86%	1862	41%	48%

^a AC, assessed contribution; VC, voluntary contribution

^b 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's approved Programme budget 2010–2011 amounts to US\$ 4540 million. As at the end of 2010, available funds⁶ 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.⁷

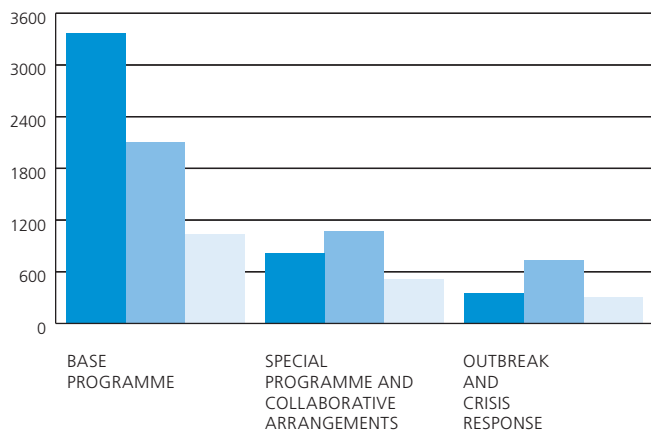
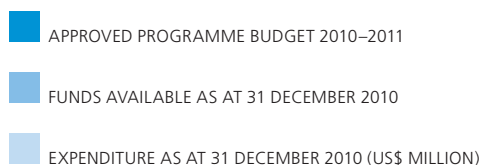
Strategic objectives 4, 6, 7 and 9 are currently the least well-funded, but funding for some strategic objectives exceeds the approved Programme budget. In the case of strategic objective 1, for example, the available funding includes in-kind vaccine contributions to the Organization's pandemic (H1N1)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

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

SEGMENT	APPROVED PROGRAMME 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
		AC	VC	TOTAL				
US\$ million								
Base programmes	3368	918	1191	2109	63%	1035	31%	49%
Special Programmes and collaborative arrangements	822	6	1066	1072	130%	517	63%	48%
Outbreak and crisis response	350	1	737	738	211%	309	88%	42%
TOTAL	4540	925	2993	3918	86%	1862	41%	48%

⁶ 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.

⁷ 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.



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.

The funds available⁸ 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).

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, coupled with the need for an adequate carry-forward to cover the opening of the biennium 2012–2013, 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.

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).

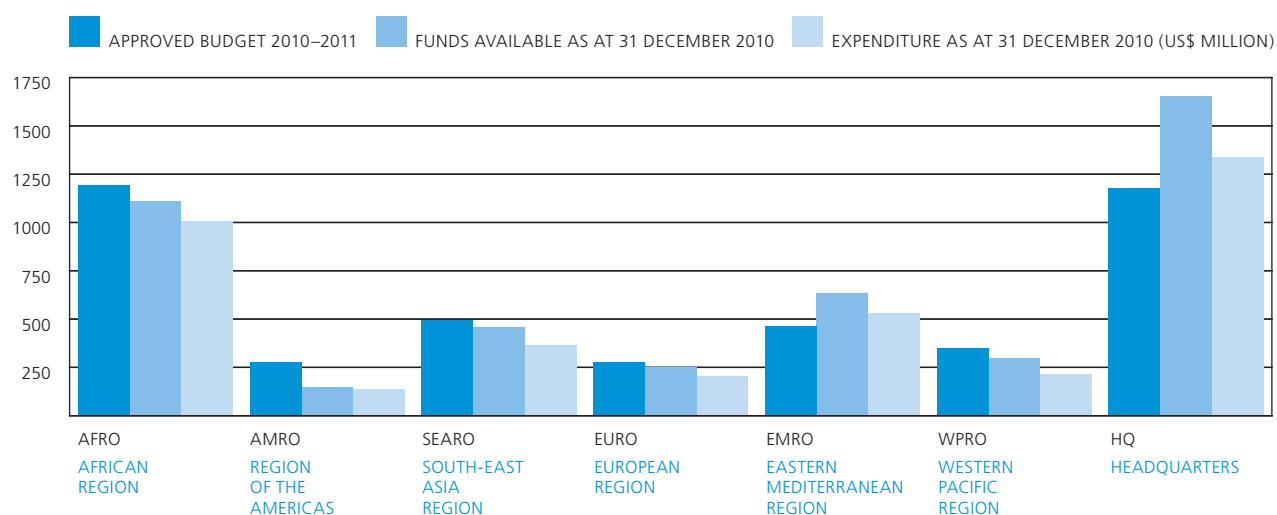
The outbreak and crisis response segment also increased, with available resources of US\$ 738 million (211% of the approved budget). The growth in outbreak and crisis response was largely driven by WHO's response to the pandemic (H1N1) 2009 and increasing operational responsibilities in emergencies and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

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

⁸ 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 PROGRAMME 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
		AC	VC	TOTAL				
US\$ million								
African Region	1263	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	1389	314	1334	1648	119%	747	54%	45%
Not yet distributed to Major Offices			153	153				
TOTAL	4540	925	2993	3918	86%	1862	41%	48%



In most offices, the funds available⁹ 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 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. ■

⁹ 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 of 31 December 2010.

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

In view of the current financial insecurity, a task force convened by the Global Policy Group¹⁰ 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 activities and results that will not be achieved because of insufficient financial resources and will, therefore, be reduced or no longer delivered. ■

IDENTIFICATION OF PRIORITY RESULTS

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 and noncommunicable conditions) and 6 (risk factors for health) in order to support critical Organization-wide expected results under the two strategic objectives
- 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 social determinants of health and environmental health, and, instead, striving to mainstream those 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.

More details on priority results for 2011 can be found in the reports by strategic objective. ■

¹⁰ The Global Policy Group is composed of the Director-General, Deputy Director-General and the six regional Directors.

IDENTIFICATION OF SPECIFIC PLANS TO ACHIEVE EFFICIENCIES AND COST REDUCTIONS

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 ACTIVITIES AND RESULTS THAT WILL BE REDUCED OR NO LONGER DELIVERED

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 and the consequent need to redistribute available resources to priority areas with limited capacity to implement them.

More details on specific results to be reduced or no longer delivered can be found in the reports by strategic objective. ■

SO1

TO REDUCE THE HEALTH, SOCIAL AND ECONOMIC BURDEN OF COMMUNICABLE DISEASES



PROGRESS TOWARD THE ACHIEVEMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

OF THE NINE ORGANIZATION-WIDE EXPECTED RESULTS FOR THIS STRATEGIC OBJECTIVE, SIX WERE "ON TRACK" AND THREE "AT RISK"

OVERVIEW

While estimated global coverage with three doses of diphtheria-tetanus-pertussis vaccine was maintained at 82%, the number of countries reaching 90% or more immunization coverage continued to increase.

By late 2010, with support from WHO in planning vaccine introduction and from the Global Alliance for Vaccines and Immunisation in delivering long-term financial support, pneumococcal vaccine was introduced in a total of 58 countries and rotavirus vaccine in a total of 27 countries. New conjugate meningococcal meningitis A vaccine was successfully launched in mass campaigns in December 2010, nationally in Burkina Faso and sub-nationally in Mali and Nigeria. In the African Region, hepatitis B and *Haemophilus influenzae* type b vaccines have been introduced in 44 and 45 countries respectively.

A training and technology transfer hub for vaccine adjuvants was established and training and technology are being provided to Indonesia and Viet Nam. A simplified system of dengue case classification was developed through a multi-centre prospective clinical study before being evaluated in 18 countries and adopted and widely used in Latin America, and, increasingly, in Asia. Active case detection methods for visceral leishmaniasis were assessed and are being applied in India, Bangladesh and Nepal using standard operating procedures. In the European Region, computer modules for monitoring performance in eliminating certain infectious diseases were piloted and introduced in Kazakhstan and Kyrgyzstan. In the Western Pacific Region, a strategic plan template for national neglected tropical diseases was prepared and is being used in Cambodia, Lao People's Democratic Republic and Viet Nam.

In 2010, the Global Polio Eradication Initiative saw a 97% reduction in poliomyelitis case numbers in Nigeria, a 94% reduction in India, from 1073 cases in 2009 to 84 in 2010, and the interruption of imported wild poliovirus transmission in 16 of the 19 countries that were re-infected in 2009.

In 2010, WHO published its first report on neglected tropical diseases, *Working to overcome the global impact of neglected tropical diseases*. In addition, it also facilitated external support and regional action for stepping up preventive chemotherapy coverage to combat neglected tropical diseases in targeted countries, and elicited greater commitment to improving access to medicines, including through increased pharmaceutical donations. In the South-East Asia Region, 10 out of 11 countries have eliminated leprosy.

Throughout 2010, 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 Committee on the functioning of the International Health Regulations (2005) in relation to pandemic (H1N1) 2009. The Committee's final report will be presented to the Sixty-fourth World Health Assembly. A course targeting public health professionals involved in implementing the International Health Regulations (2005) was launched, and tools and guidance continued to be offered to countries to assist them in meeting the 2012 deadline for their implementation. A monitoring system that includes a web-based tool allowing countries to report on their progress in implementing the Regulations was also developed. The Regional Offices for South-East Asia and the Western Pacific

jointly revised and expanded the Asia Pacific Strategy for Emerging Diseases.

International specialist networks for preventing and combating specific communicable diseases and fostering collaboration on specialized interventions continued to receive support. Global response and surveillance for all communicable diseases was progressively strengthened through those networks and through joint activities with the regions and Member States.

Introduction of the global event-management system is on track to exceed the indicator target, with 481 users at 148 WHO sites at country, regional and headquarters level; integration of headquarters and regional operations centres is proceeding.

WHO has responded to all Member States' requests for emergency assistance under the International Health Regulations (2005) by means of technical resources at headquarters, diverse specialist networks and the Global Outbreak Alert and Response Network. Outbreak response actions in 2010 centred on: pandemic (H1N1) 2009; dengue in Cape Verde; suspected viral haemorrhagic fevers in Democratic Republic of Congo and Uganda; cholera in Haiti, Rift valley fever in South Africa; cholera, Crimean Congo haemorrhagic fever and dengue in Pakistan; meningitis and yellow fever in Cameroon, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of Congo, Ghana, Guinea, Niger, Nigeria and Sudan; and plague in Peru.

Pandemic (H1N1) 2009 was declared to be over in August 2010 and WHO's response is currently under review by an independent committee, as well as by the Review Committee on the functioning of the International Health Regulations (2005) in relation to pandemic (H1N1) 2009. Significant progress has been made in increasing capacity for influenza vaccine production in developing countries. Three manufacturers licensed influenza vaccine in 2009–2010.

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. ■

1.1 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.

ON TRACK

While estimated global coverage with three doses of diphtheria-tetanus-pertussis vaccine was maintained at 82%, the number of countries with immunization coverage of 90% or over continued to increase.

To further strengthen national immunization programmes, raise awareness of the value of immunization and elicit more support from national governments and partners, the Regional Office for the Eastern Mediterranean followed the Regional Offices for the Americas and Europe in implementing vaccination weeks. Its first, in April 2010, saw the participation of all countries in the region. In the European Region, 47 countries (more than ever) supported vaccination week, focusing mainly on the measles and rubella elimination goals. In the Region of the Americas the target was to vaccinate over 44 million people.

The number of countries that introduced hepatitis B into routine immunization programmes increased from 177 in 2008 to 178 in 2010, including in parts of India and the Sudan.

Support for vaccine introduction was provided to initial adopters of pneumococcal and rotavirus vaccines. By late 2010, pneumococcal vaccine had been introduced into 58 countries compared to 44 in 2009 (including partial introduction into one country) and rotavirus vaccine into 27 countries (compared to 22 in 2009). Long-term financial support from the Global Alliance for Vaccines and Immunisation facilitated decisions on the adoption of new vaccines in eligible developing countries. However, the price of new vaccines limits the ability of middle-income countries to introduce them.

Global measles routine immunization coverage with the first dose of measles vaccine was sustained at 82%. The recent reduction in measles mortality is threatened by declining political and financial commitment to measles control. During 2010, a resurgence of measles in 30 African countries resulted in renewed efforts to accelerate measles mortality reduction.

Although, overall, progress was made in extending routine immunization coverage, many countries continue to experience gaps in coverage and even setbacks, particularly in Africa and South Asia. Weak delivery systems that limit immunization coverage rates are a major impediment to sustaining and accelerating the progress achieved so far, for example, in controlling and eliminating measles. Planning and service delivery at operational level within the context of the renewed focus on primary health care need to be strengthened.

National commitment and ownership should be ensured as key elements in achieving immunization goals. Joint planning and coordination between headquarters and regional and country offices, including integration with other WHO programmes, greatly facilitated the implementation of activities. Such practices should be maintained and even enhanced. Partnerships, bilateral agencies, private companies and social organizations also contributed to social mobilization, advocacy and overall quality assurance and such participation and commitment should be sustained and, if possible, augmented. ■

PERFORMANCE INDICATORS

CURRENT STATUS

1.1.1 Number of Member States with at least 90% national vaccination coverage (DTP3)

ON TRACK

1.1.2 Number of Member States that have introduced Haemophilus influenzae type b vaccine in their national immunization schedule

ON TRACK

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.

AT RISK

The Global Polio Eradication Initiative strategic plan 2010–2012 was launched in June 2010. The strategic plan was informed by the outcomes of the 2009 Programme of Work and prepared in consultation with major stakeholders, including spearheading partners, representatives of infected countries and donors. At the request of the Executive Board and the World Health Assembly, a new independent monitoring board will evaluate the major milestones, monitor the development and implementation of mid-course corrections, and guide the programme on major issues of policy, strategy and priority. The independent monitoring board was constituted in late October 2010 and held its first meeting in December 2010.

In 2010, WHO coordinated the introduction globally, and subsequent scaling up, of distribution of the new bivalent oral polio vaccine, which was a primary factor in the marked reduction in both type 3 and type 1 wild poliovirus. A number of new operational tactics were refined and developed, including: standardized, independent monitoring to more accurately determine whether children had been reached during campaigns; lot quality assurance surveys in countries with discordant epidemiological and supplementary immunization activities performance data to guide programme decision-making; and environmental sampling in conjunction with regular surveillance reviews and the application of rapid surveillance reviews. In addition, seroprevalence studies were introduced in particularly high risk areas, such as western Uttar Pradesh and central Bihar in India and large population centres in Pakistan. Pilot studies were also conducted to determine the feasibility of using geographic information systems to support the implementation and monitoring of supplementary immunization activities.

In terms of preparing for post-eradication risk management, the Working Group on Inactivated Polio Vaccine of the Strategic Advisory Group of Experts on Immunization, provided recommendations that underpinned a new comprehensive WHO position paper on the routine use of oral polio vaccine and inactivated polio vaccine, entitled “Polio vaccines and polio immunization in the pre-eradication era”, which was published in June 2010. The final draft of a global action plan for the containment of polioviruses after global wild poliovirus interruption was developed for public comment. A full research agenda continued to support the development of post-eradication strategies for low-income countries, particularly the development of affordable inactivated polio vaccines for those low-income countries that might choose to use that type of vaccine after oral polio vaccine cessation. Inactivated polio vaccine fractional dose schedules were evaluated and reduced following clinical trials. In addition, the technology transfer process was initiated for the new Sabin-Inactivated Polio Vaccine in December 2010. The tender to vaccine manufacturers for the post-eradication monovalent oral polio vaccine bulk stockpile was also issued. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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

AT RISK

1.2.2 Percentage of Member States using trivalent oral poliovirus vaccine that have a time line and strategy for eventually stopping its use in routine immunization programmes

ON TRACK

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.

ON TRACK

In 2010, WHO published its first report on neglected tropical diseases, *Working to overcome the global impact of neglected tropical diseases*. In addition, it also 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. The Regional Office for Africa developed and disseminated regional guidelines for a comprehensive multi-year strategic plan to combat neglected tropical diseases. More effective communication strategies using traditional and new media sources were designed and implemented and communications and public relations indicators evaluated. Support was provided to enable regions and countries to prepare country plans of action for neglected tropical disease control.

The launch of a mass drug administration campaign in Yemen resulted in coverage of 2.6 million people. A donation of 50 000 tablets served to increase coverage with praziquantel in the schistosomiasis affected areas of Somalia. The dracunculiasis eradication programme continued to make progress in targeted countries in the African Region and in Southern Sudan in the Eastern Mediterranean Region.

The Regional Office for Africa provided support to national leprosy programmes in two countries in order to scale up leprosy case management. All countries in the Eastern Mediterranean Region have reached the goal of a prevalence rate of 1 per 10 000 or less. Ten out of 11 countries in the South-East Asia Region and 34 out of 37 countries and territories in the Western Pacific Region have eliminated leprosy at national level. The Regional Office for the Americas has assessed the regional leprosy Organization-wide expected result as "at risk" because four countries failed to achieve the regional leprosy elimination goal.

The year 2010 saw publication of Control of the leishmaniasis: report of a meeting of the WHO Expert Committee on the Control of Leishmaniasis and the securing of consensus on management of the disease. A decision was taken to target human African trypanosomiasis for elimination using innovative and intensive disease management tools, including drugs and diagnostic tools, in collaboration with the Drugs for Neglected Tropical Diseases Initiative and the Foundation for Innovative New Diagnostics (FIND). The WHO sample bank for human African trypanosomiasis diagnostics development became operational, and clinical trials for Buruli ulcer are being prepared.

Implementation of the Asia-Pacific Dengue Strategic Plan (2008–2015) is progressing. In the Eastern Mediterranean Region, 11 of the 13 disease endemic countries now have an integrated vector management plan and have established national intersectoral coordination mechanisms.

Targeted support was provided to the regional offices, particularly those involved in the elimination of human and dog rabies in developing countries. A platform for neglected zoonotic diseases was established with several partners including FAO, the International Livestock Research Institute and OIE. Certain countries in the African and Western Pacific Regions were supported in the procurement of human and dog rabies vaccines and immunoglobulin.

Technical cooperation between countries needs to be established in order to improve the effectiveness of the activities being carried out to control rabies and neglected tropical diseases. The current financial situation gives cause for concern regarding the Organization's ability to sustain the gains made thus far and to reach some of the key global and regional goals in the area of communicable disease prevention, control, elimination and eradication. ■

PERFORMANCE INDICATORS	CURRENT STATUS
1.3.1 Number of Member States certified for eradication of dracunculiasis	ON TRACK
1.3.2 Number of Member States that have eliminated leprosy at subnational levels	ON TRACK
1.3.3 Number of reported cases of human African trypanosomiasis for all endemic countries	ON TRACK
1.3.4 Number of Member States having achieved the recommended target coverage of population at risk of lymphatic filariasis, schistosomiasis and soil-transmitted helminthiasis through regular anthelmintic preventive chemotherapy	ON TRACK

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.

ON TRACK

Between 1998 and 2010, the number of laboratories included in WHO's measles and rubella laboratory network grew from fewer than 40 to 679 national and sub-national proficient laboratories serving 177 countries. Virological surveillance for measles proved to be beneficial in identifying the sources of measles outbreaks and tracking virus transmission within and between regions. More than 8700 viruses have been sequenced and submitted to the WHO measles genotype database since 2006, with 1001 viruses representing 10 different genotypes submitted in 2010 by 57 countries.

In 2010, WHO coordinated the hospital based sentinel surveillance network which collects data from health care providers in medical clinics and hospitals on diseases targeted by newer vaccines, such as *Haemophilus influenzae* type b (Hib), pneumococcal and rotavirus. This network provides information for evidence-based decision making on vaccine introduction, monitoring disease epidemiology, and evaluation of vaccine impact after introduction. The data generated, which includes the different types of organisms causing *Haemophilus influenzae* type b, pneumococcal and rotavirus disease, was analysed and shared with global, regional and national partners, and a plan to further strengthen laboratory capacity in that regard is being put forward.

Sixteen training courses on communicable disease control were supported through development of course material and facilitation. WHO has further revised and updated guidance, standards and policy for disease early warning systems, vaccines and communicable disease control in humanitarian emergencies.

All levels of the Organization contributed to building national surveillance networks. To that end, tools, guidelines and training programmes related to epidemiology, points of entry, laboratory and biosafety/biosecurity were launched in 2010 for use by health professionals worldwide involved in implementation of the International Health Regulations (2005). At the mid-term, 128 countries reported undertaking activities that would enhance their capacity to contribute to global networks for epidemiological surveillance and response to diseases and public health risks and emergencies under the International Health Requirements (2005).

Implementation of the Integrated Disease Surveillance and Response strategy in the African Region was shown to be at different stages in the 42 countries. In the Region of the Americas, countries enhanced their surveillance systems and harmonized guidelines will be implemented shortly. In the Eastern Mediterranean Region, 18 countries have a functioning surveillance system for all communicable diseases of public health concern. A regional workshop on field investigation and response to outbreaks of influenza and other epidemic prone respiratory infections was conducted for representatives from all countries in the region. In the European Region, measles and rubella surveillance guidelines were finalized and shared with Member States, and all national measles and rubella laboratories were accredited. In the South-East Asia Region, seven countries reached the target for indicator 1.4.1 and the remaining four (Bhutan, Indonesia, Myanmar and Timor Leste) are expected to do so in 2011. In the Western Pacific Region, the Asia Pacific Strategy for Emerging Diseases (2010) was developed following intensive consultations at country and regional level, and was endorsed by the Regional Committee. Out of 37 countries and territories, 10 received direct support to strengthen their communicable disease surveillance and monitoring systems. ■

PERFORMANCE INDICATORS

CURRENT STATUS

1.4.1 Number of Member States with surveillance systems and training for all communicable diseases of public health importance for the country **ON TRACK**

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 time lines **ON TRACK**

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.**

ON TRACK

In the Western Pacific Region, the draft regional research plan of action on infectious diseases of poverty was further refined, with inputs from the Special Programme for Research and Training in Tropical Diseases, the Regional Network for Asian Schistosomiasis and other Helminthiasis Zoonoses, WHO collaborating centres, and researchers and research institutions within and outside the region. The plan is expected to encourage political commitment and lead to increased allocation of resources. Similarly, in the South-East Asia Region, regional research priorities are being identified and research capacity strengthened. In the Region of the Americas, the public health administrations of Argentina and Ecuador are considering establishing technical cooperation between their countries in order to foster research on communicable diseases. Strategic partnerships for south-south cooperation between Brazil and other countries are also being promoted. The importance of operational research in preventing and controlling communicable diseases needs to be emphasized through advocacy.

New and improved tools and implementation strategies were introduced in 2010 in at least one developing country. A new conjugate meningococcal meningitis A vaccine, developed according to a public-private partnerships model, was registered, prequalified and launched in the African meningitis belt. Clinical trials of rotavirus and conjugate meningitis A vaccines were conducted in countries in the African Region prior to their eventual introduction in selected countries in the region. A simplified system of dengue case classification was developed through a multi-centre prospective clinical study before being evaluated in 18 countries and adopted and widely used in Latin America, and, increasingly, in Asia. Active case detection methods for visceral leishmaniasis were assessed and are being applied in India, Bangladesh and Nepal based on standard operating procedures. In the European Region, surveillance computer modules for monitoring performance in eliminating certain infectious diseases were piloted and introduced in Kazakhstan and Kyrgyzstan. In the Western Pacific Region, a strategic plan template for national neglected tropical diseases was prepared and is being used in Cambodia, Lao People's Democratic Republic and Viet Nam.

The proportion of peer-reviewed publications based on research supported by WHO where the main author's institution was in a developing country increased from 55% to 71%. However, in the African Region, the proportion of such publications was about 10%. Most of the publications related to major vaccine clinical trials and did not focus on research. In the South-East Asia Region, the number of studies published rose from seven to nine, and in the Eastern-Mediterranean Region the target of two publications with developing country authorship was met. In the Western Pacific Region, all the publications supported by the regional office came 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; the African Network for Drugs and Diagnostics Innovations became a legal entity in October 2010 through a Memorandum of Understanding between WHO and the United Nations Economic Commission for Africa. The African Network promotes and supports the development of regional networks with the aim of stimulating product innovations in disease endemic countries. Regional reference training centres for training local researchers and research managers in good research practices are being established. ■

In the Western Pacific Region, small grants were used to support new researchers in resource-constrained Member States, and to encourage operational research on neglected tropical diseases. During the past four years, the Special Programme for Research and Training in Tropical Diseases funded the research fellows who manage and coordinate the scheme and those positions have been extended for a further year. The three studies that received funding in 2009 were completed, and in 2010, small grants were awarded to four research projects on: viral infections, including dengue in the aetiology of febrile seizures in children in Papua New Guinea; morbidity due to *Opisthorchis viverrini* in Lao People's Democratic Republic; sero-prevalence of major bovine-associated infectious diseases also in Lao People's Democratic Republic; and empowering village health workers to promote integrated community-based control of food-borne trematodes among indigenous populations in the Philippines. Two other studies on immunodeficiency-related vaccine-derived poliovirus in China and the Philippines focused on strategy development and programmatic gaps and sought to establish the prevalence of prolonged and chronic poliovirus excretion among persons with primary immune deficiency disorders in middle- and low-income countries. The studies explored the extent to which persons with primary immune deficiency disorders could serve as potential reservoirs for vaccine derived polioviruses and subsequent poliomyelitis outbreaks in countries with low population immunity. Technical assistance was provided to the Pacific Island countries and Philippines, which exposed the need for operational research into leprosy. A lack of funding and human resources prevented any activities being carried out.

In the Eastern Mediterranean Region, three projects dealing with leishmaniasis were awarded small grants: two of them evaluated new regimens for anthroponotic cutaneous leishmaniasis in Iran (Islamic Republic of Iran), and the third was a multi-country study on the impact of insecticide resistance on prevalence of the disease in Egypt, Iraq and the Syrian Arab Republic. Other successful proposals were: epidemiological studies on hepatitis and filariasis in Yemen and Egypt, respectively; evaluating the impact of community-based vector control interventions on dengue; and evaluating new diagnostic tools for schistosomiasis and Crimean Congo haemorrhagic fever in Egypt and Iran (Islamic Republic of), respectively.

In the South-East Asia Region, nine research projects in Bangladesh, India and Nepal received small grants from the Special Programme for Research and Training in Tropical Diseases. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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	ON TRACK
1.5.2 Proportion of peer-reviewed publications based on WHO-supported research where the main author's institution is in a developing country	ON TRACK

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.

AT RISK

Overall, the progress made at national and regional level to achieve the minimum core capacities required by the International Health Regulations (2005) was satisfactory, although meeting the June 2012 deadline is likely to be challenging for Member States. There needs to be a balance between advocacy for institutionalizing key public health functions, activities to support specific technical areas of work, and ensuring visibility.

A global monitoring system was developed and implemented: 128 countries reported undertaking activities that would enhance their capacity to contribute to global networks for epidemiological surveillance and response to diseases and public health risks and emergencies under the International Health Requirements (2005).

Progress was made in updating the following: integrated disease surveillance and response in the African Region; the Asia Pacific Strategy for Emerging Diseases in the South-East Asia and Western Pacific Regions; and the emerging infectious disease strategy in the Eastern Mediterranean Region. In the African Region, seven more countries (Ethiopia, Malawi, Mozambique, Nigeria, South Africa, Swaziland and the United Republic of Tanzania) received support to assess and develop their core capacity in the context of the International Health Regulations (2005) implementation plan. In the Region of the Americas, Organization-wide expected result 1.6 was reported as “at risk” because indicator 1.6.1 had not been achieved. However, as a result of the consultation on harmonizing International Health Regulations (2005) implementation monitoring activities in the Region, which will help in determining the workplan for the next three to five years, and the current involvement of the Mercosur countries, by the end of 2011, the target should be achievable. In the South-East Asia Region, five more countries, (Bhutan, Democratic People’s Republic of Korea, India, Myanmar and Sri Lanka) are expected to achieve the target during 2011. In the Eastern Mediterranean Region, delays in implementing some planned activities resulted in the Organization-wide expected result being rated as “at risk”. However, pandemic (H1N1) 2009 prompted the convening of an intercountry meeting to evaluate the overall functioning of the International Health Regulations (2005), as well as countries’ capacity in terms of diagnosis, surveillance, response and communication. As a result, and combined with actions taken by the Regional Office, the targets should be reached during 2011. In the Western Pacific Region, assessments were carried out using the Asia Pacific Strategy for Emerging Diseases checklists in 15 Member States, and 10 countries went on to develop national plans that comply with the Strategy. All 27 Member States have designated national focal points under the International Health Regulations (2005), among whom about 20 indicated they had had full access to the WHO Event Information Site (EIS) for IHR National Focal Points during the pandemic of influenza A(H1N1) 2009.

In the European Region, the number of capacity building activities associated with the International Health Regulations (2005) was lower than planned owing to financial constraints. Funding gaps affecting such activities in countries were discussed with potential donors and the detection process improved through the updating of the International Health Regulations (2005) Annex II guidelines. ■

WHO engaged with international partners, including the European Centre for Disease Prevention and Control, Food and Agriculture Organization, International Atomic Energy Agency, International Air Transport Association, International Civil Aviation Organization, International Committee of the Red Cross, International Maritime Organization, International Society of Travel Medicine, World Organization for Animal Health, United Nations Office for the Coordination of Humanitarian Affairs, United Nations World Tourism Organization, United States Centers for Disease Control and Prevention and the World Trade Organization, in implementing the International Health Regulations (2005). Good working relations have been established with United Nations organizations, regional organizations and international agencies dealing with transport and travel, and common guidelines published.

Support was provided in the form of global and regional projects on quality systems, human resource strengthening and networks for sharing resources, knowledge and expertise, including projects on the External Quality Assurance Program in 46 African countries and 20 in the Eastern Mediterranean Region. Among the countries supported in the African Region, 20 received an optimal performance rating for meningitis and enteric pathogen. In the South-East Asia Region, in addition to the baseline of seven countries (Bangladesh, Democratic People's Republic of Korea, India, Indonesia, Nepal, Sri Lanka and Thailand), Bhutan and Timor Leste also achieved the target in 2010. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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 RISK
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	AT RISK

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.

ON TRACK

WHO continued to support international and regional specialist networks, including the Global Influenza Surveillance Network, networks for infection control, clinical management and natural ventilation, the emerging and dangerous pathogens laboratory network, international coordinating groups for vaccine provision for meningitis and yellow fever, the Smallpox Laboratory diagnostic Network, the Meningitis Environmental Risk Information Technologies (MERIT) initiative, global communities of practice, and the Asia Pacific Strategy for Emerging Diseases, and new initiatives are under development for leptospirosis and rickettsiosis. Such networks can be scaled up in emergencies. For instance, during and after pandemic (H1N1) 2009, the Global Influenza Surveillance Network and influenza epidemiological, clinical and modelling networks were used to create a global picture of influenza activity. The weekly collation, analysis and reporting by WHO of global epidemiological, virological and clinical influenza surveillance data provided up-to-date information on the evolving situation.

Building capacity to maintain global health security continued in several regions, including through the preparation of training modules and standard operating procedures for rapid response team members, and of regional rapid response databases. In some regions, specific situations required specially tailored responses, such as training in line with the Asia-Pacific dengue control strategy. In the Eastern Mediterranean Region, a masters degree programme in Gezira, Sudan, supported by the regional office, is now in its third year and recent graduates are expected to boost regional capacity in medical entomology and vector control. With the first group of graduates in a similar course in Pakistan, a total of 72 people are now trained to postgraduate level. Headquarters collaborated with the Regional Offices for the Eastern Mediterranean and South-East Asia in training health case workers from Saudi Arabia, Sudan and Yemen in controlling dengue fever and dengue hemorrhagic fever.

Member States are better prepared to respond to threats that could put health security at risk. Support was provided to ensure and inform functional and integrated preparedness guidance, prevention and response, as well as to build the capacity needed to deal with epidemic and pandemic prone diseases, including pandemic influenza (141 Member States prepared plans), chikungunya, cholera and dengue. The Regional Office for the Eastern Mediterranean provided technical support to the health authorities in Saudi Arabia during the Hajj 2010 in order to strengthen field surveillance for influenza and other epidemic-prone respiratory infections circulating during mass gatherings.

In order to combat specific epidemic prone diseases, stocks of personal protective equipment, Tamiflu and laboratory supplies were amassed in several regions. Progress was made in yellow fever prevention and control in the African Region as a result of co-ordinated preventive and outbreak response campaigns. In the Region of the Americas, detection of epidemic-prone viral pathogens for yellow fever and flavivirus in Member States located in endemic areas improved, and work is continuing to maintain the gains made. Interventions and control strategies for dengue are on track, however, environmental and climatic factors are contributing to endemoepidemic transmission patterns.

Finally, as directed under resolution WHA60.1 on Smallpox eradication: destruction of variola virus stocks, WHO completed a major review of the current research on variola virus that included a scientific review of variola virus research and a review by an advisory group of independent experts, through the Advisory Committee on Variola Research. The resulting reports will be used by the Sixty-fourth World Health Assembly when considering destruction of the remaining variola virus stocks. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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	ON TRACK
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	ON TRACK
1.7.3 Number of severe emerging or re-emerging diseases for which prevention, surveillance and control strategies have been developed	ON TRACK

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.

AT RISK

All WHO major offices reported carrying out successful coordinated, collaborative action for detecting, verifying, assessing and responding to public health risks through strengthened systems and cooperation with national focal points for the International Health Regulations (2005). Epidemic information products were produced and shared regularly in most regions.

In the European Region, an all-hazards, event-based crisis management framework is being used to draw lessons from across WHO's operational spectrum in order to develop a harmonized system for hazard detection, assessment and response.

Introduction of the global event-management system is on track to exceed the indicator target, with 481 users at 148 WHO sites at country, regional and headquarters level; integration of headquarters and regional operations centres is proceeding.

The global event-management system has been introduced in 148 WHO sites, including 110 where WHO staff received briefing or training. Additional training sessions are planned for the Eastern Mediterranean Region. Organization-wide expected result 1.8 is rated as "at risk" because uptake of the global event-management system remains uneven across the regions. Sites include headquarters, regional offices, sub-regional offices and country offices, and are distributed as follows: headquarters 20, Regional Office for the Americas 27, Regional Office for Africa 47, Regional Office for the Eastern Mediterranean 2, Regional Office for Europe 34, Regional Office for South-East Asia 2; and Regional Office for the Western Pacific 8. In 2010, within the ambit of the event-management system, 364 events were jointly assessed as public health risks. In addition, 83 event postings appeared on the event information site for International Health Regulations (2005) national focal points, and more than 80 event updates were made public through the disease outbreak news portal on the WHO web site.

Risk assessment training courses focusing on key concepts of public health risk management, event risk assessment and the prioritization of risks, and all-hazard risk assessment, were held in Indonesia, Japan, Malaysia and New Zealand.

The Global Outbreak Alert and Response Network carried out operations relating to the leptospirosis outbreak in the Philippines, cholera in Papua New Guinea, and the response to pandemic (H1N1) 2009. Regional meetings and workshops that received support in 2010, included: the annual regional meeting of Global Outbreak Alert and Response Network partners from the Western Pacific, held in Cambodia; regional training workshops conducted in Brazzaville and Beirut; the development, in partnership with the Regional Office for the Western Pacific, of a Global Outbreak Alert and Response Network course on training facilitators; and pilot field training courses in the Philippines and Malaysia. Institutions from Russian speaking countries are being identified for Network membership. Specialized operational support for the management of mass gatherings was provided, inter alia, to Brazil, Poland and Ukraine, Saudi Arabia and South Africa for major sporting events.

Global standards for emergency event management were developed, including a common set of objectives and strategies for regional and country offices during crises, and a functional model for an all-hazards approach for emergency operations centres. Numerous preparedness exercises were conducted in headquarters and co-conducted at country level. Regional strategic health operations centres have been established in the African, Eastern Mediterranean and Western Pacific Regions, while those in the European and South-East Asia Regions are undergoing redesign and a systems upgrade, respectively.

Despite the indicator target being on track, the Organization-wide expected result was assessed as "at risk" because adoption of the event-management system was uneven across the regions and financial pressures continued to mount. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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

ON TRACK

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

ON TRACK

All Member States' requests for assistance were answered either through WHO technical and logistics resources or the Global Outbreak Alert and Response Network mechanism for providing international technical expertise. In 2010, outbreak response and country support actions were carried out in connection with: widespread pandemic influenza; dengue in Cape Verde, Central America, Philippines, Sudan and Yemen; suspected viral haemorrhagic fevers in Democratic Republic of Congo and Uganda; cholera in Cambodia, Haiti, Lao People's Democratic Republic and Papua New Guinea; Rift valley fever in South Africa; Crimean Congo haemorrhagic fever in Kazakhstan; dengue, Crimean Congo haemorrhagic fever and cholera in Pakistan; meningitis and yellow fever in Cameroon, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of Congo, Ghana, Guinea, Niger, Nigeria and Sudan; and plague in Peru. WHO also supported Member States in their response to noncommunicable disease threats, including environmental threats, such as lead poisoning in Nigeria and a chemical spill in Hungary.

Influenza preparedness and response capacity was maintained and enhanced for both seasonal outbreaks and pandemic (H1N1) 2009. In 2010, WHO provided comprehensive risk assessments for several unusual events related to zoonotic influenza in collaboration with Food and Agriculture Organization and the World Organization for Animal Health in order to guide the response. Specific guidance and capacity building were provided to Member States to facilitate the detection of novel influenza viruses with pandemic potential, and to treat severe cases in low-resource settings. Progress was made in increasing influenza vaccine production in developing countries; three manufacturers licensed influenza vaccine in 2009–2010.

Headquarters supported the Organization's response to the influenza pandemic by: monitoring and tracking the disease through the Global Influenza Surveillance Network and influenza epidemiological, clinical and science and knowledge networks; generating evidence-based tools and guidelines for effective interventions; supporting countries through training courses, workshops and capacity-building initiatives; accelerating access to vaccines and antiviral medications; and providing global leadership, in collaboration with other United Nations agencies, civil society and nongovernmental organizations. ■

PERFORMANCE INDICATORS

CURRENT STATUS

1.9.1 Proportion of Member States' requests for assistance 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

ON TRACK

SUMMARY OF FINANCIAL IMPLEMENTATION

(AS AT 31 DECEMBER 2010)

The approved budget for strategic objective 1 was US\$ 1268 million, of which US\$ 542 million are for base programmes, US\$ 626 million for special programmes and collaborative arrangements and US\$ 100 million for outbreak and crisis response. The outbreak and crisis response budget segment was increased to US\$ 531 million in 2010, primarily to accommodate in-kind vaccine contributions to the Organization's response to pandemic (H1N1) 2009.

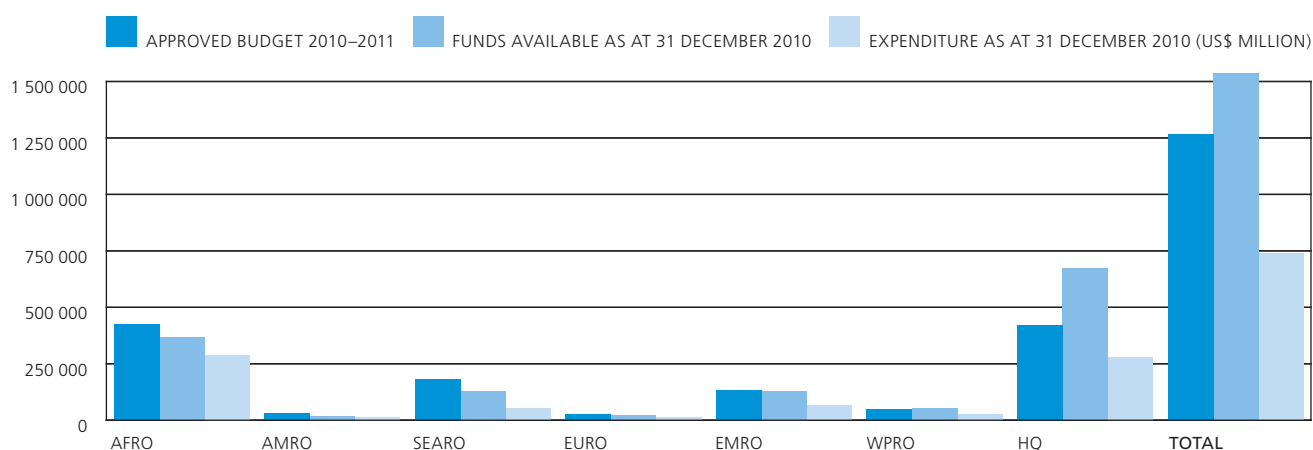
For strategic objective 1, globally, US\$ 1535 million were available by the mid-term, of which US\$ 319 million have been distributed to base programmes, US\$ 733 million to special programmes and collaborative arrangements and US\$ 481 million to the outbreak and crisis response segment. A total of US\$ 148 million had not been distributed as of 31 December 2010. Strategic objective 1 is relatively well resourced, with funding available equal to 121% of the approved budget and 85% of the currently approved budget, after the increase in the budget for the outbreak and crisis response segment mentioned above, but this available funding is uneven across segments. The funds available include more than US\$

319 million in in-kind contributions, which have been implemented through vaccine deliveries, but as of 31 December 2010 only US\$ 100 million had been paid out. A discussion is ongoing on the value of showing the implementation of outbreak and crisis response in-kind vaccine contributions across major offices, which would result in a shift of 65% of the expenditures and their associated budget ceiling from headquarters to regional offices.

Available funding for base programmes is only 59% of the approved budget for base programmes, while the highly specified special programmes and collaborative arrangements and outbreak and crisis response segments are funded at 117% and 481%, respectively, of the approved budget for special programmes and collaborative arrangements and outbreak and crisis response. This limits the ability to reallocate funds within the strategic objective.

Most areas face challenges in raising sufficient resources to complete planned activities, and further reductions in planned costs and activities are anticipated in 2011, especially in the light of carry forward requirements for the next biennial workplan. ■

2010–2011 (US\$ 000)		AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	TOTAL
Approved programme budget 2010–2011		424 120	30 450	180 357	28 560	134 357	48 485	422 024	1 268 353
Funds available as at 31 December 2010 ^a	AC	16 322	8 455	7 237	1 641	7 266	6 507	25 205	72 633
	VC	348 977	9 373	122 743	20 319	123 243	45 286	645 750	1 462 226
	TOTAL	365 299	17 828	129 980	21 960	130 509	51 793	670 955	1 534 859
Funds available as % of approved budget		86%	59%	72%	77%	97%	107%	159%	121%
Expenditure as at 31 December 2010		288 386	13 437	51 963	11 233	65 245	27 423	279 554	737 243
Expenditure as a % of approved budget		68%	44%	29%	39%	49%	57%	66%	58%
Expenditure as a % of available funds		79%	75%	40%	51%	50%	53%	42%	48%



^a Total funds available includes US\$ 147 million of funds which were undistributed as of 31 December 2010.

PRIORITY RESULTS FOR 2011

All levels of the Organization recognize the importance of cost and efficiency savings through careful prioritization of activities and scrutiny of cost factors, including travel expenses. Enhanced resource mobilization efforts are planned at every level.

WHO will accord priority to sustaining the progress made in achieving vaccine-preventable disease objectives, particularly for poliomyelitis, measles, and rubella. Globally, WHO recognizes the important challenges that exist in reaching the national core capacity targets established by the International Health Regulations (2005). All levels of the Organization will give priority to deepening integration across headquarters and country and regional offices for the purposes of identifying events, assessing risk and managing response operations – primarily under Organization-wide expected result 1.8. The South-East Asia and Western Pacific Regions will continue to implement the Asia-Pacific Strategy for Emerging Diseases.

In the area of immunization and vaccination, WHO will continue to serve as technical and programmatic lead of the Measles Initiative in order to achieve the target of a 95% reduction in the mortality rate by 2015, as considered by the Sixty-third World Health Assembly (A63/18). In addition, WHO will maintain and ensure the availability and use of high quality programmatic and epidemiological data, will promote the development and implementation of new strategies to increase routine immunization coverage and equity, will support regions in meeting established quality indicators for the surveillance of vaccine preventable diseases and will strengthen country decision-making systems and processes, and prepare them for the successful and sustainable introduction of new and underused vaccines. The Secretariat will also support the development of priority vaccines and technologies for developing countries through partnerships involving vaccine manufacturers in developing countries and will generate evidence to inform policy recommendations on the introduction and use of new and underused vaccines.

Funding priority will be given to the implementation of the poliomyelitis eradication strategy; global monitoring and evaluation processes; and resource mobilization, in that order. The first is critical for interrupting wild poliovirus transmission, and the second for the optimal targeting of technical support in a cost-effective manner. At the activity level, priority, in terms of financing, will be given to surveillance and mopping up activities, oral polio vaccine campaigns in infected/endemic areas, field security, meetings of the newly-established independent monitoring board and resource mobilization. WHO, will implement a 10–15% cut across the board in operational costs of acute flaccid paralysis surveillance, for example, by deferring capital investments and reducing the frequency of active surveillance field visits and will reduce high fixed costs of the Global Polio Eradication Initiative infrastructure by freezing vacant posts, reducing peripheral, and, where possible,

central, fixed-term staff positions not directly involved in the priority areas identified above. Finally, the number, frequency and geographic scope of polio campaigns in at-risk countries will also be reduced.

Priorities in the area of neglected tropical diseases, will include intensified implementation of activities by countries, for example, preventive chemotherapy in targeted countries and innovative and intensive disease management of specific diseases. WHO will consolidate existing neglected tropical disease partnerships.

WHO will identify synergies between surveillance strengthening initiatives in the contributions to the Organization-wide expected result 1.4, for example, training, network and tools development. Training in connection with the Early Warning Alert and Response Network for emergencies will also be a major priority.

Under Organization-wide expected result 1.5 on tropical diseases research, the priority will be to integrate eco-bio-social strategies in vector management of dengue and Chagas' disease by 2013, to ensure that clinical data on macrofilaricide drug (moxidectin) development for onchocerciasis eradication are available by 2016. In addition, WHO will develop a comprehensive framework for increasing access to quality assured syphilis rapid diagnostic tests to ensure their integration into national control programmes in Brazil, China, Haiti, Peru, Uganda, United Republic of Tanzania and Zambia as well as a comprehensive package of interventions and delivery strategies to support the elimination of visceral leishmaniasis in the Indian sub-continent by 2014. The Secretariat will also focus on work to generate evidence on community directed approaches to support primary health care by 2013.

The Special Programme for Research and Training in Tropical Diseases is undergoing a restructuring process that includes: reducing its budget from US\$ 100 million in 2010–2011 to US\$ 70 million in 2012–2013; prioritizing key results; reviewing its structure and processes in order to improve efficiency; merging units where appropriate to increase synergies and reduce the number of coordinators; adapting post descriptions; and reducing personnel costs as a proportion of total programme costs by about 30%.

Priorities under Organization-wide expected result 1.6 on International Health Regulations (2005) include identification of priority countries with the most vulnerable health systems for support in implementing the International Health Regulations (2005) and assessment of all International Health Regulations (2005) activities in order to identify duplication. ■

In the area of influenza and epidemic/emergency preparedness and response WHO will focus on maintenance of global influenza surveillance and revision of the pandemic preparedness guidelines, development and implementation of new strategies to combat influenza, prevention and control epidemic and pandemic prone infections in health-care settings. WHO will provide vaccines for yellow fever and meningitis in emergencies. Priority activities that support the Global Action Plan to increase influenza vaccine supply and follow up the findings of the Open Ended Working Group of Member States on pandemic influenza preparedness will receive re-programmed funds from United States Agency for International Development and the German Development Agency.

The Secretariat will ensure coordinated responses to epidemics, strengthen the global event-management system, Organization-wide standard operating procedures and the Global Outbreak Alert and Response Network, will further develop the common operations platform for responding to all public health and humanitarian emergencies.

Synergies and savings will be achieved by working with other programmes on surge capacity, stockpiling, training, field deployment, standard operating procedures and the Strategic Health Operations Centre.

Priorities under Organization-wide expected result 1.9 on epidemic and pandemic prone diseases include provision of support to national authorities in evaluating their specific zoonoses surveillance and control programmes, and promote the integration of such programmes in both animal and human health system.

Funding from United States Agency for International Development and the German Development Agency will be allocated to antimicrobial resistance and related programmes. Resolution WHA63/18 on Viral hepatitis will be supported by re-programmed funding from United States Agency for International Development and the German Development Agency. Finally activities being carried out under the auspices of the Mediterranean Zoonoses Control Programme will be incorporated within existing WHO programmes. ■

IDENTIFICATION OF SPECIFIC ACTIVITIES AND RESULTS THAT WILL BE REDUCED OR NO LONGER DELIVERED

Under Organization-wide expected result 1.1, support for routine immunization programme development in countries that are not eligible for funding from the Global Alliance for Vaccines and Immunisation will decline in line with an overall reduction in funding for the area. Lower middle-income countries and middle-income countries that are on the verge of expanding their immunization programmes will mainly be affected. Such countries are already lagging behind those that are fully funded by the Global Alliance for the introduction of new vaccines.

The reduction or suspension of funding for strengthening immunization services from the Global Alliance for Vaccines and Immunisation means that outreach and pulse vaccination activities in eligible countries will be reduced in number or cancelled, increasing the difficulty of addressing programmatic efficacy and transition issues.

Revision of the immunization programme review methodology will be postponed because of a lack of funding for designing and piloting new methodologies. As a result, countries will have to rely on outdated methodologies that exclude key issues, such as evaluation of new vaccines and sustainable financing.

For Organization-wide expected result 1.2 on poliomyelitis, all the expected results are crucial to poliomyelitis eradication, but achievement of some will have to be deferred. Therefore, some activities connected with post-eradication planning and policy development, research and eventual bio-containment of polio viruses might not be achieved.

In the area of tropical diseases research, direct funding of drug discovery by the Special Programme for Research and Training in Tropical Diseases will be reduced and promising leads and project leads transferred to other partners. Emphasis will be placed on utilizing existing capacity and partnerships to establish regional networks to foster innovation, and, where possible, to transfer projects to those networks. A number of diagnostics evaluation studies will be abandoned. Dedicated advisory groups on the development of vaccines against enteric diseases and other vaccines of public health importance will not be maintained or created.

Under Organization-wide expected result 1.6 on International Health Regulations (2005), the number of priority countries will be reduced .

In the area of epidemic/emergency preparedness and response, specialist networks for clinical management, modelling, infection control and diagnostics will be aligned or merged within programmes under the Organization-wide expected result. In addition, influenza training materials and support countries in providing home-based and community care will be developed and laboratory training connected with influenza to WHO collaborating centres will be outsourced.

For Organization-wide expected 1.9 on epidemic and pandemic prone diseases, a shortage of funding will mean that leadership training for 231 professional staff will not be available and two key posts will not be filled. The Mediterranean Zoonoses Control Centre will be closed. ■

SO2

TO COMBAT HIV/AIDS, TUBERCULOSIS AND MALARIA



PROGRESS TOWARD THE ACHIEVEMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

OF THE SIX ORGANIZATION-WIDE EXPECTED RESULTS FOR THIS STRATEGIC OBJECTIVE, FOUR WERE "ON TRACK" AND TWO "AT RISK"

OVERVIEW

During 2010, WHO and its main partners, through increased support, enabled Member States to gain access to new diagnostics, medicines and other products, and innovative approaches for the prevention, diagnosis and treatment of HIV, tuberculosis and malaria in order to reach more people at risk worldwide. In *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector: progress report 2010*, Global tuberculosis control: WHO report 2010 and the World malaria report 2010, WHO presented the latest data on all three epidemics and the nature, scale and impact of the response.

In monitoring the HIV/AIDS epidemic, in 2010, WHO reported on recent progress made in extending HIV care in 144 countries. Fifteen countries provided more than 80% of HIV-positive pregnant women with services and medicines to prevent mother-to-child transmission of HIV; 14 countries offered treatment to more than 80% of HIV-positive children; and eight countries achieved the target of universal access to antiretroviral treatment for adults. Preventing HIV transmission in most-at-risk populations, such as sex workers, drug users and men who have sex with men, continued to present a significant challenge. A total of 23 HIV policy and technical documents covering prevention, treatment and care were prepared or updated in 2010, including a core set of guidelines on antiretroviral therapy for adults and children, prevention of mother-to-child transmission, infant feeding, and HIV and tuberculosis coinfection. Headquarters and all regional offices collaborated with partners to prepare the Global Health Sector Strategy for HIV/AIDS 2011–2015, which will be considered by the Sixty-fourth World Health Assembly. The Regional Offices for the Eastern Mediterranean and Europe have already developed regional strategies in line with the global approach. The new strategy and guidelines set an ambitious course for 2011 and the next biennium. However, it is feared that some of the momentum may be lost if funding is further restricted at a time when capacity needs to be expanded in order to implement guidance on prevention, treatment and care.

In monitoring tuberculosis in 2010, using data supplied by 192 countries, WHO reported that the success rate for treating tuberculosis had reached its highest level and that incidence worldwide was estimated to be declining, that mortality from tuberculosis had fallen by 35% since 1990, and that six million lives had been saved between 1995 and 2010 as a result of tuberculosis care policies. Advances were made in testing people infected with HIV for tuberculosis, and in caring for people with tuberculosis and HIV. Nevertheless, some cases of tuberculosis remain undetected or are detected late, incidence of the disease is declining too slowly, and the global response to multidrug-resistant tuberculosis is inadequate. Only 12% of the estimated number of patients suffering from multidrug-resistant tuberculosis were diagnosed and notified. In 2010, WHO carried out a scientific review of a new diagnostic test that could revolutionize tuberculosis care and control by speeding up diagnosis, thereby reducing transmission and allowing earlier access to treatment, especially for people with multidrug-resistant tuberculosis and tuberculosis and HIV coinfection. Following its endorsement, WHO is working with partners to rapidly expand access to the test. The WHO report, *Multidrug and extensively drug-resistant TB (M/XDR-TB): 2010 global report on surveillance and response*, includes data from 114 countries.

To prevent malaria, in the African Region, 289 million insecticide treated mosquito nets were distributed and a total of 75 million people were protected by indoor residual spraying. Some 42 countries worldwide reported a 50% or higher reduction in the number of cases and deaths since 2000; two countries were certified to be free of malaria in 2010; and the European Region reported having no locally transmitted cases. However, resurgences of malaria were reported in three African countries and the emergence of artemisinin resistance continued to cause concern. 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 therapy. A new policy recommendation was issued on universal diagnostic testing of suspected malaria prior to treatment by either quality microscopy or a rapid diagnostic test. WHO released the *Global report on antimalarial drug efficacy and drug resistance: 2000–2010*, and developed, with more than 100 stakeholders, a global plan for artemisinin resistance containment. A second edition of *Malaria rapid diagnostic test performance* was issued. Other areas given priority included revitalizing vector control, enhancing case management capacity, and increasing the rational use of drugs while extending access.

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. ■

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.

AT RISK

The strategic objective includes targets for implementation of policies recommended by WHO, as well as for their adoption. WHO is on track in the development and updating of prevention, treatment and care guidelines and guidance on disease prevention and control. However, the strategic objective sets ambitious targets for some disease response indicators, especially in the light of the new guidelines for HIV/AIDS and the inherent challenges in implementing drug-resistant tuberculosis management programmes in high-burden settings. Progress continued to be made in the adoption of policies on malaria and tuberculosis.

All regions disseminated and promoted the new guidelines at country level. However, as a result of changes in the guidance on HIV treatment and ensuing increase in the number of people in need, it is expected that the level of coverage achieved in 2009 will not be surpassed until after 2011, which explains the “at risk” rating. Similarly, despite the scaling up of multidrug-resistant tuberculosis management programmes in many of the 27 countries with a high burden of disease, only a limited number of them made treatment available to an extent that would enable the 2013 targets to be met. It is expected that efforts will be accelerated in 2011–2013, but inadequate domestic and global funding remains a major obstacle. ■

PERFORMANCE INDICATORS	CURRENT STATUS
2.1.1 Number of low- and middle-income countries that have achieved 80% coverage for antiretroviral therapy and the prevention of mother-to-child transmission services	AT RISK
2.1.2 Proportion of endemic countries that have achieved their national intervention targets for malaria	ON TRACK
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	ON TRACK
2.1.4 Number of countries among the 27 priority ones 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 estimated cases of multidrug-resistant tuberculosis	AT RISK
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	AT RISK

2.2 Policy and technical support provided to countries towards expanded gender-sensitive delivery of prevention, treatment 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.

ON TRACK

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. 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. Higher priority was accorded to interventions against tuberculosis and HIV coinfection, such as improved testing for HIV among tuberculosis patients, in countries with a high burden of disease, including in the African Region. But despite an increased level of commitment to screening people living with HIV for tuberculosis and providing preventive therapy, progress in that area was slower. WHO's ability to respond to growing demands arising from new recommendations is being adversely affected by a shortage of human resources, especially in the African Region. ■

PERFORMANCE INDICATORS	CURRENT STATUS
2.2.1 Number of targeted Member States with comprehensive policies and medium-term plans in response to HIV, tuberculosis and malaria	ON TRACK
2.2.2 Proportion of high-burden countries monitoring provider initiated HIV testing and counseling in sexually transmitted infection and family planning services	ON TRACK
2.2.3 Number of countries among the 63 ones 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	ON TRACK

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.

ON TRACK

WHO continued to respond to the growing number of requests for support in assessing, prequalifying and gaining access to medicines and diagnostics in collaboration with, inter alia, the AIDS Medicines and Diagnostic Service, the Global Drug Facility, the Stop TB Partnership's Global Laboratory Initiative, the Medicines for Malaria Venture, Roll Back Malaria, the Foundation for Innovative New Diagnostics and the Global Fund to Fight AIDS, Tuberculosis and Malaria. ■

PERFORMANCE INDICATORS	CURRENT STATUS
2.3.1 Number of new or updated global norms and quality standards for medicines and diagnostic tools for HIV/AIDS, tuberculosis and malaria	ON TRACK
2.3.2 Number of priority medicines and diagnostic tools for HIV/AIDS, tuberculosis and malaria that have been assessed and pre-qualified for United Nations procurement	ON TRACK
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)	ON TRACK
2.3.4 Number of Member States implementing quality-assured HIV/AIDS screening of all donated blood	ON TRACK
2.3.5 Number of Member States administering all medical injections using sterile single use syringes	ON TRACK

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.

ON TRACK

2010 saw the publication of *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector: progress report 2010*, *Global tuberculosis control: WHO report 2010* and the *World malaria report 2010*. The reports contain routinely collected data and survey findings on the three diseases from a wide range of Member States. Despite stepping up capacity building and technical support for all three diseases in the African Region, including for drug resistance surveillance, the size of the disease burden and weakness of national health systems hampered the ability of the Regional Office to provide quality-assured data on time. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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 **ON TRACK**

2.4.2 Number of Member States reporting drug resistance surveillance data to WHO for HIV/AIDS, tuberculosis or malaria **ON TRACK**

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.

ON TRACK

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 the chances of Member States in achieving the targets set out in the Medium-term strategic plan 2008–2013, as well as the Millennium Development Goals. WHO continued to build the capacity of those applying for Global Fund Round 10 grants, including national disease control programmes. As a result, financing was made available for increasing universal access to services and strengthening pandemic control. A reduction in financial and human resources during the second half of the biennium means that WHO is having to re-set its priorities with regard to partnerships. ■

PERFORMANCE INDICATORS

CURRENT STATUS

2.5.1 Number of Member States with functional coordination mechanisms for HIV/AIDS, tuberculosis and malaria control

ON TRACK

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

ON TRACK

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.**

AT RISK

In general, increased support for research and knowledge management led to the development and adoption of new disease prevention and control strategies, and support for new tools surpassed the initial targets. WHO and the Special Programme for Research and Training in Tropical Diseases, with numerous partners, published the evidence-based results of clinical, epidemiological and operational research. However, the Organization-wide expected result is deemed to be at risk because the Regional Offices for Africa and South-East Asia reported that research was being hampered as a result of inadequate financial and human resources. ■

PERFORMANCE INDICATORS

CURRENT STATUS

2.6.1 Number of new and improved tools or implementation strategies for the prevention and control of HIV/AIDS, tuberculosis or malaria implemented by the public sector in at least one developing country	ON TRACK
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	ON TRACK

SUMMARY OF FINANCIAL IMPLEMENTATION

(AS AT 31 DECEMBER 2010)

The approved budget envelope of US\$ 634 million is composed of US\$ 556 million for base programmes and US\$ 78 million for partnerships and collaborative arrangements.

As at 31st December 2010, US\$ 480 million were available in the form of assessed contributions (US\$ 39 million or 8% of total available funding) and voluntary contributions (US\$ 440 million or 92% of available funding).

A total of US\$ 179 million of available resources at the end of 2010 was under special programmes and collaborative arrangements, reflecting agreements with donors under partnership arrangements. With projected expenditure of US\$ 145 million, planned activities under special programmes and collaborative arrangements can count on sufficient carry-over funds for the beginning of the 2012–2013 biennium.

With US\$ 300 million of resources being mostly highly specified, the financial situation for base programmes under the strategic objective across the Organization will be more challenging during the remainder of the current biennium and carry over at the beginning of the next biennium will be limited. As at December 2010, programmes under the strategic objective in the African and European Regions projected a financial gap of about 20% of their projected expenditures for the biennium. Both offices have adjusted their structure and staffing level in order to address the situation.

Other major offices that had adjusted their staffing level in previous years are expected to break even, with a small percentage of funds being available for carrying over.

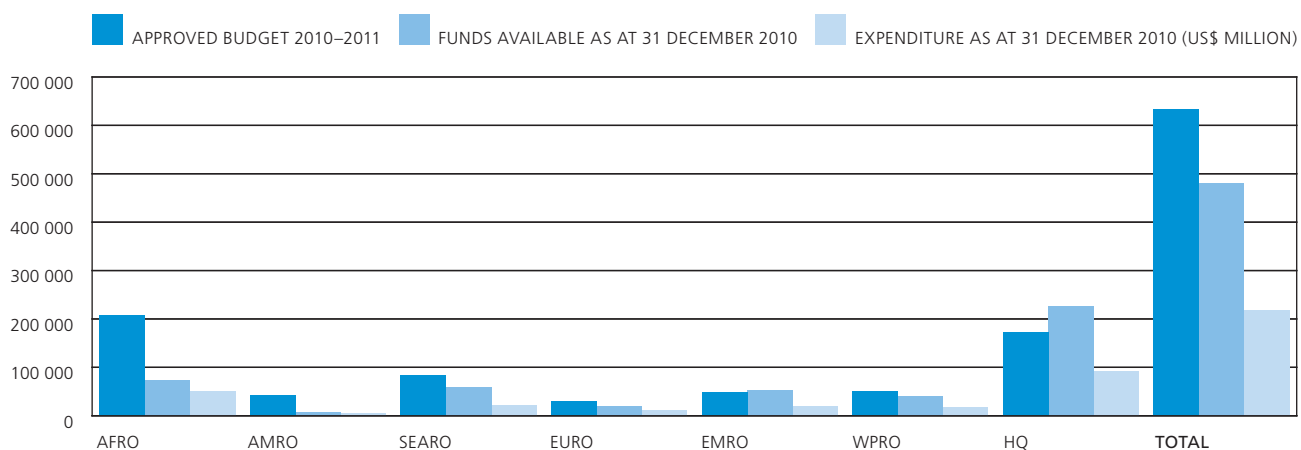
Headquarters' figures, include special programmes and collaborative arrangements, such as the Stop TB Partnership and the Special Programme for Research and Training in Tropical Diseases, which account for 45% of the total.

The focus continued to be on a fair re-distribution of funds between headquarters and major offices. Over 70% of the resources for base programmes, 80% of the resources for assessed contributions and 95% of the resources for fully flexible funding are distributed at regional and country level.

With resources for base programmes under the strategic objective at 50% of their 2006–2007 level and often earmarked for specific activities, a strategic review and reorganization need to be carried out in order to allow core functions to be fulfilled and progress made towards achieving targets within the projected available resources.

With a projected carry over for the next biennium of only a few per cent, all programmes and offices are making further adjustments in preparation for funding restrictions in 2012. ■

2010–2011 (US\$ 000)		AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	TOTAL
Approved programme budget 2010–2011		208 208	41 449	83 461	29 755	47 540	50 526	172 941	633 880
Funds available as at 31 December 2010	AC	9 161	2 760	6 422	1 627	3 849	4 844	11 454	40 117
	VC	64 590	4 852	53 004	18 077	49 504	34 922	215 171	440 122
	TOTAL	73 751	7 612	59 426	19 704	53 353	39 766	226 625	480 239
Funds available as % of approved budget		35%	18%	71%	66%	112%	79%	131%	76%
Expenditure as at 31 December 2010		51 246	4 324	22 309	10 365	19 396	18 391	91 265	217 297
Expenditure as a % of approved budget		25%	10%	27%	35%	41%	36%	53%	34%
Expenditure as a % of available funds		69%	57%	38%	53%	36%	46%	40%	45%



PRIORITY RESULTS FOR 2011

WHO will give priority to maintaining WHO's core functions, foster strategic partnerships within and outside the Organization in order to exploit any comparative advantage, avoid duplication and increase efficiency. The Secretariat will continue resource mobilization in close cooperation with donors and partners to ensure reliable funding and minimize funding gaps as well as with the implementation of contingency measures at all levels.

WHO will scale up technical support and capacity building for the prevention, diagnosis and treatment of HIV/AIDS, tuberculosis and malaria in countries experiencing specific challenges.

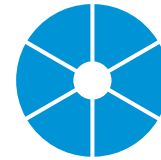
Each Regional Office will review the biennium workplans to ensure that they reflect priorities, are viable in the light of the available resources, and the quality of future work is assured. ■

IDENTIFICATION OF SPECIFIC ACTIVITIES AND RESULTS THAT WILL BE REDUCED OR NO LONGER DELIVERED

Currently no results will be reduced or no longer delivered under strategic objective 2. ■

SO3

TO PREVENT AND REDUCE DISEASE, DISABILITY AND PREMATURE DEATH FROM CHRONIC NONCOMMUNICABLE DISEASES, MENTAL DISORDERS, VIOLENCE AND INJURIES AND VISUAL IMPAIRMENT



PROGRESS TOWARD THE ACHIEVEMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

OF THE SIX ORGANIZATION-WIDE EXPECTED RESULTS FOR THIS STRATEGIC OBJECTIVE, ALL WERE "ON TRACK"

OVERVIEW

The commitment of Member States to the areas covered by strategic objective 3 continued to grow rapidly, as evidenced by several high-level resolutions adopted in 2010, including United Nations General Assembly resolution A/RES/64/265 on the prevention and control of noncommunicable diseases; United Nations General Assembly resolution A/RES/64/255 on improving global road safety and the launch of the Decade of Action for Road Safety 2011–2020; and resolution WHA63.13 on the Global strategy to reduce the harmful use of alcohol.

The number of Member States that nominated focal persons or created units within ministries of health to address chronic noncommunicable diseases, mental disorders, and violence and injuries continued to grow. In 2010, support was given to many Member States to develop and implement action plans in those areas. The mental health Gap Action Programme (mhGAP) was established in order to improve service delivery, reduce treatment gaps and increase financial and human resources for mental health care. In all areas covered by the strategic objective, emphasis was increasingly placed on the implementation of existing guidelines and plans and on supporting Member States to strengthen their programmes.

A package of high-impact, cost-effective, interventions for noncommunicable diseases was prepared and field tested for implementation in primary care in resource constrained settings. The new *mhGAP Intervention Guide* focuses on improving care for persons with mental, neurological and substance abuse disorders; pilot projects were initiated in several countries. A WHO document entitled *Preventing intimate partner and sexual violence against women: taking action and generating evidence*, and a collection of case studies in trauma care were published.

During 2010, the regional offices focused on providing technical support to Member States. Some regional highlights include: the Regional High-level Consultation on Noncommunicable Diseases in the European Region; development of a European action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases; preparation of a regional noncommunicable diseases action plan and a regional community-based rehabilitation strategy in the Eastern Mediterranean Region; resolution SEA/RC63.R2 on injury prevention and safety promotion; and a progress report on implementation of the regional noncommunicable diseases framework in the South-East Asia Region.

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. ■

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.

ON TRACK

Advocacy by WHO, international partners and some Member States played a key role in the adoption of United Nations General Assembly resolution A/RES/64/255 on improving global road safety, and resolution A/RES/64/265 on the prevention and control of noncommunicable diseases. The global noncommunicable disease network was established to encourage the involvement of relevant stakeholders and existing regional and global initiatives. The first meeting of the International Advisory Council of the network and the NCDnet Global Forum identified ways of raising the profile of noncommunicable diseases on the global development agenda.

Capacity building and support for units and focal points with responsibility for noncommunicable diseases in ministries of health continued to be a priority. Technical support was given to many Member States in that regard and regional and global meetings for focal points were convened.

WHO and the International Agency for the Prevention of Blindness met to review the progress made by the VISION 2020 Right to Sight global initiative, and to discuss ways of overcoming obstacles to progress. ■

PERFORMANCE INDICATORS	CURRENT STATUS
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	ON TRACK
3.1.2 <i>The world report</i> on disability and rehabilitation published and launched, in response to resolution WHA58.23	ON TRACK
3.1.3 Number of Member States with a mental health budget of more than 1% of the total health budget	ON TRACK
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	ON TRACK

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.**

ON TRACK

Emphasis was placed on providing technical support to Member States for the development and implementation of national noncommunicable disease, mental health and violence and injury prevention policies, plans and legislation in line with international human rights standards and best practice.

WHO, in collaboration with United Nations Regional Commissions and other partners, prepared a global plan of action for the Decade of Action for Road Safety 2011–2020, as called for by United Nations General Assembly resolution A/RES/64/255. The plan provides a document to guide national and local governments in preparing plans for the Decade. ■

PERFORMANCE INDICATORS	CURRENT STATUS
3.2.1 Number of Member States that have national plans to prevent unintentional injuries or violence	ON TRACK
3.2.2 Number of Member States that have initiated the process of developing a mental health policy or law	ON TRACK
3.2.3 Number of Member States that have adopted a multisectoral national policy on chronic noncommunicable diseases	ON TRACK
3.2.4 Number of Member States that are implementing comprehensive national plans for the prevention of hearing or visual impairment	ON TRACK

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.

ON TRACK

Mortality surveillance guidelines were piloted in five countries, and the Adverse Childhood Experiences International questionnaire was finalized and piloted in six countries. Preparations began for the second Global status report on road safety and a global status report on violence prevention.

Data on mental health indicators are currently being collected through the 2010 Mental Health Atlas project. Updated figures on the number of Member States with basic mental health indicators reported annually will be available by the end of 2011.

The second Global noncommunicable disease survey was conducted, with a 95% participation rate, to collate data on the capacity of Member States for prevention and control of noncommunicable diseases. A prioritized noncommunicable disease research agenda was developed based on expert consultations, surveys and an extensive review process. A meeting was held to review the prevalence and socio-economic burden of near vision impairment caused by uncorrected Presbyopia in which six research institutes participated. ■

PERFORMANCE INDICATORS	CURRENT STATUS
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	ON TRACK
3.3.2 Number of Member States that have a published document containing national data on the prevalence and incidence of disabilities	ON TRACK
3.3.3 Number of low- and middle-income Member States with basic mental health indicators annually reported	ON TRACK
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	ON TRACK
3.3.5 Number of Member States documenting, according to population-based surveys, the burden of hearing or visual impairment	ON TRACK

Data collection for Global Status Report on Road Safety will occur in 2011 and the target is expected to be reached.

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.

ON TRACK

The mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized settings that drew on a review of the evidence was launched in 2010. It provides recommendations to facilitate high-quality care at first- and second-level facilities by non-specialist health-care providers. The Guide outlines the integrated management of priority mental, neurological and substance-use disorders using protocols for clinical decision-making.

Evidence-based guidance was developed for a cost-effective total cardiovascular risk approach to preventing heart attacks and strokes. A multiple risk-factor approach for cardiovascular risk management was adopted by Member States in all regions. The diagnostic criteria for myocardial infarction and diabetes were reviewed, taking into account their applicability within weak health systems in low- and middle-income countries. Simplified implementation tools were developed to facilitate the implementation of cost-effective and integrated programmes for noncommunicable diseases in primary care.

The global elimination of trachoma campaign (GET2020) was successfully implemented in four countries. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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	ON TRACK
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	ON TRACK

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.

ON TRACK

A key achievement in violence prevention was the publication of the manual *Preventing intimate partner and sexual violence against women: taking action and generating evidence*. A regional seminar on implementation of the guide was held in the Region of the Americas.

Road traffic injury prevention programmes were initiated under the Bloomberg Philanthropies funded Road Safety in 10 countries project, and eight countries were on the verge of planning or implementing child maltreatment prevention initiatives. 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.

Technical assistance was provided and documents made available for the initiation of community-based projects in order to reduce suicides and suicidal behaviours. Several Member States have already begun implementation of the mhGAP programme and the accompanying Intervention Guide, which was launched in 2010.

The 35th session of the Non-Governmental Development Organization (NGDO) Coordination Group for Onchocerciasis Control was held in Ouagadougou, Burkina Faso. ■

PERFORMANCE INDICATORS	CURRENT STATUS
3.5.1 Number of guidelines published and widely disseminated on multisectoral interventions to prevent violence and unintentional injuries	ON TRACK
3.5.2 Number of Member States that have initiated community-based projects during the biennium to reduce suicides	ON TRACK
3.5.3 Number of Member States implementing strategies recommended by WHO for the prevention of hearing or visual impairment	ON TRACK

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.

ON TRACK

Technical support continued to be provided to Member States for improving the quality of trauma care. Strengthening care for the injured: success stories and lessons learned from around the world is a collection of case studies publicizing affordable ways in which trauma and emergency care services can be strengthened. Work continued on the revision and finalization of the Trauma Care checklist through a network of hospitals and stakeholders.

Publication of the Community-based rehabilitation (CBR) guidelines was the result of collaboration between more than 180 individuals and nearly 300 organizations. The guidelines include five components – health, education, livelihood, social and empowerment. Those who implement community-based rehabilitation programmes can select components and tailor implementation to local needs and priorities.

The WHO Assessment Instrument for Mental Health Systems project assists Member States to strengthen their mental health systems through a comprehensive assessment and the development of information-based plans. Seventy-eight country reports are now available on the mental health evidence and research web site.

The conceptual framework for a package of essential noncommunicable disease interventions for primary health care in low-resource settings was developed, including a minimum set of technologies and essential medicines needed for implementation of a core set of evidence-based interventions. Simplified tools are provided in the package to assess capacity in primary care facilities for resource planning, workforce training, and monitoring and evaluation. Technical guidance was provided to 10 low- and middle-income countries to enable them to assess primary care capacity and to implement the package.

A comprehensive training package was also designed to support countries in implementing Article 14 of the WHO Framework Convention on Tobacco Control, and to promote integration of tobacco dependence treatment in primary health care. Train-the-trainer workshops were held in two countries to improve the delivery of tobacco dependence treatment using the comprehensive training package. ■

PERFORMANCE INDICATORS	CURRENT STATUS
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	ON TRACK
3.6.2 Number of Member States implementing community-based rehabilitation programmes	ON TRACK
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)	ON TRACK
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	ON TRACK
3.6.5 Number of Member States with tobacco cessation support incorporated into primary health care	ON TRACK

SUMMARY OF FINANCIAL IMPLEMENTATION

(AS AT 31 DECEMBER 2010)

The WHA approved budget for strategic objective 3 was US\$ 146 million, mainly for base programmes.

Available funding by the mid-term was US\$ 98 million (67% of the approved programme budget) of which US\$ 80 million (82% of funds available) were for base programmes. Implementation as at 31 December 2010 was US\$ 40 million corresponding to 28% of the approved budget and 41% of the available resources.

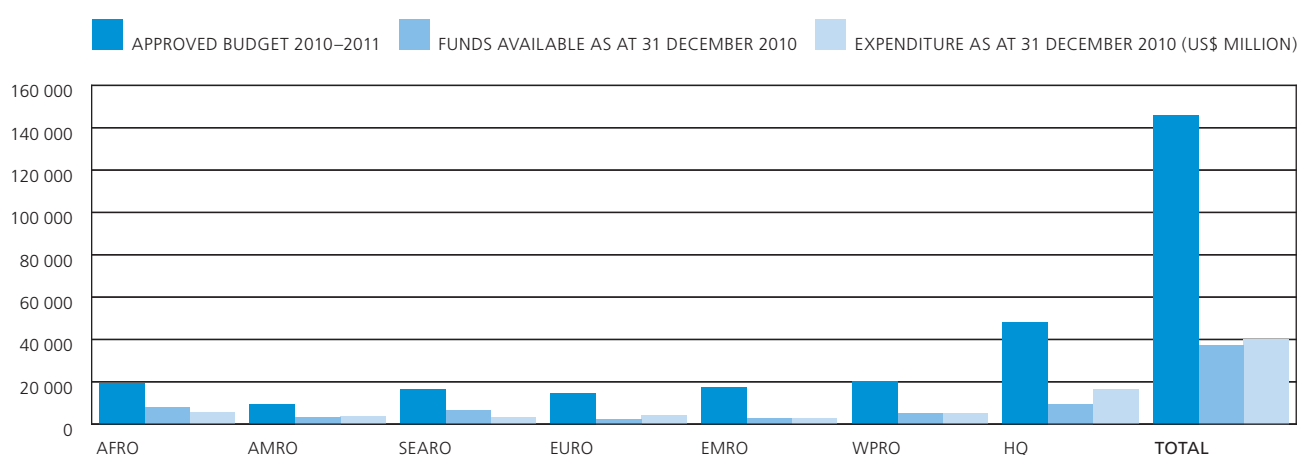
All major offices, except the Regional Office for the Eastern Mediterranean, have more than 55% of funds available against the Programme budget.

It should be noted that most funds for the strategic objective are specified, not flexible, and, therefore, cannot easily be used to fill gaps across budget centres. Additional fundraising is needed to ensure full implementation of the Programme budget and adequate carry-over for the next biennium.

Available resources have been earmarked mainly to build the evidence base and carry out the normative work related to primary health care, and to provide technical support for noncommunicable disease policy development and implementation.

Overall, some areas of work, for example, hearing impairment and human genetics, are suffering from financial constraints and lack of technical expertise, which has provided challenges in terms of delivering on some planned products and services. ■

2010–2011 (US\$ 000)		AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	TOTAL
Approved programme budget 2010–2011		19444	9180	16603	14674	17594	20261	48193	145949
Funds available as at 31 December 2010	AC	7997	3313	6512	2370	2629	5055	9552	37428
	VC	4036	1843	3617	7042	3688	9926	30377	60530
	TOTAL	12033	5156	10129	9412	6317	14981	39929	97958
Funds available as % of approved budget		62%	56%	61%	64%	36%	74%	83%	67%
Expenditure as at 31 December 2010		5650	3726	3099	4072	2553	4922	16226	40250
Expenditure as a % of approved budget		29%	41%	19%	28%	15%	24%	34%	28%
Expenditure as a % of available funds		47%	72%	31%	43%	40%	33%	41%	41%



PRIORITY RESULTS FOR 2011

One of the major priorities for 2011, is the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases which will take place in September 2011 and its related preparatory events, such as the first global ministerial conference on healthy lifestyles and non-communicable disease control and the Global Forum on noncommunicable diseases in April 2011.

Technical support will be provided to countries for achievement of the Organization-wide expected results 3.2, 3.3, 3.5 and 3.6 and more specifically for the implementation of the Noncommunicable Disease Action Plan; the implementation of the Mental health Gap Action Programme (mhGAP); the publication and dissemination of *The world report on disability*; for the Decade of Action for Road Safety 2011–2020; for the development and launch of global alliance for care of the injured; for data collection for the global status reports on road safety and violence prevention and support to countries and to regional and global community-based rehabilitation networks for implementation of guidelines.

Chronic noncommunicable diseases, mental disorders, violence, injuries and visual impairment are all comparatively new or neglected public health areas. The strategic approaches reflected in all six Organization-wide expected results remain valid and their importance should continue to be emphasized. In the area of noncommunicable diseases, it is crucial to focus on the priorities included in the Noncommunicable Disease Action Plan and place less emphasis on other existing activities. ■

IDENTIFICATION OF SPECIFIC ACTIVITIES AND RESULTS THAT WILL BE REDUCED OR NO LONGER DELIVERED

No results will be no longer delivered. Constraints on technical capacity due to insufficient staffing levels put specific work areas at risk in different regions: publications on the cost-effectiveness and cost/benefit ratios of interventions for chronic noncommunicable conditions could be delayed; and work on the 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 by the strategic objective has had a noticeable impact. ■

SO4

TO REDUCE MORBIDITY AND MORTALITY AND IMPROVE HEALTH DURING KEY STAGES OF LIFE, INCLUDING PREGNANCY, CHILDBIRTH, THE NEONATAL PERIOD, CHILDHOOD AND ADOLESCENCE, AND IMPROVE SEXUAL AND REPRODUCTIVE HEALTH AND PROMOTE ACTIVE AND HEALTHY AGEING FOR ALL INDIVIDUALS



PROGRESS TOWARD THE ACHIEVEMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

OF THE EIGHT ORGANIZATION-WIDE EXPECTED RESULTS FOR THIS STRATEGIC OBJECTIVE, THREE WERE "ON TRACK" AND FIVE "AT RISK"

OVERVIEW

The commitment of governments, international agencies and partners to achieving Millennium Development Goals 4 and 5 strengthened in the wake of the high-level plenary meeting of the General Assembly in September 2010, which opened with the launching, by the United Nations Secretary General, of his Global Strategy on Women's and Children's Health. The availability of resources at country level has increased in tandem with requests for WHO technical support.

Progress was made in key action areas towards the attainment of Millennium Development Goals 4 and 5. Particular emphasis was placed on integrated service delivery and approaches to removing barriers to essential reproductive, maternal, child and adolescent health services, for example, the launch of the campaign for accelerated reduction of maternal mortality in 21 African countries. In addition, 16 of the 42 countries in the African Region have undertaken a mid-term review of their road map for the reduction of maternal mortality. Capacity in programme review and management was strengthened in Member States.

Countries in all regions have been supported to improve the skills of health-care workers in providing newborn care by means of the essential newborn care course. In two regions, gaps in the care of the newborn in the first days after birth are being filled through the provision of care in the home.

Coverage of integrated management of childhood illness was expanded, although challenges remain in ensuring follow-up of trained health workers and providing essential medicines and supplies. To bridge the gap between health facility and home, and to increase access to essential care for sick children, integrated care of children in the community has been introduced in a number of countries and its effectiveness in reducing under-five mortality is being closely monitored.

The progress made in building the capacity of national experts in operational research in reproductive health is contributing to the implementation of the reproductive health strategy.

The WHO global network of age-friendly cities was established. By December 2010, four national programmes were affiliated to the network, including over 150 member cities in France, Ireland, Portugal and Slovenia, and 17 individual member cities, inter alia, Brussels, La Plata, New York and Qiqihar.

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. ■

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.

ON TRACK

Overall, progress was made in achieving Organization-wide expected result 4.1 with all regions having either developed or updated their strategies for maternal, newborn and child health. Some countries prepared a comprehensive strategy that includes adolescent health. The regional offices have also supported countries in devising policies aimed at achieving universal access to sexual and reproductive health services. Many countries are also developing a new national Medium-term strategic plan for 2010–2015. It is encouraging to see that the area of reproductive, maternal, newborn, child and adolescent health is being accorded the attention it deserves. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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	ON TRACK
4.1.2 Number of Member States that have developed, with WHO support, a policy on achieving universal access to sexual and reproductive health	ON TRACK

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.

ON TRACK

Overall, the Organization-wide expected result is on track due to the availability of specified funds. Headquarters supports much of the research, although a number of countries have also initiated studies with WHO backing. Comprehensive institutional development and support, including through grants, contributed to strengthening research centres. Research products were supported under the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP). ■

PERFORMANCE INDICATORS	CURRENT STATUS
4.2.1 Number of research centres that have received an initial grant for comprehensive institutional development and support	ON TRACK
4.2.2 Number of completed studies on priority issues that have been supported by WHO	ON TRACK
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	ON TRACK

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.

AT RISK

Although this is a priority area for all regions, a lack of adequate resources limited the support provided by WHO, especially in the African Region. Many of the activities carried out at country level receive funding from partners and technical support from WHO.

The Regional Offices for Africa, the Americas and South-East Asia designated reducing maternal mortality as a flagship programme with enhanced monitoring and reporting of progress. Three regions have introduced maternal mortality audits using the “beyond the numbers” tool, and report significant progress in the countries that measure causes of maternal – and in the case of some countries, newborn – deaths.

Delivery under the Organization-wide expected result is on track for all regions except the African Region, and headquarters. The global emphasis placed on attainment of Millennium Development Goals 4 and 5 has provided the impetus for accelerated action. WHO provided technical support, but only limited financial support. Collaboration with other United Nations agencies, especially through the H4+ (UNICEF, UNFPA, WHO, World Bank, UNAIDS) in this respect was good. ■

PERFORMANCE INDICATORS

CURRENT STATUS

4.3.1 Number of Member States implementing strategies for increasing coverage with skilled care for childbirth

ON TRACK

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.

ON TRACK

Delivery of the Organization-wide expected result is on track. Following the completion, during the previous biennium, of guidance for the adaptation of the integrated management of childhood illness (IMCI) strategy to include newborns, most regions reported that countries have adapted national IMCI strategies to include newborn care. Training on essential newborn care around the time of birth has been introduced in countries in all regions, and the number of countries implementing the training is growing. Home visits for newborns in the first week of life have begun to be introduced in countries of the African and Western Pacific Regions. ■

PERFORMANCE INDICATORS

CURRENT STATUS

4.4.1 Number of Member States implementing strategies for increasing coverage with interventions for neonatal survival and health

ON TRACK

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.

AT RISK

All regions accorded high priority to the Organization-wide expected result, although a lack of financial and technical resources hampered a rapid scale up, especially in the African Region. Coverage of the integrated management of childhood illness strategy was expanded through innovative training approaches, including computerised training, and introduced in pre-service training in most regions.

Skills in programme management were enhanced through training in programme management for child health, particularly in the African and South-East Asia Regions.

The home-based care of the sick child programme was introduced in selected countries in three regions and three regions also addressed the issue of hospital care improvement.

Linkages between HIV and the integrated management of childhood illness were strengthened in the African Region, the Region of the Americas and the South-East Asia Region. Overall, progress continued to be made, but the pace was slower than anticipated owing to diminishing financial resources. Requests for technical support from countries could not all be met.

Delivery of the application of guidelines and tools for child health, including building capacity at all levels of the Organization, is rated as “at risk”, as is work related to generating and monitoring strategic information on newborn, child and adolescent health. ■

PERFORMANCE INDICATORS

CURRENT STATUS

4.5.1 Number of Member States implementing strategies for increasing coverage with child health and development interventions	AT RISK
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	AT RISK

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.

AT RISK

Organization-wide expected result 4.6 was most affected by the limited financial resources available, in particular for giving systematic support to countries for strengthening adolescent friendly health services. Delivery will be further curtailed in 2011 as the Regional Offices for Africa and the Western Pacific are abolishing their adolescent health posts owing to financial constraints, which has also had a negative impact on the availability of expertise in adolescent health at headquarters. Achievements in 2010 included: the provision of support to countries for developing adolescent health strategies as part of a multisectoral approach to adolescent health, and introduction of guidelines for adolescent-friendly health services, although their implementation is limited. A systematic review on the prevention of too-early pregnancy was completed and will be translated into guidelines for countries in 2011. ■

PERFORMANCE INDICATORS

CURRENT STATUS

4.6.1 Number of Member States with a functioning adolescent health and development programme

AT RISK

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 reproductive health services, particularly in areas of unmet need, and with respect for human rights as they relate to sexual and reproductive health.

AT RISK

The delivery of products supporting the development of programmes on sexual and reproductive health has been slow, both at headquarters in countries. Funding cuts have led to cut-backs in the integration of clinical, managerial and programme guidelines into national programmes. Nevertheless, the development of standards and guidelines continued, including release of an updated version of the guidelines on medical eligibility criteria for contraceptive use, and clinical tools, such as the companion wheel for by clinicians. Over 100 000 copies of the wheel were distributed by WHO, Member States and partners. Increased emphasis was placed on the translation of WHO tools into languages other than English; the Spanish version of the WHO reproductive health library now has more readers than the English version.

Countries in two regions reported having reviewed their laws and policies on sexual and reproductive health. Resource constraints in some countries meant they were having to implement the reproductive health strategy selectively. ■

PERFORMANCE INDICATORS

CURRENT STATUS

<p>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</p>	<p>ON TRACK</p>
<p>4.7.2 Number of targeted Member States having reviewed their existing national laws, regulations or policies relating to sexual and reproductive health</p>	<p>ON TRACK</p>

4.8 Guidelines, approaches, tools and technical assistance 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 through the life course and for the training of health-care providers in approaches that ensure healthy ageing.

AT RISK

The WHO global network of age-friendly cities was established. By December 2010, four national programmes were affiliated to the network, including over 150 member cities in France, Ireland, Portugal and Slovenia, and 17 individual member cities, inter alia, Brussels, La Plata, New York and Qiqihar.

WHO's partnership with the International Association of Geriatrics and Gerontology has seen the establishment of a global research network on health and ageing that includes 318 centres of excellence, and the holding of a cosponsored workshop on nursing homes.

The Regional Office for Europe re-established their healthy ageing, healthy cities network and launched a cross-cutting programme on healthy ageing. The Regional Office for South-East Asia drew up a strategic framework on active healthy ageing. The area of healthy ageing is gradually gaining momentum, but will remain at risk for the duration of the biennium. ■

PERFORMANCE INDICATORS

CURRENT STATUS

4.8.1 Number of Member States with a functioning active healthy ageing programme consistent with WHA58.16 "Strengthening active and healthy ageing"

ON TRACK

SUMMARY OF FINANCIAL IMPLEMENTATION

(AS AT 31 DECEMBER 2010)

The The WHA approved budget for strategic objective 4 was US\$ 332 million, of which US\$ 302 million are for base programmes (91%) and US\$ 42 million (9%) for special programmes and collaborative arrangements.

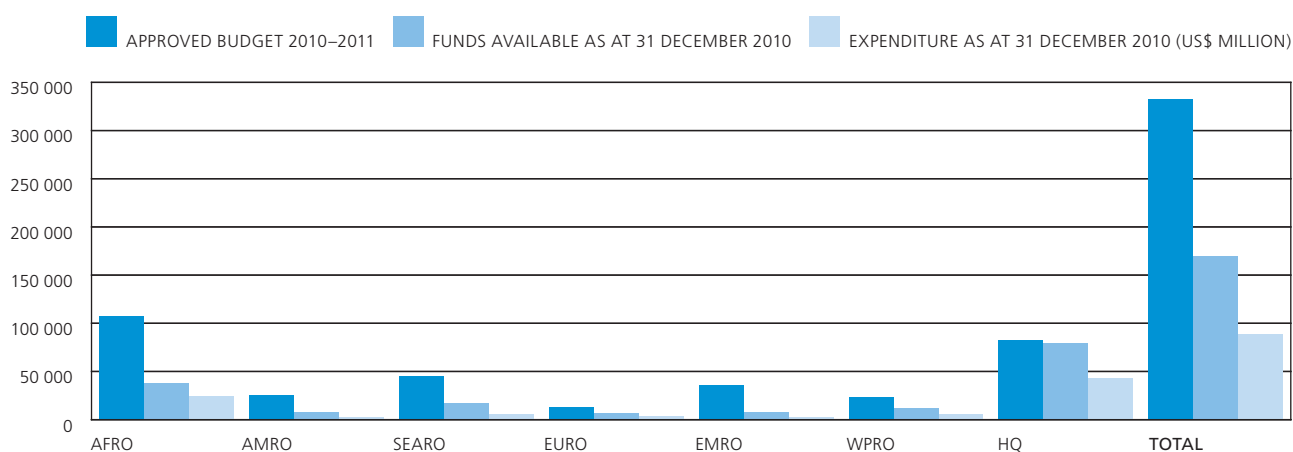
Available funding by the mid-term was US\$170 million, of which US\$ 131 million have been distributed to base programmes and US\$ 39 million to special programmes and collaborative arrangements.

Implementation as at 31 December 2010 was US\$ 88 million, which corresponds to 27% of the approved budget and 52% of the available resources.

Despite the current high level of political awareness and commitment to accelerating action to meet Millennium Development Goals 4 and 5, the funding gap is significant. A notable increase in overall funding is required in order to maintain current activities and accelerate implementation at country level.

The high availability of resources in headquarters (97%) stems from available resources specified for research. Furthermore, the available resources in headquarters include funding for the strategic partnership for the human reproductive health programme, which is fully funded through specified resources. ■

2010–2011 (US\$ 000)		AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	TOTAL
Approved programme budget 2010–2011		107 735	25 362	44 702	12 937	36 114	23 329	82 519	332 698
Funds available as at 31 December 2010	AC	15 219	6 323	7 549	2 224	2 926	4 217	7 169	45 627
	VC	22 766	1 844	9 656	4 574	5 163	7 553	72 682	124 238
	TOTAL	37 985	8 167	17 205	6 798	8 089	11 770	79 851	169 865
Funds available as % of approved budget		35%	32%	38%	53%	22%	50%	97%	51%
Expenditure as at 31 December 2010		24 840	2 989	5 421	3 644	2 958	5 575	42 866	88 293
Expenditure as a % of approved budget		23%	12%	12%	28%	8%	24%	52%	27%
Expenditure as a % of available funds		65%	37%	32%	54%	37%	47%	54%	52%



PRIORITY RESULTS FOR 2011

All areas with specified resources in line with Health Assembly resolutions and key priority areas, such as sexual and reproductive health, and maternal and newborn health are considered key priorities for 2011. Countries of strategic focus are selected on the basis of clear criteria for consolidated support to programmes on the integration of norms, tools and strategies relating to sexual and reproductive health, and maternal, child and adolescent health.

Additional resources will be allocated to the activities under Organization-wide expected results 4.2 and 4.7 (contributing to attainment of Millennium Development Goal targets for universal access to reproductive health), 4.3, 4.4, 4.5 and 4.6 (all of which contribute to achieving Millennium Development Goals 4 and 5).

Adolescent Health is at risk because the African and Western Pacific Regions have abolished dedicated posts, and the number of staff specializing in adolescent health in headquarters has been reduced. ■

IDENTIFICATION OF SPECIFIC ACTIVITIES AND RESULTS THAT WILL BE REDUCED OR NO LONGER DELIVERED

No areas will be totally no longer delivered, however, adolescent health is at risk in the African and Western Pacific Regions and some areas of the work could be no longer delivered. ■

SO5

TO REDUCE THE HEALTH CONSEQUENCES OF EMERGENCIES, DISASTERS, CRISES AND CONFLICTS, AND MINIMIZE THEIR SOCIAL AND ECONOMIC IMPACT



PROGRESS TOWARD THE ACHIEVEMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

OF THE SEVEN ORGANIZATION-WIDE EXPECTED RESULTS FOR THIS STRATEGIC OBJECTIVE, FIVE WERE "ON TRACK" AND TWO "AT RISK"

OVERVIEW

In 2010, progress was made by Member States in making and fulfilling high-level policy commitments, and by WHO in providing practical support for developing countries' capacity in risk reduction and emergency preparedness; the Hospital Safety Index was introduced in priority countries; vulnerability and risk assessment mapping was initiated in several high-risk countries; health emergency management was integrated in guidance to countries for national health planning, for country cooperation strategies and for local health workforce initiatives; Member States' preparedness and response mechanisms for food safety and environmental health emergencies were strengthened; and participation in relevant early warning networks was broadened.

As lead agency of the health cluster of the United Nations Inter-Agency-Standing Committee, WHO supported Member States in leading the overall health response to acute crises and ongoing complex emergencies. Such support was directed towards: strategic planning, deployment of staff, assessments, technical guidance, development of coordinated multi-agency action plans, and provision of emergency medical supplies. Surge capacity was strengthened and used in the rapid deployment of supplies, human resources and funds. Standard operating procedures were further developed to enable WHO to act quickly. Training courses were conducted to build response capacity among WHO and partner agency staff, including heads of WHO country offices. Standard training packages were developed and a global roster of trained emergency experts was enlarged. Standard competencies for humanitarian expertise were identified. Learning pathways for humanitarian action were developed with partners to ensure stand-

ardized skill sets for actors in the field. New technologies aimed at facilitating learning and information management were assessed to ensure field staff have access to lessons learnt and best practices. Early warning and surveillance systems for communicable diseases were strengthened.

Progress was made in developing the health component of consolidated appeals launched in chronic protracted emergencies and the normative and technical components of post disaster and post conflict needs assessments and of the analysis of disrupted health systems.

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 two regions (Region of the Americas and the Eastern Mediterranean Region): the Eastern Mediterranean Region 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 both in receiving funds and in recruiting Health Cluster Coordinators; and in the Eastern Mediterranean Region because of the open-ended nature of chronic emergencies in the Region that has led to donor fatigue; it should be noted that HQ cited a lack of capacity in terms of the necessary human resources to respond to technological emergencies. Nevertheless, WHO has managed to support Member States by mobilizing coordinated action in most crises and to implement action plans with partners in most chronic emergency situations. ■

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.

ON TRACK

Progress was made in developing countries' capacities in risk reduction and emergency preparedness and high-level commitment to that goal was articulated in regional resolutions in the Region of the Americas and the African and Eastern Mediterranean Regions. Progress was also made in designing norms and standards for health risk reduction and emergency preparedness, including for assessing disaster risk reduction in the Region of the Americas, mass casualty management in the Western Pacific Region, and health emergency risk management at headquarters and in regional offices.

The health systems crisis preparedness assessment tool was further adapted and revised following consultations in the European Region, and a tool for assessing preparedness and response was tested in the South-East Asia Region using 12 benchmarks. Health emergency management was integrated in work on national health plans and in the global learning programme in the Region of the Americas and the Eastern Mediterranean, European, South-east Asia and Western Pacific Regions, as well as in urban health, climate change adaptation, pandemic preparedness, and local health workforce initiatives with the Global Health Workforce Alliance and other partners.

The health component of multisectoral regional strategies for disaster risk reduction was strengthened through the International Strategy for Disaster Reduction system. The Hospital Safety index was introduced in priority countries, and a hospital emergency preparedness template was designed by the Regional Office for Europe. The WHO Regional Committee for the Americas, at its sixty-second session, adopted resolution CD50.R15 that paved the way for Member States to adopt national policies for safe hospitals. An advocacy campaign was conducted in all 11 countries in the South-East Asia Region to elicit support for high-level commitment to the Kathmandu Declaration on Protecting Health Facilities from Disasters.

The vulnerability and risk assessment mapping process of identifying health sector vulnerabilities and emergency related capacities was initiated in several high-risk countries. A standardized template was designed for emergency country profiles highlighting baseline capacities and health challenges.

The information and knowledge management programme was launched and has produced systemic reviews and a draft list of operational research needs for emergencies settings. ■

PERFORMANCE INDICATORS

CURRENT STATUS

5.1.1 Proportion of Member States with national emergency preparedness plans that cover multiple hazards

ON TRACK

5.1.2 Number of Member States implementing programmes for reducing the vulnerability of health facilities to the effects of natural disasters

ON TRACK

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.

ON TRACK

Surge capacity was further strengthened to facilitate a swift and efficient response to crises in terms of: emergency supplies and equipment; emergency funds; trained, experienced, deployment-ready staff; and emergency standard operating procedures. Emergency operations rooms were established in all regional offices, and the range of health-related humanitarian stockpiles was expanded in four United Nations humanitarian response depots in Ghana, Italy, Panama and the United Arab Emirates. The African and South-East Asia Regions reported that the use of humanitarian supply hubs improved delivery times for emergency supplies. A global roster was established, as were regional rosters in the African and South-East Asia Regions. The rapid response account worked smoothly, complemented by a regional revolving fund in the South-East Region.

Emergency standard operating procedures were made compatible with the Global Management System. A global training platform and regional training courses were established. All regional offices ran workshops on various aspects of emergencies, including training courses for Health Cluster Coordinators, Health Emergencies in Large Populations courses, and workshops on public health in complex emergencies and operational readiness. A standardized package for training Health Cluster Coordinators was designed, and four training courses were conducted in collaboration with the Regional Offices for the Americas, the Eastern Mediterranean, South-East Asia and the Western Pacific. Experts from Member States also participated in the Health Cluster training courses, as well as other standard emergency preparedness, response and recovery related courses.

Training in the analysis of disrupted health system was carried out in English and French and participants were mainly selected from countries that experienced crises and emergencies. ■

PERFORMANCE INDICATORS

CURRENT STATUS

5.2.1 Operational platforms for surge capacity in place in regions and headquarters ready to be activated in acute-onset emergencies	ON TRACK
5.2.2 Number of global and regional training programmes on public health operations in emergency response	ON TRACK

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.

ON TRACK

A methodology for needs assessment and a planning framework for the health component of post disaster needs assessment and post conflict needs assessment processes were formulated in collaboration with relevant United Nations agencies, as well as the World Bank and the European Union; WHO participated in post disaster needs assessment in Haiti and Yemen.

Guidance on health recovery for the Health Cluster was developed in collaboration with multiple stakeholders, in particular with partners. Advocacy and technical guidance were provided for sexual and reproductive health in protracted emergencies in collaboration with UNFPA, following on from the Granada Consensus. *Analysing disrupted health sectors: a modular manual*, first published in 2009, was translated into French and Spanish, disseminated widely and used for training programmes.

A global consultation on the health of migrants was organized in collaboration with IOM and the Government of Spain and attended by 60 representatives of key stakeholders, including governments, agencies and the academic sector. A framework for joint action by IOM and WHO in the field is being implemented.

Progress was made by country offices in formulating the health component of the 19 consolidated appeals launched for chronic emergencies in close collaboration with health cluster partners, the United Nations Office for the Coordination of Humanitarian Affairs and others.

Overall, this Organization-wide expected result is on track even though the Regional Office for Europe reported a lack of resources for capacity building in analysing disrupted health systems. Despite that, the Regional Office reported that indicators 5.3.1 and 5.3.2 were on track. ■

PERFORMANCE INDICATORS	CURRENT STATUS
5.3.1 Number of humanitarian action plans with a health component formulated for ongoing emergencies	ON TRACK
5.3.2 Number of countries in transition that have formulated a recovery strategy for health	ON TRACK

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

ON TRACK

Coordinated technical support for the control of communicable diseases was provided to Member States and partners in all major acute humanitarian emergencies in 2010. The three levels of the Organization jointly produced public health risk assessment guidance, specific communicable disease epidemiological profiling for affected countries, and targeted guidance on specific diseases and interventions. Early warning surveillance and response systems following crises and disasters were implemented and strengthened.

Overall, the Organization-wide expected result is on track despite the lack of funding reported by the Regional Office for Europe. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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

ON TRACK

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.

AT RISK

The Regional Offices for Africa, Europe and South-East Asia reported have made progress in developing national, all-hazard plans for public health emergencies, covering chemical and radiological incidents, as well as major climatic events, such as floods and heat waves.

Synergies between the work under strategic objectives 1, 5 and 8 were maximized, for example, regional and headquarters training programmes for International Health Regulations (2005) national focal points included modules on chemical and radiological events, thereby raising awareness at country level of the need for preparedness planning and response capacity. Regional offices, with support from headquarters, continued to assist countries in dealing with a range of environmental emergencies, including chemical incidents, potential release of hazardous substances following earthquakes and floods, and smoke from uncontrolled forest fires.

Training materials for alert, preparedness and response to environmental emergencies are being prepared on the basis of WHO manuals, such as the Manual for the Public Health Management of Chemical Emergencies and the *TMT Handbook – Triage, Monitoring and Treatment of people exposed to ionizing radiation following a malevolent act*.

All regions reported making progress in the area of food safety and in involving Member States in the International Food Safety Authorities Network. The Regional Office for the Western Pacific highlighted the role of new guidance and training in the improved response to food safety emergencies.

The Organization-wide expected result is rated as “at risk” because the Regional Offices for the Americas and the Eastern Mediterranean reported lacking adequate resources, particularly for network development. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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

ON TRACK

5.5.2 Number of Member States with focal points for the International Food Safety Authorities Network and for the environmental health emergencies network

AT RISK

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.

ON TRACK

WHO continued in its role as lead agency of the Global Health Cluster, which promotes and guides joint action towards a more effective implementation of emergency response and recovery and now includes 42 partners from the United Nations system, nongovernmental organizations and the International Federation of Red Cross and Red Crescent Societies. *The Health Cluster Guide* has been translated from English into French and Spanish and more than 12,000 copies have been disseminated and are being used to guide cluster leadership and action in line with Inter-Agency Standing Committee standards. Policy papers on user fees and civil military interaction were prepared for use at country level. ■

PERFORMANCE INDICATORS

CURRENT STATUS

5.6.1 Proportion of Member States affected by acute-onset emergencies and those with protracted emergencies and a humanitarian coordinator in which the Inter-Agency Standing Committee Humanitarian Health Cluster is operational in line with IASC cluster standards	ON TRACK
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	ON TRACK

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

AT RISK

As lead agency of country Health Clusters, WHO supported Member States in leading the overall health response to acute crises and ongoing complex emergencies; particularly challenging in 2010 were the earthquake in Haiti and the flooding in Pakistan.

WHO formulated the health components of consolidated and flash appeals, joint United Nations workplans and other Inter-Agency planning tools in all countries with Inter-Agency-Standing Committee processes.

Responses improved in Bangladesh, Indonesia, Myanmar and Sri Lanka as a result of preparedness measures taken in the South-East Asia Region under Organization-wide expected result 5.1.

To complement the standard operating procedures, the Regional Office for Europe activated its emergency fast-track procedures for the emergencies in Kyrgyzstan, Tajikistan and Uzbekistan.

Overall, the Organization-wide expected result is at risk in two regions: as a result of delays in receiving funds and in recruiting health cluster coordinators in the European Region; and because of the open-ended nature of chronic emergencies in the Eastern Mediterranean Region, in addition to the major disasters that occurred in 2010, which have resulted in donor fatigue and a consequent reduction in WHO's ability to implement long-term recovery plans for the respective health systems; headquarters cited a lack of capacity in terms of the necessary human resources to respond to technological emergencies. Despite the challenges, WHO managed to mobilize coordinated action in most crises and implement action plans with partners in most chronic emergency situations. ■

PERFORMANCE INDICATORS

CURRENT STATUS

5.7.1 Proportion of acute-onset emergencies for which WHO mobilizes coordinated national and international action ^a	AT RISK
5.7.2 Proportion of interventions for chronic emergencies implemented in accordance with humanitarian action plans' health components	AT RISK

a Afghanistan, Benin, Burkina Faso, Central African Republic, Chad, Democratic Republic of the Congo, El Salvador, Guatemala, Haiti, Iraq, Kenya, Kyrgyzstan, Mongolia, Nepal, Niger, the Occupied Palestinian Territories, Pakistan (floods and humanitarian action plan), Republic of Congo, Somalia, Sri Lanka, Sudan, Syrian Arab Republic, Uganda, West Africa, Yemen and Zimbabwe

SUMMARY OF FINANCIAL IMPLEMENTATION

(AS AT 31 DECEMBER 2010)

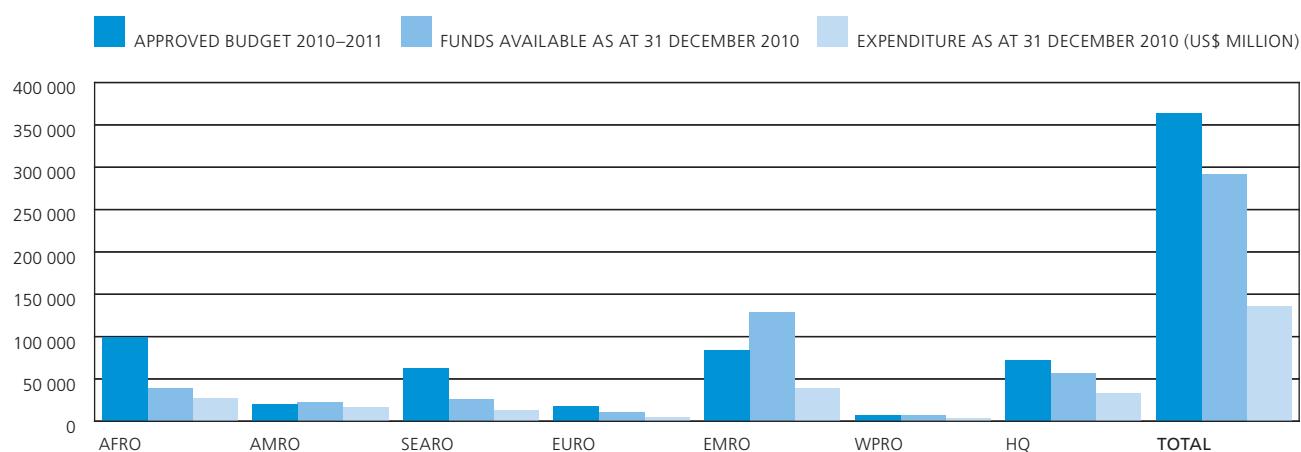
The total approved budget for strategic objective 5 was US\$ 364 million, of which US\$ 109 million (30%) was for base programmes and an initial estimated amount of US\$ 250 million for outbreak and crisis response to fund specific country-level appeals in response to crises. During 2010, the budget ceiling for the strategic objective was raised to US\$ 510 million to allow for increased resources for the continued procurement of supplies and medicines.

As at 31 December 2010, available resources for the strategic objective amounted to US\$ 291, representing 80% of the approved budget. An estimated US\$ 34 million (12%) of the funds were for base programmes. The remainder of US\$ 257 million was for crisis response in Afghanistan, Benin, Burkina Faso, Central African Republic, Chad, Democratic Republic of the Congo, El Salvador, Guatemala, Haiti, Iraq, Kenya, Kyrgyzstan, Mongolia, Nepal, Niger, Occupied Palestinian Territories, Pakistan, Republic of the Congo, Somalia, Sri Lanka, Sudan, Syrian Arab Republic, Uganda, West Africa, Yemen and Zimbabwe.

Of the available resources, US\$ 15 million (5%) was from assessed contributions and US\$ 276 million from voluntary contributions.

The implementation rate (expenditures) against available funds as at 31 December 2010 was 47% and against the approved budget 37%. ■

2010–2011 (US\$ 000)		AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	TOTAL
Approved programme budget 2010–2011		98 782	20 118	63 202	17 960	84 277	7 581	72 103	364 023
Funds available as at 31 December 2010 ^a	AC	3 371	1 494	4 205	1 687	1 166	1 300	2 180	15 403
	VC	35 383	21 110	22 119	8 595	127 548	6 435	54 786	276 001
	TOTAL	38 754	22 604	26 324	10 282	128 714	7 735	56 966	291 404
Funds available as % of approved budget		39%	112%	42%	57%	153%	102%	79%	80%
Expenditure as at 31 December 2010		26 883	16 357	12 736	4 559	38 954	3 848	32 839	136 176
Expenditure as a % of approved budget		27%	81%	20%	25%	46%	51%	46%	37%
Expenditure as a % of available funds		69%	72%	48%	44%	30%	50%	58%	47%



^a Total funds available includes US\$ 25,000 of funds which were undistributed as of 31 December 2010.

PRIORITY RESULTS FOR 2011

Two of the seven Organization-wide expected results are currently at risk because at least two regions reported possible difficulties in meeting the targets by 2011 owing to a lack of resources. Despite the current funding situation that has put the two Organization-wide expected results at risk, the key functions under the strategic objective will remain. However, the targets in certain areas will be reduced. Priority will continue to be given to: emergency preparedness and risk reduction; WHO's leadership of the Health Cluster and its work in specific technical areas during emergency response and recovery; normative and technical work in emergencies; and institutional readiness."

No reprioritization of the programme budget between Organization-wide expected results or major offices is foreseen at this time.

Programmatic priorities for 2012–2013 include: country-based, all-hazards, health-sector disaster risk management fully integrated in national health systems, plans and strategies, including for environmental and food safety emergencies; national and community level emergency preparedness; preparedness and risk reduction as a key element in primary health care; global surveys of health emergency preparedness used by national authorities and other key actors to advocate for and build health emergency capacity; programmes for reducing vulnerability and increasing preparedness of health facilities implemented during natural disasters; alert and response mechanisms for food-safety and environmental health emergencies.

In addition, countries in crisis should be in possession of a health sector strategy and action plan that is included in appeals and is effectively implemented; the Health Cluster approach, guidance and tools accepted as standard and fully institutionalized and implemented in accordance with Inter-Agency Standing Committee policy and WHO representatives and staff in countries implementing, or likely to implement, the Health Cluster approach, to introduce a staff development plan to build capacities for Health Cluster leadership; All countries in which WHO leads the Health Cluster to produce a weekly Health Cluster bulletin;

An Organization-wide incident management system agreed; Organization-wide expertise developed in WHO emergency operations, particularly in Health Cluster leadership, strategic planning, health information and communications; Organization-wide knowledge and ownership of emergency standard operating procedures; Organization-wide operational platform; Standard global emergency training programmes as part of an Organization-wide staff development plan, including for food-safety emergencies; Communicable disease-control interventions, early-warning systems and disease-surveillance for emergencies in place; Operational research to increase the impact and cost effectiveness of emergency programmes; Normative and technical support for child and adolescent health, maternal health, women's health, essential medicines, mental health and psychosocial support and nutrition; Health systems analysis for health recovery in countries emerging from crisis documented. ■

IDENTIFICATION OF SPECIFIC ACTIVITIES AND RESULTS THAT WILL BE REDUCED OR NO LONGER DELIVERED

At present, it is planned not to reduce or to postpone any of the functions or expected results under strategic objective 5 during the biennium. However, in light of current financial and budgetary constraints, the necessary shifts will be made in the projected targets and deliverables. Operational planning for the strategic objective in the Proposed programme budget 2012–2013 will be carried out under the leadership of the new Assistant Director General from 1 April 2011. ■

SO6

**TO PROMOTE HEALTH AND DEVELOPMENT,
AND PREVENT OR REDUCE RISK FACTORS FOR
HEALTH CONDITIONS ASSOCIATED WITH USE
OF TOBACCO, ALCOHOL, DRUGS AND OTHER
PSYCHOACTIVE SUBSTANCES, UNHEALTHY DIETS,
PHYSICAL INACTIVITY AND UNSAFE SEX**



**PROGRESS TOWARD
THE ACHIEVEMENT OF
ORGANIZATION-WIDE
EXPECTED RESULTS**

OF THE SIX ORGANIZATION-WIDE EXPECTED RESULTS FOR THIS STRATEGIC OBJECTIVE, ALL WERE "ON TRACK"

OVERVIEW

Progress was achieved, despite financial and human resource constraints and consequent risk to specific products and activities.

Highlights include the adoption of United Nations General Assembly resolution A/RES/64/265 on the prevention and control of noncommunicable diseases and resolution WHA63.13 on the Global strategy to reduce the harmful use of alcohol.

The Urban Health Equity and Response Tool (Urban HEART) has been implemented in 26 cities, and 82 countries are using the WHO STEPwise approach for monitoring noncommunicable disease risk factors in their adult populations. A total of 21 new surveys using the method were conducted, as well as 28 country missions or regional training workshops. A total of 63 countries used the global school-based student health survey methodology.

Monitoring of the global tobacco epidemic was carried out through the Global Adult Tobacco Survey in 13 countries and the Global Youth Tobacco Survey in 160 countries. Comparable data on the prevalence of tobacco use among adults obtained through recent national surveys was available in 68 Member States. The theme of World No Tobacco Day 2010 was "Gender and tobacco with an emphasis on marketing to women".

The Regional Committee for Africa, at its Sixtieth Session, adopted resolution AFR/RC60/R2 on Reduction of the harmful use of alcohol: a strategy for the WHO African Region and the Sixty-third World Health Assembly adopted resolution WHA63.14 on Marketing of food and non-alcoholic beverages to children. Technical tools for the prevention of childhood obesity and salt-reduction strategies were developed and the *ATLAS on resources for the prevention and treatment of substance use disorders* was published in 2010.

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. ■

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.

ON TRACK

Overall, the Organization-wide expected result is on track. The Regional Offices for Europe and the Western Pacific have progressed satisfactorily, achieving more than 40% of their respective two year target, followed by the Regional Office for Africa reaching some 25%. The Regional Office for the Americas (3 to be achieved), the Regional Office for the Eastern Mediterranean (2 to be achieved) and the Regional Office for South-East Asia (3 to be achieved) have reported to be on course whereas headquarters is lagging behind, contributing little to the achievement of the regional targets in 2010. Despite the slow progress, headquarters has repositioned itself in the later part of 2010 and will fulfill all its commitments..

The Regional Offices for Africa and Europe provided technical support for developing health promotion policies and plans at regional and country level to four and 11 Member States, respectively. In the Western Pacific Region, five out of 17 Pacific island countries and territories received support to advance the programme on healthy islands as a platform for health promotion. Given the importance of intersectoral approaches and capacity building in the development and implementation of evidence-based health promotion projects, priority was given to: mainstreaming health promotion by the Regional Offices for the Americas and Europe and headquarters; the development of tools to assess adult health literacy and document health promotion interventions by the Regional Office for the Eastern Mediterranean; and to school health promotion by the Regional Office for South-East Asia.

Although not mentioned explicitly by some major offices, financial resources for health promotion are insufficient across the Organization, particularly in headquarters.

It should be noted that the baseline and target for indicator 6.1.1 have been changed to reflect the figures contained in the reports submitted by the regions, in other words they represent the sum total of the numbers extracted from the reports of all six regions.

By the end of 2010, 26 cities had developed plans and implemented the Urban Health Equity and Response Tool (Urban HEART), which has led to a better understanding of how to address urban health inequalities. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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

ON TRACK

6.1.2 Number of cities that have implemented healthy urbanization programmes aimed at reducing health inequities

ON TRACK

6.2 Guidance and support provided in order to strengthen national systems for surveillance of major risk factors through development and validation 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.

ON TRACK

By the end of 2010, a total of 82 countries were using the WHO STEPwise approach to surveillance of noncommunicable disease risk factors in their adult populations. During 2009 and 2010, 21 new surveys (including repeat surveys in some countries) using the method were carried out and 28 country missions or regional training workshops were conducted.

Overall, 63 countries used global school-based student health survey methodology to implement risk factor surveillance of youth at national level. A total of 23 new surveys were carried out using the same methodology, and nine related regional training workshops were conducted. Increased efforts are required to sustain, resource and implement surveillance systems for noncommunicable diseases in countries. Risk surveillance of young people tends to lag behind adult risk-factor surveillance.

Surveillance activities can only continue if supported by increased funding from the core voluntary contributions account and donors and progress will only be made in achieving the Organization-wide expected result in 2011 if the requisite number of dedicated human and financial resources are available. The Regional Office for the Americas rated the Organization-wide expected result as “at risk”. A significant increase in demand for surveillance of noncommunicable diseases is expected as a result of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases to be held in September 2011. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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	ON TRACK
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	ON TRACK

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.

ON TRACK

Through the *WHO report on the global tobacco epidemic, 2009*, and implementation of the Global Adult Tobacco Survey in 14 countries and the Global Youth Tobacco Survey in 160 countries, the Organization has become a unique repository for information on the response of Member States to the tobacco epidemic. Comparable data on the prevalence of tobacco use among adults obtained through recent national surveys was available in 68 Member States.

The substantial funding provided made it possible to complete the Global Adult Tobacco Survey in 14 of the 16 proposed countries thereby exceeding the target of 65 surveys by 17, and making a total of 82.

WHO worked directly to increase the efficiency and effectiveness of tobacco tax systems with the result that five countries have increased their tax on tobacco. At the end of 2010, tobacco taxes represented more than 75% of the price of cigarettes in 25 Member States. Smoke-free legislation in its entirety was approved by 29 countries, seven more than expected. WHO also contributed to the introduction of graphic health warnings covering more than 30% of packaging in a total of 41 Member States at the end of 2010.

WHO is developing a technical resource in order to extend the implementation of comprehensive bans on tobacco advertising, promotion and sponsorship in line with Article 13 of the Framework Convention. Such a ban had been introduced in 20 countries by the end of 2010. As a result of the adjustment of indicator 6.3.3 in line with Article 13 of the Framework Convention, the number of Member States that achieved it was lower than expected.

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.

In view of the limited financial resources available from development agencies to support the global tobacco control effort, WHO is considering the practicability of a solidarity tobacco levy for innovative financing as proposed by some Member States.

The theme of World No Tobacco Day 2010 was "Gender and tobacco with an emphasis on marketing to women". A monograph on the topic was also published. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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	ON TRACK
6.3.2 Number of Member States with comprehensive bans on smoking in indoor public places and workplaces	ON TRACK
6.3.3 Number of Member States with bans on tobacco advertising, promotion and sponsorship	ON TRACK

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.

ON TRACK

An important milestone was reached when the Sixty-third World Health Assembly adopted resolution WHA63.13 on a Global strategy to reduce the harmful use of alcohol. The Regional Committee for Africa, at its Sixtieth Session, adopted resolution AFR/RC60/R2 on Reduction of the harmful use of alcohol: a strategy for the WHO African Region. Development of the global network of WHO national counterparts for implementation of the Global Strategy to Reduce the Harmful Use of Alcohol was initiated by WHO, and preparations were made for the first meeting of the global network in early 2011. A draft implementation plan for the Global Strategy was developed for discussion at the first global meeting.

In the Region of the Americas, a new regional strategy to reduce harmful substance use was approved. WHO advanced its work through the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) project and within the framework of the Joint WHO/United Nations Office on Drugs and Crime programme on Drug Dependence Treatment and Care.

Progress was made in monitoring and surveillance through the analysis of data on alcohol consumption, alcohol-related harm and policy responses for 193 Member States, and preparation of the global status report on alcohol and health for publication in early 2011. The Global Information System on Alcohol and Health, as well as the integrated regional information systems, were maintained, updated and prepared for integration with the Global Health Observatory. The global research projects on fetal spectrum disorders and harm to others were initiated.

The *ATLAS on resources for the prevention and treatment of substance use disorders* was published in December 2010. A global information system on prevention and treatment resources for substance use disorders is being prepared.

By the end of 2010, 42 countries had received technical support to develop strategies, plans and programmes for combating or preventing public health problems caused by alcohol, drugs and other psychoactive substance use. However, the adoption of the Global Strategy to Reduce the Harmful Use of Alcohol and of regional strategies in the Region of the Americas and the African Region have increased the demand from Member States for technical support and capacity building. Insufficient financial and human resources make it difficult to meet their expectations and to achieve the targets, particularly in the case of headquarters and the Regional Office for the Americas. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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 **ON TRACK**

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 **ON TRACK**

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.

ON TRACK

During 2010, the World Health Assembly, at its Sixty-third Session, adopted resolution WHA63.14 on Marketing of food and non-alcoholic beverages to children. Global recommendations on physical activity for health were approved and published. Technical tools related to the prevention of childhood obesity and salt-reduction strategies were developed through a series of technical meetings and information exchange forums.

The resources available for Organization-wide expected result 6.5 are concentrated on implementation of the Global Strategy on Diet Physical Activity and Health, mainly for development of guidelines and provision of technical support to Member States. However, across the Organization, capacity to support implementation is limited. Human and financial resources therefore need to be increased.

For the Organization-wide expected result to be fully implemented in all countries, more evidence on effective and cost-effective interventions is urgently required. Further, as most interventions related to diet and physical activity involve non-health sectors, guidance on engagement with sectors other than health is also required. While the Organization-wide expected result is rated as "on track", the Regional Office of the Americas rated it as "at risk" because of complications associated with multisectoral action. Support to Member States for implementation of resolution WHA63.14 on Marketing of food and non-alcoholic beverages to children may have to be scaled back if resources are not forthcoming. The United Nations General Assembly decision to host a high-level meeting on noncommunicable diseases in 2011 (resolution A/RES/64/265) will place greater demands on WHO. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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

ON TRACK

6.5.2 Number of WHO technical tools that provide support to Member States in promoting healthy diets or physical activity

ON TRACK

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.

ON TRACK

Technical support continued to be provided to Member States in all regions for the generation of evidence on the determinants and consequences of unsafe sex, including unintended pregnancies and sexually transmitted infection. A special tool for surveillance of unsafe sex, its determinants and consequences, using the WHO STEPwise approach to Surveillance of NCD Risk Factors (STEPS) approach was finalized. Indicators for the WHO STEPwise approach to Surveillance of NCD Risk Factors (STEPS) unsafe sex tool were introduced through regional workshops and support was provided for their inclusion in reproductive health monitoring frameworks. Only limited activities to tackle and manage the consequences of unsafe sex were carried out in the African and Eastern Mediterranean Regions.

In the area of prevention of HIV, work on the development of guidelines to prevent sexual transmission of HIV, using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology, have been initiated.

Support was provided to 34 Member States for the generation of evidence on determinants or consequences of unsafe sex, including those associated with multiple risk factors, such as alcohol intake and unsafe sex.

Comparative data on unsafe sex indicators were generated by a number of Member States, for example in Albania, Belarus and Latvia.

Elements of the WHO STEPwise approach to Surveillance of NCD Risk Factors (STEPS) unsafe sex module were included in the monitoring frameworks of reproductive health programmes and surveys, for example, in a knowledge, attitude and practices survey in Malaysia.

The target for indicator 6.6.1 has already been exceeded as a result of: inclusion of target B on achievement of universal access to reproductive health by 2015 under Millennium Development Goal 5, a sharper focus on improving measurement and surveillance activities in countries in general, and incorporating the indicator in other measurement systems. ■

PERFORMANCE INDICATORS

CURRENT STATUS

6.6.1 Number of Member States generating evidence on the determinants and/or consequences of unsafe sex	ON TRACK
6.6.2 Number of Member States generating comparable data on unsafe sex indicators using WHO STEPS surveillance tools	ON TRACK

SUMMARY OF FINANCIAL IMPLEMENTATION

(AS AT 31 DECEMBER 2010)

The approved budget for strategic objective 6 was US\$ 162 million of which US\$ 149 million (92% of the approved budget) was for base programmes and US\$ 13 million (8% of the approved budget) for special programmes and collaborative arrangements.

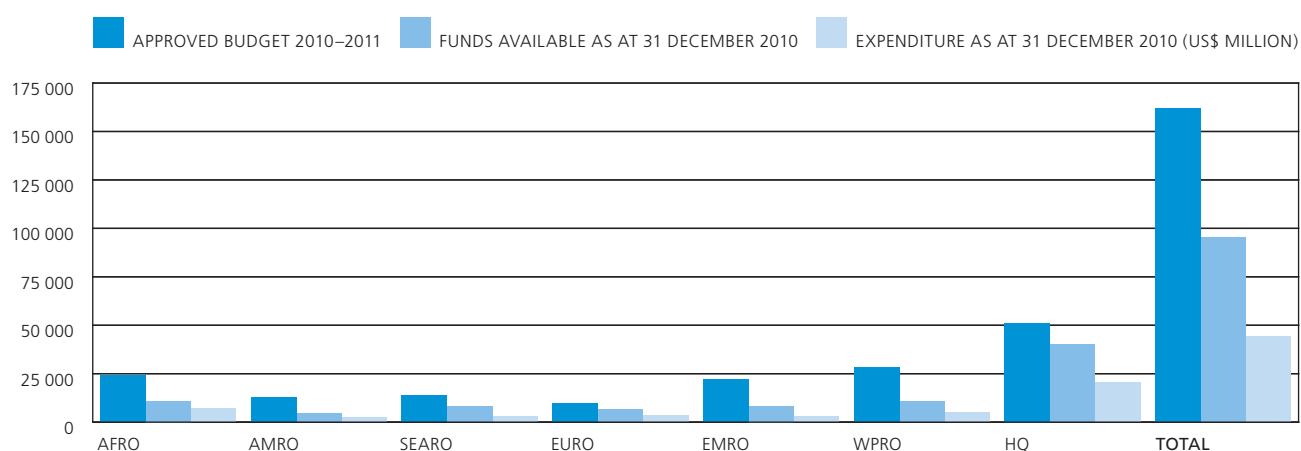
Available funding by the mid-term was US\$ 95 million (59% of the approved programme budget), US\$ 80 million (89% of the total available resources) and US\$ 15 million (11% of available resources) for special programmes and collaborative arrangements. Implementation as at 31 December 2010 was US\$ 44 million, which corresponds to 27% of the approved budget and 47% of the available resources. US\$ 37 million (84% of total resources implemented) were for base programmes and US\$ 7 million (16% of funds implemented) for special programmes and collaborative arrangements.

Limited financial and staff resources could make it difficult to meet all the targets for the strategic objective.

Inadequate financial resources for health promotion (Organization-wide expected result 6.1) across WHO, particularly in headquarters, are responsible for delaying activities. Coordinated resource mobilization is needed to re-position health promotion within and outside WHO.

The inadequacy of the resources available for Organization-wide expected result 6.4 could make it difficult to meet the expectations of Member States. While the demands of Member States have significantly increased in relation to implementation of the Global Strategy to Reduce the Harmful Use of Alcohol, the area of work remains underfunded and the number of staff at all levels of WHO is inadequate to deal with the public health problems caused by alcohol, illicit drugs and other psychoactive substances. ■

2010–2011 (US\$ 000)		AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	TOTAL
Approved programme budget 2010–2011		23 943	12 898	13 702	9 713	22 119	28 172	51 133	161 680
Funds available as at 31 December 2010 ^a	AC	8 202	2 876	3 568	1 097	4 502	3 326	7 548	31 119
	VC	2 745	1 477	4 621	5 556	3 857	7 511	32 690	63 989
	TOTAL	10 947	4 353	8 189	6 653	8 359	10 837	40 238	95 108
Funds available as % of approved budget		46%	34%	60%	68%	38%	38%	79%	59%
Expenditure as at 31 December 2010		7 047	2 379	2 961	3 510	3 033	5 011	20 321	44 262
Expenditure as a % of approved budget		29%	18%	22%	36%	14%	18%	40%	27%
Expenditure as a % of available funds		64%	55%	36%	53%	36%	46%	51%	47%



^a Total funds available includes US\$ 5.5 million of funds which were undistributed as of 31 December 2010.

PRIORITY RESULTS FOR 2011

An overall priority for the strategic objective, is the preparation for the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases to be held in September 2011.

In addition, special focus will be placed on supporting the implementation of the action plan for the global strategy for the prevention and control of noncommunicable diseases.

Other priorities include the completion of health promotion reviews under Organization-wide expected result 6.1 on health promotion, provision of support for the surveillance of noncommunicable diseases, including through the STEPwise approach and the global school-based student health survey methodology.

For Organization-wide expected result 6.3 on tobacco, technical assistance to Member States for the implementation of the WHO Framework Convention on Tobacco Control is the main priority. WHO will also support the establishment of the solidarity tobacco levy for innovative financing to improve country-level implementation of the Framework Convention and closely monitor attempts by the tobacco industry to undermine public health.

Priority will also be given to the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol under Organization-wide expected result 6.4. For Organization-wide expected result 6.5 on diet, physical activity and health, implementation of the Global Strategy on Diet, Physical Activity and Health, and the recommendations contained in resolution WHA63.14 on Marketing of foods and non-alcoholic beverages to children, as well as monitoring pledges by the food and non-alcoholic beverages industry to promote healthy diets and increase physical activity, are the main priorities.

The work under Organization-wide expected result 6.6 on consequences of unsafe sex, will focus on the implementation and monitoring of the global reproductive health strategy, including in relation to unsafe sex, preparation of a progress report on global reproductive health for consideration by the Executive Board and World Health Assembly in 2012 and support the WHO STEPwise approach to Surveillance of NCD Risk Factors (STEPS) unsafe sex module. ■

IDENTIFICATION OF SPECIFIC ACTIVITIES AND RESULTS THAT WILL BE REDUCED OR NO LONGER DELIVERED

Currently no results will be reduced or no longer delivered under strategic objective 6. ■

SO7

TO ADDRESS THE UNDERLYING SOCIAL AND ECONOMIC DETERMINANTS OF HEALTH THROUGH POLICIES AND PROGRAMMES THAT ENHANCE HEALTH EQUITY AND INTEGRATE PRO-POOR, GENDER-RESPONSIVE, AND HUMAN RIGHTS BASED APPROACHES



PROGRESS TOWARD THE ACHIEVEMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

OF THE FIVE ORGANIZATION-WIDE EXPECTED RESULTS FOR THIS STRATEGIC OBJECTIVE, FOUR WERE "ON TRACK" AND ONE "AT RISK"

OVERVIEW

A regional strategy on social determinants of health was developed in the African Region. A review of social determinants of health and the health divide was carried out in the European Region in 2010. Evidence on implementation of social determinants of health in countries was presented to the World Conference on Social Determinants of Health, held in Rio de Janeiro, Brazil, in October 2010.

The Regional Office for the Americas continued to promote the Faces, Voices and Places initiative with the Network of Healthy Municipalities for the advancement of the Millennium Development Goals

Three countries in the Western Pacific Region and two in the South-East Asia Region were supported to strengthen knowledge and awareness on trade and health linkages and the implications of certain flexibilities in the trade-related aspects of intellectual property rights (TRIPS) agreement. The Regional Committee for Europe, at its Sixtieth session, adopted resolution EUR/RC60/R6 on Health in foreign policy and development cooperation: public health is global health.

A policy dialogue was organized in October 2010 on improving women's health through better quality gender and health statistics, and concrete actions for promoting gender equality were discussed with partners.

Human rights-based tools and guidance documents were produced, including on assessing policy coherence in relation to human rights and gender equality in health sector strategies, as well as an information sheet on a human rights-based approach to health, a fact sheet on the right to water, and a manual on public health law. The Regional Office for Europe appointed a technical officer with responsibility for work on human rights. The subject is a core element in the new European "Health 2020" policy, and in a global project on managing a rights-based approach to the Millennium Development Goals being coordinated by the Danish Institute for Human Rights.

In the Region of the Americas, six countries were given technical assistance in order to apply the provisions of human rights treaties and standards in specific health areas. The Regional Office for Africa provided training for about 23 people from the Economic Community of West African States on approaches to integrating health and human rights aspects in programmes.

The Regional Office for South-East Asia supported numerous advocacy and capacity building efforts, including training and orientation courses on the health workforce; creation of a health workforce web site; distribution of advocacy materials; and through the provision of technical support to countries.

WHO was reconfirmed as the permanent secretariat for the Global Summit of National Bioethics Advisory Bodies, and the Organization played a leading role in high-level global consultations. A document on guidance on the ethics of tuberculosis prevention, care and control was published and further guidance on the ethics of research in international epidemic response is under development.

Monitoring and evaluation of gender was undertaken through the Global Management System and the gender indicator in the Mid-term review of implementation of the Programme budget 2010–2011. The WHO report, *Women and health: today's evidence tomorrow's agenda* was issued, and a policy meeting was held to strengthen the knowledge base on gender and women and health.

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. ■

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.

ON TRACK

The Regional Committee for Africa, at its Sixtieth session, adopted resolution AFR/RC60/R1 on a strategy for addressing key determinants of health in the African Region. The strategy places emphasis on addressing the structural causes of ill-health and premature death associated with access, affordability and availability, and deals with issues beyond the risk factors. Some specific interventions proposed in relation to the health sector are: strengthening the stewardship and leadership role of ministries of health; building capacity for policy development, leadership and advocacy; advocating for legislation and regulations to ensure a high level of protection of the general population; creating health systems based on universal and quality health care; and, enhancing fairness in health financing and resource allocation.

Five countries in the Western Pacific Region were supported to develop and implement health with a focus on equity. A review on social determinants of health and the health divide was carried out in the European Region; it will inform the new European Health Policy: Health 2020 to be presented to the Regional Committee in 2012. Technical advice on achieving equity was also provided to the Spanish Ministry of Health, in preparation for the country's assumption of the European Union presidency in January 2010. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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

ON TRACK ■

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.

ON TRACK

Knowledge sharing and the development of tools in the area of social determinants of health were given strategic priority. A web-based interactive platform was developed. A web-based tool for health system actions to tackle socially determined health inequalities, including 10 case studies, was developed by the Regional Office for Europe. The Regional Office for the Americas issued a set of indicators for assessing the progress made towards ameliorating the causes of the determinants of ill health, in order to improve the tracking of advances in addressing social determinants of health. The Regional Office continued to promote the Faces, Voices and Places initiative in pursuit of achievement of the Millennium Development Goals.

Meetings attended by academics and practitioners were held on evaluating intersectoral action for social determinants of health, and joined-up governance. The WHO discussion paper series on social determinants of health was published. The Regional Offices for Africa, South-East Asia, the Eastern Mediterranean and Western Pacific, and headquarters, provided support to about 10 country offices for building the knowledge base on social determinants of health, convening meetings to strengthen intersectoral collaboration at the national level and for documenting case studies. In response to the recommendations of the Commission on Social Determinants of Health, a capacity building workshop on health in all policies was held, and materials were prepared to guide health policymakers in promoting health in all policies and intersectoral action for health in dialogue with other sectors, in this case, agriculture and education and the private sector.

Three countries in the Western Pacific Region were supported to strengthen knowledge and awareness on trade and health linkages, and the implications of certain flexibilities in the trade-related aspects of intellectual property rights (TRIPS) agreement. The Regional Committee for Europe, at its Sixtieth session, adopted resolution EUR/RC60/R6 on Health in foreign policy and development cooperation: public health is global health. ■

PERFORMANCE INDICATORS

CURRENT STATUS

7.2.1	Number of published country experiences on tackling social determinants for health equity	ON TRACK
7.2.2	Number of tools to support countries in analysing the implications of trade and trade agreements for health	ON TRACK

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).

AT RISK

A lack of demand for technical support from Member States under Organization-wide expected result 7.3 (social and economic data relevant to health) was reported by the Regional Office for the Eastern Mediterranean and headquarters, hence the “at risk” rating.

The Regional Offices for the Americas, Europe, South-East Asia and Western Pacific are “on track” to achieve the indicator in terms of undertaking activities to promote the generation and analysis of disaggregated data. The Regional Offices for Africa and the Eastern Mediterranean have carried out capacity building in the area of equity analysis, however, no progress was made towards publishing additional national reports. A policy dialogue to strengthen evidence to improve women’s health through gender and health statistics was held in October 2010. ■

PERFORMANCE INDICATORS

CURRENT STATUS

7.3.1 Number of country reports published during the biennium incorporating disaggregated data and analysis of health equity

AT RISK

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

ON TRACK

Human rights-based tools and guidance documents were developed by headquarters, including on assessing policy coherence in relation to human rights and gender equality in health-sector strategies. An information sheet on a human rights-based approach to health, a fact sheet on the right to water, and a manual on public health law were also produced. The Regional Office for Europe appointed a technical officer with responsibility for human rights-based work. The subject is a core element in the new European “Health 2020” policy, and in a global project on managing a rights-based approach to the Millennium Development Goals being coordinated by the Danish Institute for Human Rights.

The Regional Office for South-East Asia supported numerous advocacy and capacity building efforts, including training and orientation courses on the health workforce; creation of a health workforce web site; distribution of advocacy materials; and through the provision of technical support to countries, for example, Maldives, Nepal and Sri Lanka. New tools, including fact sheets on toxic waste and the health of older persons, were prepared.

In the Region of the Americas, six countries were given technical assistance for the application of the provisions of human rights treaties and standards in specific health areas. The Regional Office for Africa provided training for about 23 people from the Economic Community of West African States on approaches to integrating health and human rights aspects in programmes.

WHO’s collaboration with the United Nations Human Rights System on a human rights-based approach to health was enhanced through its participation in, inter alia, the expert group meeting on the human rights of older persons, and a consultation on access to essential medicines as a component of the right to health, both organized by the United Nations Office of the High Commissioner for Human Rights. WHO also contributed to a number of strategic documents and reports, including a report by the United Nations Office of the High Commissioner for Human Rights on preventable maternal mortality and morbidity and other reports issued by the United Nations Office of the High Commissioner for Human Rights on the human rights of migrants, human rights and extreme poverty, and principles and guidelines for the elimination of discrimination against persons affected by leprosy and their family members.

WHO was reconfirmed as the permanent secretariat for the Global Summit of National Bioethics Advisory Bodies, and the Organization played a leading role in high-level global consultations, in particular through collaboration with the United Nations Inter-agency Committee on Bioethics, the Council of Europe and the World Medical Association. The Global Summit of National Bioethics Advisory Bodies established a working group to contribute to the dissemination and implementation of the WHO document on guidance on the ethics of tuberculosis prevention, care and control; it also entered into an agreement on monitoring and implementation activities connected with adoption by the Sixty-third World Health Assembly of resolution WHA63.22 on Human organ and tissue transplantation. The WHO guidance document on ethics and pandemic influenza was further disseminated. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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 **ON TRACK**

7.4.2 Number of tools produced for Member States or the Secretariat giving guidance on use of ethical analysis to improve health policies **ON TRACK**

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.

ON TRACK

The WHO report, *Women and health: today's evidence tomorrow's agenda* was issued. Workshops and training activities to promote gender responsiveness across the Organization were conducted, and technical support provided to advance gender mainstreaming in public health programmes. A policy meeting on strengthening the knowledge base on gender, and women and health, resulted in a call for action to improve the quality of gender and health statistics and reduce inequities. WHO introduced a gender classification into the Global Management System, and continued to develop strategies at national and local level on the promotion of intersectoral action to incorporate health and health promotion into all policies, and to strengthen technical cooperation in the areas of gender, ethnicity and human rights. However, finding concrete ways in which to address health inequities and social determinants of health continued to elude many Member States. ■

PERFORMANCE INDICATORS

CURRENT STATUS

7.5.1 Number of WHO tools, documents developed or updated or joint activities by WHO technical units undertaken, in order to promote gender-responsive actions in the work of WHO

ON TRACK

7.5.2 Number of gender mainstreaming activities conducted in Member States and supported by WHO

ON TRACK

SUMMARY OF FINANCIAL IMPLEMENTATION

(AS AT 31 DECEMBER 2010)

The total approved budget for the biennium 2010–2011 for strategic objective 7 was US\$ 63 million for base programmes. As at 31 December 2010, available resources were US\$ 35 million (56% of the approved budget).

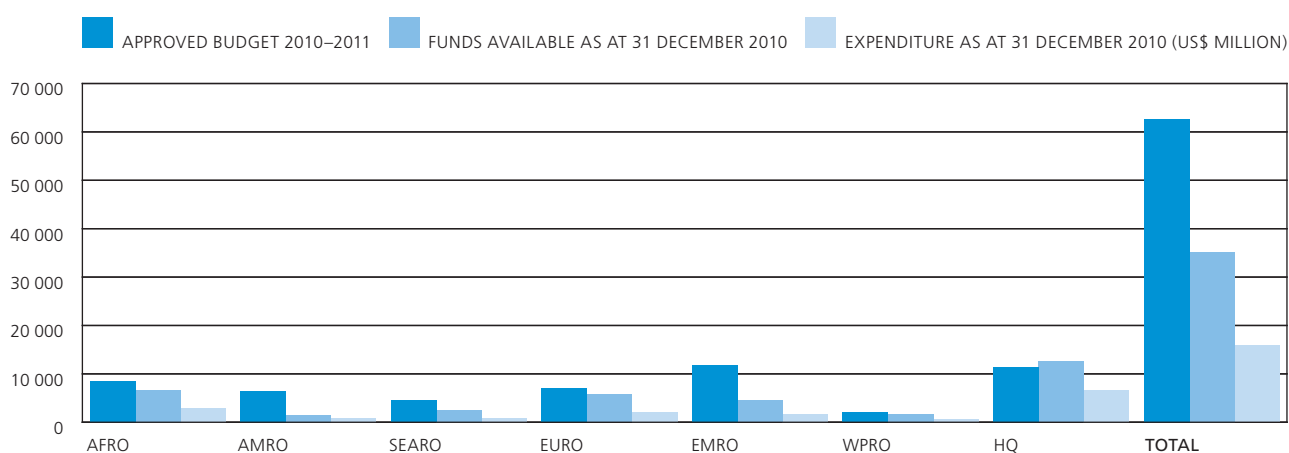
The implementation rate (expenditures) against available funds as at 31 December 2010 was 45%, which is as expected for the first year of the biennium.

Five of the seven major offices have available resources of 50% or more compared to the approved programme budget.

Much of the funding secured during 2010 was specified for Organization-wide expected results 7.1 to 7.3. Organization-wide expected result 7.4 relied on core funding and also included activities that were supported by funding from other strategic objectives. While the Programme budget allocation remains adequate, shifts are needed between Organization-wide expected results 7.1 and 7.4 to allow for an increase in the allocation for Organization-wide expected result 7.4 (human rights and ethics) in order to bring it into line with the planned costs. In view of the proposed mainstreaming of social determinants of health and increasing demand for country work on priority public health conditions to address social determinants within public health programmes, more resources will be required for this area.

The gender strategy needs strong leadership and commitment in order to fully fund the budget for Organization-wide expected result 7.5. ■

2010–2011 (US\$ 000)		AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	TOTAL
Approved programme budget 2010–2011		8495	6422	4501	6944	11835	2011	22439	62647
Funds available as at 31 December 2010 ^a	AC	4962	1299	1072	651	2428	178	4796	15386
	VC	1705	210	1413	5043	2069	1534	7742	19851
	TOTAL	6667	1509	2485	5694	4497	1712	12538	35237
Funds available as % of approved budget		78%	24%	55%	82%	38%	85%	56%	56%
Expenditure as at 31 December 2010		2979	912	828	2111	1760	636	6679	15905
Expenditure as a % of approved budget		35%	14%	18%	30%	15%	32%	30%	25%
Expenditure as a % of available funds		45%	60%	33%	37%	39%	37%	53%	45%



^a Total funds available includes US\$ 134,000 of funds which were undistributed as of 31 December 2010.

PRIORITY RESULTS FOR 2011

Strategic objective 7 will continue providing support to countries to implement regional strategies on social determinants of health, and will continue the work on public health programmes to mainstream health equity and social determinants of health.

Specific priority activities include the organization of the World Conference on Social Determinants of Health in 2011 and follow-up activities will require significant human and financial resources. A web-based community of practice portal (linked to tools for Organization-wide expected result 7.1) will be created for following up the 2011 World Conference on Social Determinants of Health.

In addition, WHO will develop a tool to support intersectoral dialogue on public health, as well as a searchable evidence database containing case studies of intersectoral approaches to social determinants of health and health equity, will design and pilot a training curriculum and resource materials on health in all policies through a summer school, will publish a source book on trade and health and will develop a global health negotiation tool.

An outline for the trade and health tool will be further elaborated, in consultation with stakeholders, and made available for use by the end of 2011.

WHO will continue its normative work in headquarters and the harmonization of guidance with other entities at regional level including finalization of guidelines on monitoring health inequalities, and a template for producing a national health equity report. The Secretariat will produce a set of indicators and methodology on gender and women's health and will finalize and implement the strategic document on mainstreaming human rights across WHO.

In 2011, the Secretariat will continue the technical collaboration with national ethics committees, in particular through the Global Summit of National Bioethics Advisory Bodies, and develop internal mechanisms to ensure policy coherence in public health and research ethics. WHO will monitor and measure gender-based health inequities in collaboration with regional offices and the United Nations Statistics Division to follow up on the policy dialogue in countries and will strengthen institutional mechanisms, such as minimum standards for gender mainstreaming across the Organization. The Secretariat will also continue the work on strengthening gender-sensitive national HIV monitoring and evaluation in collaboration with UNAIDS and the German Development Agency, and on violence against sex workers. ■

IDENTIFICATION OF SPECIFIC ACTIVITIES AND RESULTS THAT WILL BE REDUCED OR NO LONGER DELIVERED

The development of a capacity building strategy on the social determinants of health, and instruments to support its implementation, might be delayed or reduced in scope, but maximum use will be made of the few contributions, especially for training purposes.

Work on a social protection floor will be abandoned while work related to trade and health will be covered under the activities related to the Global Strategy on Public Health, Innovation and Intellectual Property.

Technical support to countries for equity analysis and research will be reduced making it more difficult for them to integrate a human rights-based approach in health policies and programmes.

Activities related to capacity building on ethics in countries will either be abandoned or reduced in number, and training will have to be confined to areas in which WHO's contribution is unique.

Technical support on gender mainstreaming and the production of publications and tools will be scaled down and activities related to capacity building in that area in countries that involve travel will either be reduced in number or no longer delivered. ■



**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**



**PROGRESS TOWARD
THE ACHIEVEMENT OF
ORGANIZATION-WIDE
EXPECTED RESULTS**

OF THE SIX ORGANIZATION-WIDE EXPECTED RESULTS FOR THIS STRATEGIC OBJECTIVE, ALL WERE "ON TRACK"

OVERVIEW

Efforts have continued to successfully promote healthy environments, so as to mitigate the 25% global burden of disease attributable to modifiable environmental factors.

The normative work on traditional environmental threats to public health continued, for example through activities on chemical and radiation hazards, and, in particular, in relation to air and water quality. Some recent publications include: a revised version of the WHO classification of pesticides by hazard and guidelines to classification: 2004, which is used in pesticide regulation in developing countries, and the Human health risk assessment toolkit: chemical hazards, which is aimed at increasing capacity for risk assessment in developing countries. A WHO expert consultation concluded an assessment of the human health aspects of the use of DDT in indoor residual spraying in order to inform WHO's policies, as well as the work of the Conference of the Parties to the Stockholm Convention on Persistent Organic Pollutants in connection with disease vector control, particularly for malaria.

Encouraging other sectors to take account of public health interests is an essential part of the work under strategic objective 8. Following the First Inter-Ministerial Conference on Health and Environment in Africa held in Libreville, Gabon in August 2008, the implementation of the Libreville Declaration was initiated in 2009, and over a third of African countries have now begun, and, in most cases, completed, detailed situation analyses and needs assessments as the scientific basis for the formulation of national plans of joint action.

The Second Inter-Ministerial Conference on Health and Environment in Africa was held in Luanda, Angola on 23–26 November 2010. The Conference endorsed the conclusions and recommendations of the first regional synthesis report on the situation analyses and needs assessments completed by 12 countries, adopted the Luanda Commitment in which governments agreed on the continent's top ten priorities for health and environment linkages and pledged to implement a number of time-bound priority actions, institutionalized the Health and Environment Strategic Alliance, and adopted a common position for Africa on climate change and health.

The second major intersectoral initiative focused on climate change and human health. Progress was made in all areas of the workplan on climate change and health endorsed by the 124th Executive Board. Increased consideration is being given to health in the United Nations climate change process and a new contact group composed of interested country delegates, nongovernmental organizations and the United Nations was established following advocacy and partnership development efforts. WHO assumed responsibility for the coordination of a cross-United Nations group focusing on the social dimensions of climate change. WHO also supported the preparation and promotion by the Regional Office for Africa of the African Ministers of Health and Environment joint statement on climate change and health, as well as comparable high-level intersectoral initiatives undertaken by the Regional Offices for the Americas, South-East Asia and the Western Pacific.

WHO published summaries of the health implications of climate-change mitigation policies in major sectors; contributed to the special report on extreme events of the Intergovernmental Panel on Climate Change; carried out a systematic review of the degree to which current research on climate change and health

matches the expressed priorities of Member States, and made advances in estimating the burden of disease due to climate change. A global project on health adaptation to climate change was initiated covering seven countries from all WHO regions, as well as work with PAHO aimed at developing and field testing guidance on vulnerability and adaptation.

In 2010, WHO began to provide technical support to countries for the management of health benefits and risks from extractive industry projects in response to an increasing demand for support in that area. Intersectoral work continued with development banks to promote the adoption and implementation of health performance for their investments in developing countries following WHO guidance, and in the context of implementation of binding and non-binding international agreements for the sound management of chemicals. Consultations began on a draft strategy to promote health sector engagement in the Strategic Approach to International Chemicals Management. With UNEP, WHO established a global alliance to eliminate lead paint, which remains a leading cause of childhood lead poisoning in many countries and has a significant impact on neurological and cognitive development at even low levels of exposure. In a further effort to diminish the burden of disease attributable to chemicals, WHO contributed to the negotiations on a legally-binding treaty on mercury, which began 2010.

The Organization's technical work underpinned and facilitated the launch of the global alliance for clean cookstoves in 2010, in which WHO participated. Smoke from primitive cookstoves, the primary tool for cooking and heating for nearly three billion people, causes 1.9 million premature deaths annually and contributes to a range of acute and chronic illnesses and health impacts, with women and young children suffering most. The alliance, in which WHO is partnered by UNEP, the United Nations Foundation, UN-Energy, the WFP and others, including the Clinton Foundation, aims to reduce the global burden of disease attributable to indoor air pollution (including childhood deaths from pneumonia in accordance with Millennium Development Goal 4) and to contribute to the mitigation of climate change.

Environmental emergency-response activities, both within and outside the remit of the International Health Regulations (2005), included a field response to a major incident in Nigeria arising from the processing of lead-rich ore for the extraction of gold, and an outbreak of childhood deaths originally attributed to malaria but actually due to the toxic effects of lead. Since March 2010, 3141 children with lead poisoning have been identified, of whom 207 have died; additional populations have not yet been assessed. Field support was provided during the earthquake in Haiti and the floods in Pakistan. Headquarters and the Regional Office for Europe also supported the response to both the volcano that erupted in Iceland causing widespread concern about potential public health impacts that, in the end, did not materialize; and the forest wildfires and heat wave in Russia, which had a severe impact on respiratory health and increased mortality.

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 is likely to be reduced. ■

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 waste-water reuse).

ON TRACK

Normative outputs during 2010 included the reports of the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation and the UN-Water Global Annual Assessment of Sanitation and Drinking Water, which are the official United Nations mechanisms for monitoring progress towards attainment of Millennium Development Goal target 7C. The WHO Guidelines for drinking-water quality continue to be one of the most frequently accessed reference sources on the WHO web site. Information on the safe use of wastewater in agriculture and aquaculture was made available in September 2010. Major operational inputs were provided by two WHO staff members in the wake of the earthquake in Haiti and flooding in Pakistan.

Recent publications related to chemical hazards include: a revised version of the WHO classification of pesticides by hazard and guidelines to classification: 2009 and the Human health risk assessment toolkit: chemical hazards, aimed at increasing capacity for risk assessment in developing countries. A WHO expert consultation concluded an assessment of the human health aspects of the use of DDT in indoor residual spraying in order to inform WHO's policies, as well as the work of the Conference of the Parties to the Stockholm Convention on Persistent Organic Pollutants in relation to disease vector control.

Consultations began on a draft strategy to promote health sector engagement in the Strategic Approach to International Chemicals Management. With UNEP, WHO established a global alliance to eliminate lead paint, which remains a leading cause of childhood lead poisoning in many countries, with even low-level exposure resulting in cognitive, motor and sensory deficits and consequent learning disabilities. WHO also contributed to the negotiations on a legally-binding treaty on mercury, which began 2010.

A research agenda on radiofrequency fields was developed, published and disseminated in 2010. In addition, revision of the International basic safety standards for protection against ionizing radiation and for the safety of radiation sources was completed and co-sponsored by eight international organizations, including WHO. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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	ON TRACK
8.1.2 Number of new or updated WHO norms, standards or guidelines on occupational or environmental health issues published during the biennium	ON TRACK

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).

ON TRACK

WHO joined a global alliance for clean household energy with other United Nations agencies and stakeholders. As leader of the health component, WHO is striving to reduce the global burden of disease attributable to indoor air pollution (including childhood deaths from pneumonia in accordance with Millennium Development Goal 4). A global database on solid fuel use has been amended, and an update issued. Support was provided to countries with high indoor air pollution problems, namely, Bangladesh, Cameroon, Ethiopia, Guatemala, India, Kenya and Madagascar. An international expert group was established on building houses that are healthy for people to live in and guidelines approved by the Guidelines Review Committee are being prepared.

Workshops offering technical support for reducing risks from indoor radon were held in the African and European Regions; and for appropriate use of radiation in health-care settings in the Region of the Americas and the European and South-East Asia Regions.

Technical support on reducing environmentally-related illnesses among children was made available through workshops in South Africa and Turkey. In 2010, the first meeting of the WHO network of collaborating centres on children's health and the environment was held; it included two newly established collaborating centres. From 2010, environmental health will be a permanent agenda item on the ministerial programme of the Council of Arab Ministers Responsible for the Environment. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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

ON TRACK

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

ON TRACK

Resolution WHA60.26 on Workers' health: global plan of action has been implemented in 28 countries, with the support of WHO collaborating centres in the occupational health network in all six regions. A health-care worker protection package has been deployed in over 20 countries, and capacity-building tools disseminated. Joint WHO-ILO-UNAIDS policy guidelines for improving access for health workers to HIV and tuberculosis prevention, treatment, care and support were published in November 2010, with the involvement of 30 countries. In addition, a joint WHO-ILO global framework for national occupational health programmes for health workers was prepared. Capacity building for surveillance of occupational exposure to bloodborne pathogens was carried out in Colombia, Egypt and Peru, and in order to protect health workers from biological hazards. A project to enhance surveillance for childhood poisoning from kerosene and other chemicals was launched in Uganda and Zambia. In the Eastern Mediterranean Region, the Centre for Environmental Health Activities provided technical support and training to Jordan, Lebanon, Pakistan, Sudan, Syrian Arab Republic and Yemen for the development of their national health-care waste management guidelines. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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

ON TRACK

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.

ON TRACK

Tools to assess the health impact of transportation in developing country cities have been developed and are being implemented.

Training in radiation risks was provided through the International Chernobyl Research and Information Network project to populations in Belarus, the Russian Federation and Ukraine. Guidance on electromagnetic fields, particularly in connection with mobile telephones and health, was provided to Member States.

The Regional Office for South-East Asia engaged all countries in the Region in developing advocacy materials and participating in the urbanization and health 1000 cities, 1000 lives campaign. ■

PERFORMANCE INDICATORS

CURRENT STATUS

8.4.1 Number of Member States that are implementing WHO-supported initiatives to identify and respond to the health impacts of activities in one or more of the following sectors: agriculture, energy and transportation

ON TRACK

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.

ON TRACK

Three reports on children's special vulnerability to chemicals in the environment were published: *Healthy environments for healthy children*, *Childhood lead poisoning*, and *Children's environmental health units*.

The Fifth European Ministerial Conference on Environment and Health, held in Parma, Italy in March 2010, resulted in the adoption of the Parma Declaration on Environment and Health and in a new institutional framework to advance the implementation of the Parma commitments. In 2010, a ministerial board for environment and health was established. The members with health expertise were elected by the Regional Committee for Europe and those dealing with the environment by the environmental policy committee of the United Nations Economic Committee for Europe.

An environmental due diligence procedure for public health programmes was developed, and capacity building in African countries undertaken; support for implementation of the procedure was made available to over 100 countries. In 2010, WHO began to provide technical support to countries for managing the health benefits and risks from extractive industry projects. Specific activities included: convening a meeting to share experience and good practice; provision of support to an African country for the inclusion of health in the governance mechanisms of its new oil wealth; preparation of draft guidance for managing health risks in the context of extractive activities; and organization of a side event on the same subject at the Second Inter-Ministerial Conference on Health and Environment in Africa. The demand for support in this area from countries is growing. WHO continued to encourage development banks to promote the adoption and implementation of health performance for their investments in developing countries in accordance with WHO guidance. An analysis of health in the green economy was completed for transport, housing, health

care and household energy, and the results were disseminated at the United Nations climate change negotiations, held in Cancun, Mexico, in December 2010. Good practice guidance on greening the health sector was issued and support provided for national initiatives in several countries.

In October 2010, PAHO published *Determinantes Ambientales y Sociales de Salud* and the Regional Office for the Americas initiated preparatory work, in consultation with headquarters, for the United Nations Conference on Sustainable Development, to be held in Rio de Janeiro, Brazil, on 4–6 June 2012.

The Regional Offices for South-East Asia and the Western Pacific convened a Second Ministerial Regional Forum on Environment and Health in South-East and East Asian Countries, in Jeju, Republic of Korea in July 2010, in collaboration with the UNEP Regional Office for Asia and the Pacific. The Ministers attending the Forum approved the 2010–2013 workplans of the regional thematic working groups on air quality, water, sanitation and hygiene, solid and hazardous waste, toxic chemicals, climate change, environmental health emergencies, and health impact assessment, and established a task force to enhance governance and partnership within the Regional Forum, as well as its effectiveness. ■

PERFORMANCE INDICATORS

CURRENT STATUS

8.5.1 Number of studies or reports on new and re-emerging occupational and environmental health issues published or co-published by WHO	ON TRACK
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	ON TRACK
8.5.3 Number of high-level regional forums on environment and health issues organized or technically supported by WHO biennially	ON TRACK

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.

ON TRACK

Headquarters' contributions to both technical studies and reports and country support are on track. A high baseline was set for indicator 8.6.1. because of the long-term nature of the scientific work, and output is on track for the biennium, with greater emphasis being placed on guidance and assessment of practical interventions. Support for indicator 8.6.2. is mainly provided through the seven-country WHO/UNDP/GEF global project on health adaptation to climate change. The Regional Office for South-East Asia convened a high-level meeting in Bangladesh for Member States from South-East Asia. Their common concern about the effects of climate change on health in the Region was articulated in the Dhaka Declaration issued before the Sixteenth Conference of the Parties to the United Nations Framework Convention on Climate Change, held in Cancun, Mexico in December 2010. The Regional Offices for Africa, the Americas and the Eastern Mediterranean carried out similar exercises. ■

PERFORMANCE INDICATORS

CURRENT STATUS

8.6.1	Number of studies or reports on the public health effects of climate change published or co-published by WHO	ON TRACK
8.6.2	Number of countries that have implemented plans to enable the health sector to adapt to the health effects of climate change	ON TRACK

SUMMARY OF FINANCIAL IMPLEMENTATION

(AS AT 31 DECEMBER 2010)

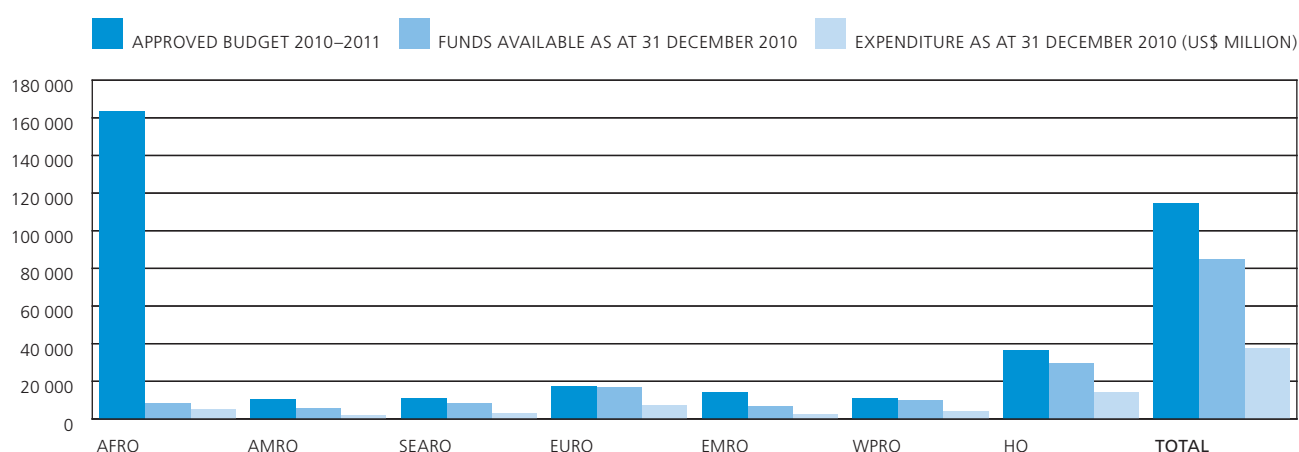
The approved budget for strategic objective 8 was US\$ 114 million relating primarily to base programmes.

Available funding by the mid-term was US\$ 85 million and implementation as at 31 December 2010 was US\$ 37 million, that is, 44% against the funds available and 33% against the approved Programme budget.

Having reached the end of the first year of the biennium, overall, the budgeted activities for strategic objective 8 are on track with an appropriate implementation rate. As a result of efforts to mobilize resources, available funding to date indicates a solid implementation rate of 74% against the programme budget ceiling.

Despite substantial funding gaps, some major offices indicate strong implementation against funds available. For example, as at 31 December 2010, the Regional Office for Africa indicated having 51% of funds available against approved Programme budget allocation with an implementation rate of 61%. Of funds available to the Regional Office of the Americas, (52% against the Programme budget), it was noted that external funding made available is earmarked for specific areas which limits capacity and restricts potential technical cooperation with countries. While current fund-raising efforts by the Regional Office for Europe have been successful, additional funds of about US\$ 2 million will be needed in 2011 to support implementation of new activities connected with implementation of the Parma commitments, and environment and health emergencies. ■

2010–2011 (US\$ 000)		AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	TOTAL
Approved programme budget 2010–2011		16 335	10 437	11 002	17 220	14 053	10 702	34 615	114 364
Funds available as at 31 December 2010 ^a	AC	4 761	4 940	5 336	1 305	3 112	2 702	7 920	30 076
	VC	3 534	439	3 164	15 235	3 569	7 141	21 674	54 766
	TOTAL	8 295	5 379	8 500	16 540	6 681	9 843	29 594	84 842
Funds available as % of approved budget		51%	52%	77%	96%	48%	92%	85%	74%
Expenditure as at 31 December 2010		5 051	1 751	2 956	7 394	2 307	3 986	13 836	37 280
Expenditure as a % of approved budget		31%	17%	27%	43%	16%	37%	40%	33%
Expenditure as a % of available funds		61%	33%	35%	45%	35%	40%	47%	44%



^a Total funds available includes US\$ 10,000 of funds which were undistributed as of 31 December 2010.

Most of the resources for strategic objective 8 continue to be highly-specified voluntary funds raised directly by the technical programmes. This limits flexibility with the strategic objective, as well as in technical activities in major offices. As a result, some funding gaps exist in certain critical areas of activity and for covering some salaries.

Because of the highly-specified nature of voluntary contributions and an increasingly unstable global economy, the support of senior management at headquarters and in the regions is vital, not only for the resource mobilization efforts of the budget centres, but also at corporate level, to ensure the continued stability of the strategic objective during the next biennium. Strategic objective 8 is reliant on the flexibility of regular budget and corporate allocations to fill existing funding gaps, particularly for salaries, as well as to ensure cash flow in budget centres as specified voluntary funds are received across calendar years, as well as bienniums.

Closer planning, fund raising and coordination across the three levels of the Organization are required to support countries' activities. ■

PRIORITY RESULTS FOR 2011

Under Organization-wide expected results 8.1 and 8.3 on environmental hazards and occupational health risks, strategy formulation is progressing for water quality and health, and for the International Small Community Water Supply Network and International Network of Drinking-Water Regulators, and will soon be initiated for the global task force on cholera control, water and sanitation in specific settings and water resources development and health. The separate strategies will then be amalgamated and used for further resource mobilization. Financial support from a country donor supported intensified capacity building for water safety planning in six countries in the South-East Asia and Western Pacific Regions, although budget ceiling complications at all levels of the Organization have delayed the distribution of funds.

Priority with regard to chemical hazards is being given to carrying out a risk assessment on aircraft disinfection chemicals in accordance with the International Health Regulations (2005), improving methodologies for chemical risk assessment, including countries' capacity to undertake them, facilitating the establishment and strengthening of poisons centres, strengthening public health inputs into international instruments, including the Strategic Approach to International Chemicals Management, implementing the global alliance to eliminate lead in paints, and preparing WHO guidelines for the clinical management of lead poisoning and prevention of lead exposure.

For Organization-wide expected results 8.4 and 8.5 on influencing policy and health-sector leadership, in 2010, five-year strategies for various programme components were developed aimed at ensuring more targeted resource mobilization. Strategies for the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation, the UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water, and the household water treat-

ment and safe storage network (co-hosted by WHO and UNICEF) were completed, and, thus far, the first two have yielded US\$ seven million and US\$ two million, respectively.

Less attention will be focused on the generation of new advocacy products and greater emphasis placed on the effective dissemination of existing and new science and policy guidance for Organization-wide expected result 8.6 on climate change. Headquarters will continue to work with regional offices to produce products that are of global relevance rather than region-specific, and to more fully involve external technical partners in carrying out the activities in the WHO workplan on climate change and health. The use of online meetings and videoconferencing will be stepped up in order to reduce travel costs and environmental impact.

The budget available for Organization-wide expected result 8.6. until the end of 2011 is sufficient for advances to be made in all activities requested by Member States under the workplan on climate change and health, with the adjustments described above. Of the 18 activities in the workplan, four will not be completed this year (3.6 indicator development, 3.7 economic assessment, 4.5 early warning system evaluation and 4.6 emergency management evaluation), but this reflects the distribution of work across the period covered by the workplan (2008–2013) rather than a lack of resources during the biennium. If resources are made available at the level specified at the time the workplan was approved by the Executive Board, all Member States' expectations will be met. ■

IDENTIFICATION OF SPECIFIC ACTIVITIES AND RESULTS THAT WILL BE REDUCED OR NO LONGER DELIVERED

The work for the global alliance to eliminate lead in paints has been redistributed among existing staff and a reduction in output, compared to initial targets, is expected as technical staff for this work may not be available this biennium owing to funding constraints. In general, funding for the chemicals team is tenuous and the situation needs to be monitored carefully.

Because of financial constraints, some activities pertaining to water resources and health, including health impact assessment and environmental management, will have to be deferred to 2012. However, the work on the formulation of health impact assessment policy in the Mekong countries is continuing. Contributions to the work on emergencies and humanitarian crises will need to be phased out unless compensation for staff time and normative functions is improved. The work of the global task force on cholera control cannot be carried out to the minimum level required without additional financial and human resource inputs.

In the African Region, the number of countries implementing the Libreville Declaration will be reduced owing to a lack of funds. ■



TO IMPROVE NUTRITION, FOOD SAFETY AND FOOD SECURITY, THROUGHOUT THE LIFE COURSE, AND IN SUPPORT OF PUBLIC HEALTH AND SUSTAINABLE DEVELOPMENT



PROGRESS TOWARD THE ACHIEVEMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

OF THE SIX ORGANIZATION-WIDE EXPECTED RESULTS FOR THIS STRATEGIC OBJECTIVE, FIVE WERE "ON TRACK" AND ONE "AT RISK"

OVERVIEW

The Nutrition Guidance Expert Advisory Group was established, with four sub-groups. A total of 147 countries have adopted the WHO growth standards. The Nutrition Landscape Information System and the WHO Vitamin and Mineral Nutrition Information System were expanded. In 2010, two international standards to limit melamine contamination in powdered infant formula and other foods were adopted. A global nutrition policy review was conducted and responses were received from 119 Member States and 4 territories. The assessment of food safety programmes continued, bringing the total number of countries with assessment reports, policies or action plans to 28. A childhood obesity surveillance system, and a database on the implementation of food and nutrition policies were established in the European Region.

The Sixty-third World Health Assembly adopted resolution WHA63.23 on Infant and young child nutrition and resolution WHA63.3 on Advancing food safety initiatives.

In the Eastern Mediterranean Region, the Fifty-seventh session of the Regional Committee approved the Regional Strategy and Plan of Action on Nutrition. South Africa received support to intensify food safety activities in preparation for the 2010 FIFA World Cup. The 5 Keys to Safer Food have now been translated into 27 European languages. Support was provided to targeted countries in the Western Pacific Region through the national plan of action on nutrition. Support was provided for the Pacific Food Summit 2010 and the adoption and implementation of the Framework for Action on Food Security in the Pacific.

WHO has played an active role in the United Nations Standing Committee on Nutrition and in global initiatives such as the Scaling Up Nutrition initiative and the 1,000 days campaign. In the Region of the Americas, the Pan American Alliance for Nutrition and Development, the new PAHO strategy to reduce chronic malnutrition, coupled with global and regional initiatives on health, provided opportunities for advancing the nutrition, food safety and food security agenda.

The Regional Offices for Africa and South-East Asia reported the largest number of Organization-wide expected results as "at risk" owing to a lack of resources for meeting the demand for technical assistance. The Regional Office Africa experienced difficulties in the area of surveillance of nutrition and food safety (Organization-wide expected results 9.3 and 9.6). The Regional Offices for South-East Asia and the Western Pacific were unable to provide sufficient support for food safety policy, planning, food-borne disease surveillance and hazard monitoring (Organization-wide expected result 9.5).

Although five of the six Organization-wide expected results are on track, the African Region may not be able to provide the necessary support to all countries to assess needs and policy responses for nutrition and food safety due 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 Regions might not be able to provide technical support to the development of policies and programmes in food safety (Organization-wide expected result 9.5). ■

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.

ON TRACK

WHO continued to collaborate with United Nations interagency partnerships, including the Standing Committee on Nutrition, and multi-stakeholder initiatives, such as the Flour Fortification Initiative, and the Network for Sustained Elimination of Iodine Deficiency. As a member of the Scaling Up Nutrition initiative, WHO coordinated two task forces on capacity building and monitoring and evaluation. A network of institutions providing scientific advice on nutrition, including the United States Department of Agriculture, the International Organization for Migration, Health Canada, the French food safety agency and Food Standards Australia New Zealand, was established.

In the African Region, partnerships and coordination were reinforced with UNICEF, WFP, other United Nations agencies, the African Union and the New Partnership for Africa's Development. In the Region of the Americas, malnutrition is on the political agenda of most countries, especially those with a high prevalence of chronic malnutrition, but implementation of remedial measures is inadequate and programme coverage low. In the Eastern Mediterranean Region, international and national multi-sectoral collaboration on food safety was strengthened through the Gulf Cooperation Council. In the South-East Asia Region, regional meetings and workshops on food safety emergency preparedness, food fortification and food-based dietary guidelines were organized. The Regional Office for the Western Pacific finalized the framework for Action on Food Security in the Pacific, which was endorsed by 22 countries at the Pacific Food Summit and the Pacific Forum Leaders meeting.

At WHO headquarters, the Initiative to Estimate the Global Burden of Foodborne Diseases organized its annual Foodborne Disease Stakeholder Meetings with key stakeholders from civil society, the industry as well as other international organizations including the World Bank and the World Organisation for Animal Health. The stakeholder meeting report will be available shortly. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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	ON TRACK
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	ON TRACK

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.

ON TRACK

The Nutrition Guidance Expert Advisory Group was established with four sub-groups on: micronutrients; nutrition throughout the life course and malnutrition; diet and health; and monitoring and evaluation. The Expert Advisory Group met twice in 2010.

The number of scientific advisory reports issued increased in 2010, and the direct link to Codex Alimentarius standard setting was improved. Six scientific expert meetings have been held in 2010 to assess a large number of microbiological and chemical hazards in food. Two international standards to limit melamine contamination in powdered infant formula and other foods were adopted in a rapid international response to a food contamination incident that had international repercussions.

WHO published a Five Keys to Safer Food Training manual targeted to women as women play a key role in the production of food all over the world and in the prevention of foodborne diseases. In order to cover the farm to fork continuum, WHO has pilot tested in Guatemala a new Five Keys to Safer Food training module targeted to rural workers to prevent microbiological contamination. The Five Keys to Safer Food poster is available in 63 languages and is used in an increasing number of various settings both to train food handlers and educate the consumer. It has served as a basis to prevent cholera outbreaks in crisis situations as well for example in Haiti.

In the biennium 2010–2011, the Foodborne Diseases Burden Epidemiology Reference Group (FERG) continued advising WHO on foodborne disease burden estimation with work commissioned for enteric, parasitic and chemical causative agents. To go beyond burden estimation and foster food safety policy-making based on sound epidemiological evidence, a new Foodborne Disease Burden Epidemiology Reference Group subgroup was established in 2010 with the mandate of promoting the utilization of burden results in food safety policy-making and practice. The subgroup developed a protocol for country foodborne disease burden studies as well as a guidance manual for national context mapping.

The Codex Alimentarius Ad Hoc Inter governmental Task Force on Antimicrobial Resistance finalized in October 2010 Draft Guidelines for Risk Analysis of Foodborne Antimicrobial Resistance.

A global consultation on the dietary management of moderate acute malnutrition was organized. In the Region of the Americas, five countries reviewed food safety guidelines; Haiti is disseminating guidelines for managing severe malnutrition in children. In the Eastern Mediterranean Region, a technical consultation on preparing guidelines for practicing clinical dieticians was conducted in the United Arab Emirates. The Regional Office for the Western Pacific oversaw the drafting of a practical guide to introducing food standards to promote health and trade for small island states, which is undergoing trials as part of the effort to advance standards in small island states. Documents on weekly iron-folic acid supplements were also developed. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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	ON TRACK
9.2.2 Number of new norms, standards, guidelines, tools and training materials for prevention and management of zoonotic and non-zoonotic foodborne diseases	ON TRACK

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.

ON TRACK

WHO continued to provide technical support to Member States for the implementation of the WHO growth standards and other norms governing nutritional surveillance at global, regional and country level. Information gathered from the global database on child growth and malnutrition was included in numerous reports and scientific papers. The WHO Vitamin and Mineral Nutrition Information System was expanded and its newly established web site contains a micronutrients Database, and information on indicators, laboratory capacity, monitoring and evaluation and publications. The Nutrition Landscape Information System portal was launched to provide access to data on nutritional status indicators and nutrition policies. A global nutrition policy review carried out in 2010, in collaboration with regional offices, elicited 123 responses.

In the African Region, support was given to Côte d'Ivoire, Mali and Sierra Leone for implementation of the WHO Child Growth Standards. A review of the new WHO Child Growth Standard card was carried out in Botswana in order to elicit comments from users. Support was provided for the development of a child health booklet with growth charts for boys and girls in Mozambique and the Democratic Republic of the Congo. Technical support was provided to strengthen nutrition surveillance in Angola, Central African Republic, Chad, Equatorial Guinea, Lesotho, Malawi, Mozambique and Zimbabwe. Nutrition indicators for integrated disease surveillance and response have been defined and a training module on building capacity in accordance with the indicators elaborated.

In the Region of the Americas, countries made progress in implementing the WHO Child Growth Standards. There is renewed interest in collecting information on the nutritional status of populations and in implementing or strengthening nutrition surveillance systems. In the Eastern Mediterranean Region, the WHO Child Growth Standards were introduced at national level in Egypt, Lebanon and the Syrian Arab Republic. Draft technical guidelines on nutrition surveillance were prepared by the Regional Office with the participation of all countries and key partners, including United States Centers for Disease Control and Prevention, UNRWA, UNICEF, FAO, WFP and Johns Hopkins University. In the South-East Asia Region, the new WHO growth standards for children under five were adopted by 10 Member States. In the Western Pacific Region, Malaysia, the Philippines and Solomon Islands, among other countries, have introduced a new training course on growth monitoring and infant and young child feeding. Support was provided for a national nutrition survey in Mongolia; the evaluation of the programme on weekly iron-folic acid supplementation in Cambodia and Viet Nam; the assessment of zinc status in the Philippines; and an integrated food security information system in the Western Pacific Region. ■

PERFORMANCE INDICATORS

CURRENT STATUS

9.3.1 Number of Member States that have adopted and implemented the WHO Child Growth Standards	ON TRACK
9.3.2 Number of Member States that have nationally representative surveillance data on major forms of malnutrition	ON TRACK

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.

ON TRACK

WHO provided support to Member States to strengthen their nutrition policies and strategies following assessment of the nutrition landscape. Headquarters targeted a subset of 10 high-burden countries for capacity building by regional consultants. The operational guidance on infant and young child nutrition is being updated. The Nutrition-Friendly Schools Initiative was promoted in the Eastern Mediterranean and European Regions, but its implementation was delayed by financial and human resource constraints.

In the African Region, support was provided to: Côte d'Ivoire, Ethiopia, Lesotho, Mozambique, Namibia, Rwanda, Swaziland, United Republic of Tanzania and Zimbabwe to review their nutrition policy; Côte d'Ivoire, Ethiopia and Mozambique for conducting landscape analyses; and Burkino Faso and Ghana to implement recommendations from their landscape analyses. A training workshop on intersectoral policy and plan development was conducted jointly with UNICEF for nutrition and food security focal points from ministries of agriculture and health. A workshop on HIV, antiretroviral therapy and infant feeding was conducted as a result of which some countries developed action plans. WHO revised the guidelines on antiretroviral therapy for HIV infected adults and children, and on prevention of mother-to-child transmission of HIV and infant feeding in the context of HIV, and the Regional Office for Africa, with the United States President's Emergency Plan for AIDS Relief, conducted orientation workshops on the revised guidelines for countries in the East and Southern Africa, West Africa and Central Africa subregions. Support was provided to: Côte d'Ivoire, Ethiopia, Guinea, United Republic of Tanzania and Zambia for integrating nutrition interventions in HIV programme activities; Ghana for assessing implementation of the national strategy on infant and young child feeding; Mauritania for conducting an integrated infant and young child feeding counselling course; and Niger and the Democratic Republic of the Congo for revising national protocols on management of acute malnutrition.

In the Eastern Mediterranean Region, national nutrition strategies and action plans received support in Egypt, Jordan, Morocco, Qatar, Somalia, Sudan, Syrian Arab Republic and United Arab Emirates. The first regional training session on planning for effective communication strategies to improve nutrition programmes was conducted in 2010. In the South-East Asia Region, all Member States have national micronutrient deficiency control and prevention programmes. In the Western Pacific Region, a workshop on national plans of action on nutrition was held. With support from WHO and FAO, the Government of Solomon Islands approved an integrated food security, food safety and nutrition policy. With United Nations support, China embarked on a programme to address food safety, nutrition and food security for women and children in the poorest areas of the country. Implementation of the essential newborn care programme in the Philippines is progressing with noticeable results. Training in the prevention and management of moderate and severe malnutrition in children was provided in Cambodia and Laos. ■

PERFORMANCE INDICATORS	CURRENT STATUS
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	ON TRACK
9.4.2 Number of Member States that have implemented strategies to prevent and control micronutrient malnutrition	ON TRACK
9.4.3 Number of Member States that have implemented strategies to promote healthy dietary practices for preventing diet-related chronic diseases	ON TRACK
9.4.4 Number of Member States that have included nutrition in their responses to HIV/AIDS	ON TRACK
9.4.5 Number of Member States that have national preparedness and response plans for nutritional emergencies	ON TRACK

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.

AT RISK

Two meetings on the prevention of leptospirosis were held in December 2009 and September 2010, and a systematic review is nearing completion. The network of Global Environmental Monitoring System Food Contact Points was revisited and revised terms of reference for national institutions recognized by WHO were developed. More than 30 institutions were recognized at the end of December 2010.

The Global Foodborne Infections Network organized seven training courses and workshops in all six Regions (United Arab Emirates, Russian Federation, Argentina, Thailand, China, Tunisia and Kenya), bringing the total to 74 training activities since 2000. The number of individual network members increased from approximately 1400 to more than 1600 and the number of countries with network members went up from 177 to 181 Member States.

In the African Region, Global Food Infections Network level III training in laboratory-based foodborne disease surveillance was organized for 50 epidemiologists and microbiologists from the public health, veterinary and food sectors from 10 countries. Laboratory supplies were provided to countries in the Global Food Infections Network. Indicators on foodborne diseases and the WHO Five Keys to Safer Food for outbreak management were incorporated in integrated disease surveillance and response. Numerous countries in the African Region, including Benin, Burkino Faso and Ghana received support to assess national food control systems, surveillance, and laboratory capacity. South Africa, in particular, received support to strengthen foodborne disease surveillance during the 2010 FIFA World Cup.

In the Region of the Americas, coordination and intensifying of surveillance and response capabilities for zoonoses and food transmitted diseases was supported by, inter alia, World Organisation on Animal Health and the Inter-American Network of Food Laboratories. The Global Foodborne Infections Network organized an advanced workshop for 44 participants from 15 countries on integrated laboratory-based surveillance. In the Eastern Mediterranean Region, 18 Member States participated in the training on surveillance, outbreak detection and response for Salmonella and Shigella. In addition, a training course on outbreak detection and response for 47 participants from the United Arab Emirates, Oman and Saudi Arabia was organized. Plans to improve zoonotic and non-zoonotic foodborne disease surveillance and hazard monitoring programmes have not been adequately carried out.

In the South-East Asia and Western Pacific Regions, a bi-regional workshop on food safety emergency preparedness (including food-borne diseases surveillance) was conducted in collaboration with FAO and with assistance from the Global Foodborne Infections Network. In the Western Pacific Region, the capacity of Member States to obtain food safety data through hazard monitoring and to conduct risk assessments was enhanced through training on various aspects of the burden of foodborne diseases. China initiated a pilot project in more than 300 sites in Qingdao in order to improve the collection and handling of data on foodborne disease surveillance. The Global Foodborne Infections Network also organized a workshop for 41 participants from China as part of the ongoing Enhanced Salmonella Surveillance Project.

In the European Region, the Global Foodborne Infections Network organized a training course for 29 microbiologists and epidemiologists from the Russian Federation, Kazakhstan, Tajikistan and Uzbekistan on foodborne disease surveillance, including antimicrobial resistance, and outbreak detection and response. ■

PERFORMANCE INDICATORS

CURRENT STATUS

9.5.1 Number of Member States that have established or strengthened intersectoral collaboration for the prevention, control and surveillance of foodborne zoonotic diseases

ON TRACK

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

ON TRACK

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.

ON TRACK

WHO, in close collaboration with FAO and OIE has continued to play a leading role on containment of antimicrobial resistance arising from antimicrobial use in food-producing animals. The WHO Advisory Group on Integrated Surveillance of Antimicrobial Resistance has established country pilot sites on antimicrobial resistance integrated surveillance in Colombia and Kenya and has developed guidance documents to support antimicrobial resistance and antimicrobial usage monitoring. The WHO list of Critically Important Antimicrobials for Human Medicine has been updated in 2010 to help Member States prioritize risk management strategies.

A total of 238 participants from 80 countries were supported by the FAO/WHO Project and Fund for Enhanced Participation in Codex (Codex Trust Fund) to attend 18 Codex meetings in 2010. The International Food Safety Authorities Network now has 177 members. The Global Foodborne Infections Network currently has members from 181 Member States. In the African Region, numerous countries received support to develop or review national food safety and quality policies, strengthen food control systems, and elaborate national food safety action plans. South Africa was supported to develop information, education and communication materials based on the WHO Five Keys to Safer Food and 3 Fives strategies for the 2010 FIFA World Cup. A healthy food market pilot programme was established in Chad and the Democratic Republic of the Congo. A national workshop was held in Gabon in order to revitalize the national Codex Alimentarius Committee.

In the Region of the Americas, all Latin America and Caribbean countries participated in the 17th Session of the Codex Commission for Latin America and the Caribbean. In the Eastern Mediterranean Region, Tunisia conducted a total diet study. The Five Keys to Safer Food posters were translated into several regional languages. Member States in the Region were given practical encouragement to adopt WHO food hygiene practices. All Member States are now members of the International Food Safety Authorities Network and its emergency network.

In the Western Pacific Region, a Western Pacific regional food safety strategy 2011–2015 was initiated. Various strategies for addressing micronutrient deficiencies and developing food regulations and standards based on the Codex Alimentarius through national legislation, such as food safety bills, are under consideration throughout the Region. Efforts were also made to transmit food safety messages to communities and businesses and to provide training related to national food safety emergency response plans. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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

ON TRACK

9.6.2 Number of selected Member States that have built national systems for food safety with international links to emergency systems

ON TRACK

SUMMARY OF FINANCIAL IMPLEMENTATION

(AS AT 31 DECEMBER 2010)

The approved budget for strategic objective 9 was US\$ 120 million of which US\$ 116 million (97%) was for base programmes and US\$ 4 million (3%) for special programmes and collaborative arrangements.

Available funding by the mid-term was US\$ 57 million (48% of the approved programme budget), and implementation as at 31 December 2010 was US\$ 27 million, which corresponds to 23% of the approved budget and 48% of the available resources.

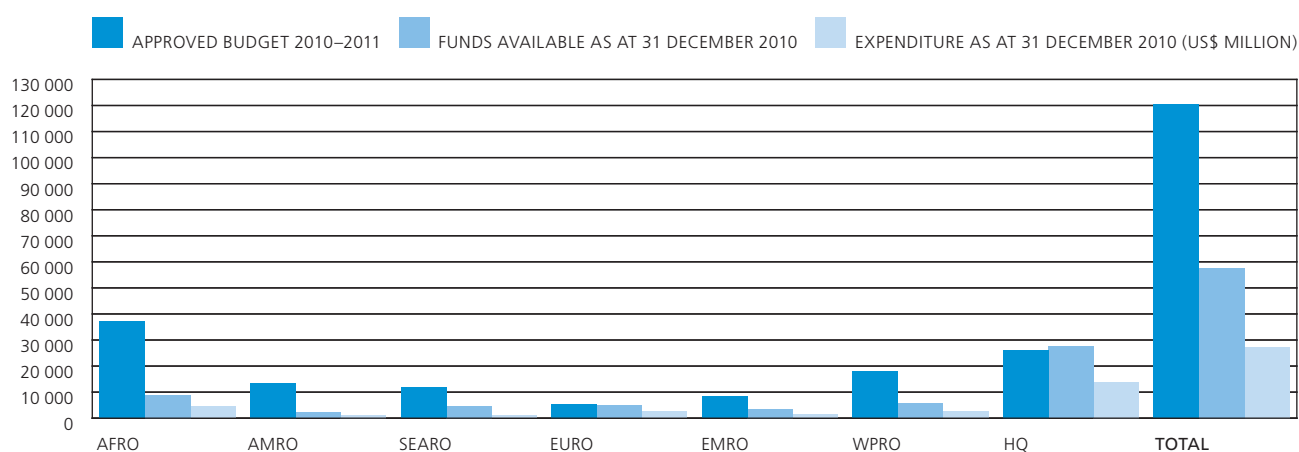
The level of available resources for five of the six regional offices is below 50% as the resource mobilization efforts have not been sufficient - no large multi-country proposals have been submitted. Donors appreciate WHO's role in capacity building and policy support and not in large scale programme implementation. Furthermore, the staffing levels in some Regions are not adequate to develop and manage large proposals. In headquarters, available resources are currently 105% of the approved budget because donors find normative products more appealing and have supported most proposals submitted. Global proposals have been submitted and funds have been provided to the Regional Offices, but still not at the level required.

Overall implementation as a percentage of expenditure compared to approved programme budget is 23%, mainly due to inadequate funding received. In fact, an average of 48% of the available funds have been spent, in line with the expectation in the middle of the biennium.

The proportion of funds coming from specified voluntary contributions has increased progressively. Strategic focus and intensive fundraising efforts have led to successful resource mobilization in headquarters and some regions and countries. However, the funds available for both staff and activities in some regional offices are insufficient. Increases in the budget ceiling have been requested by the Regional Office for Europe and headquarters in order to accommodate specified voluntary contributions. Resource mobilization should be intensified in the case of the Regional Offices for Africa and South-East Asia.

Funds available under the strategic objective for food safety and nutrition programmes have been implemented in headquarters and the Regional Offices for the Americas, Eastern Mediterranean, Europe and the Western Pacific. Implementation rates continue to be lower in the Regional Offices for Africa and South-East Asia owing to staff shortages. Support for implementation needs to be provided to those regional offices.

2010–2011 (US\$ 000)		AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	TOTAL
Approved programme budget 2010–2011		37 182	13 566	11 670	5 501	8 375	17 898	26 193	120 385
Funds available as at 31 December 2010	AC	4 181	1 913	2 041	652	1 600	1 958	5 813	18 158
	VC	4 760	380	2 594	4 318	1 939	3 755	21 674	39 420
	TOTAL	8 941	2 293	4 635	4 970	3 539	5 713	27 487	57 578
Funds available as % of approved budget		24%	17%	40%	90%	42%	32%	105%	48%
Expenditure as at 31 December 2010		4 593	1 162	1 130	2 680	1 336	2 606	13 866	27 374
Expenditure as a % of approved budget		12%	9%	10%	49%	16%	15%	53%	23%
Expenditure as a % of available funds		51%	51%	24%	54%	38%	46%	50%	48%



PRIORITY RESULTS FOR 2011

The provision of scientific advice for both nutrition and food safety needs to be significantly increased and the monitoring and surveillance capacity of countries scaled up. Headquarters should focus its work on Organization-wide strategic results 9.2, 9.3 and 9.5.

To support Member States in scaling up nutrition actions and improving food safety, technical support should be provided in the following priority areas: assessment, monitoring and evaluation of nutritional status and programmes in the Eastern Mediterranean and Western Pacific Regions; planning and implementation of multisectoral nutrition programmes in the Western Pacific Region; use of WHO growth standards and references in the South-East Asia Region; management of severe and moderate malnutrition in the Eastern Mediterranean and South-East Asia Regions; improving micronutrient status in the Eastern Mediterranean, South-East Asia and Western Pacific Regions; strengthening infant and young child feeding programmes in the Western Pacific Region; formulation of national food-based dietary guidelines and dietary interventions to address chronic diseases in the South-East Asia Region; and strengthening food safety capacity in the Western Pacific Region. ■

IDENTIFICATION OF SPECIFIC ACTIVITIES AND RESULTS THAT WILL BE REDUCED OR NO LONGER DELIVERED

Surveillance of zoonotic and non zoonotic food borne diseases may be affected by the financial situation and involvement in global partnerships may have to be scaled down, although no complete cancellation of these initiatives is envisaged. ■

SO10

TO IMPROVE HEALTH SERVICES THROUGH BETTER GOVERNANCE, FINANCING, STAFFING AND MANAGEMENT, INFORMED BY RELIABLE AND ACCESSIBLE EVIDENCE AND RESEARCH



PROGRESS TOWARD THE ACHIEVEMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

OF THE THIRTEEN ORGANIZATION-WIDE EXPECTED RESULTS FOR THIS STRATEGIC OBJECTIVE, FOUR WERE "ON TRACK" AND NINE "AT RISK"

OVERVIEW

At the mid-term, progress had been made in improving the management and organization of health service delivery in line with the policy directions for the renewal of primary health care. Member States were supported to scale up coverage, equity and quality of health services and improve service outcomes. In order to strengthen health systems, attention was centred on policy dialogue on national health policies, strategies and plans. Member States expressed broad support for such work in the five resolutions on health systems submitted to the Sixty-fourth World Health Assembly.

Support for national policy and planning processes received a boost as a result of the publication of *The world health report 2010 – health system financing: the path to universal coverage*. In response to the report, work on the health workforce was scaled up and attention given to designing better integrated programmes aimed at dealing with specific health or life-cycle problems. More reliable data and statistics were sought across health programmes and initiatives to inform such planning processes, and advances were made in ensuring that an exchange of information takes place. The adoption of the Code of Practice on the International Recruitment of Health Personnel provides an ethical basis for dealing with the movement of health workers across borders and emphasizes the need for fundamental reforms in how health workers are educated, trained, retained and managed within their respective health systems. A survey of countries' eHealth capacity is being carried out, and strategy on research for health is being implemented in countries. Although WHO's support to Member States remains focused on building country capacity for maximizing and optimizing the use of domestic resources, attention has been paid to improving aid effectiveness, particularly through multi-stakeholder forums, such as the International Health Partnership.

Overall, four of the thirteen Organization-wide expected results are on track and nine are rated as "at risk". Generally, for each of the thirteen 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 critical importance of health systems has run far ahead of the needed investments to meet this demand. Furthermore, the lack and unpredictability of resources and its effect on an already overburdened staff in headquarters, regions and countries have contributed to the "at risk" rating for 9 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 labor-intensive, painstaking and needs adept coordination with various players are country level. Specifically, the area of country planning and strategy, and the funding mechanisms for better aid effectiveness are needing close attention. The demand for WHO's technical assistance outstrips the supply it can provide. Similarly, by the end of the biennium, it is uncertain if the core function of coordination of health system research (10.6) can be sustained due to a lack of financial resources and other capacity constraints. Indicator 10.6.2 (two per cent of health budget for research) could also fail to be achieved as control over the health budget lies with countries and WHO may not have much influence.

A lack of funding for promotion of the WHO Global 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, while 21 out of the 57 human resources for health crisis countries have developed HRH plans, lack of sustainable investments at country level combined with a reduced WHO capacity to provide technical assistance for critical country planning will impede the amelioration of the human resources for health crisis in these countries. Although globally Organization-wide expected result 10.10 (health-system financing) appears healthy 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. ■

10.1

Management and organization of integrated, population-based health-service delivery through public and nonpublic 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.

AT RISK

Globally, indicators for Organization-wide expected result 10.1 have exceeded the targets, which will need to be amended given that country demand is increasing and should be in line with the principles underpinning primary health care. However, the current financial climate, is creating uncertainty about whether resources will match the expansion of the demands of Member States. If the availability of resources were to stagnate or decrease, country support and normative work under the Organization-wide expected result would be unable to keep pace with changes in Member States' expectations.

At global level, work progressed on service delivery, in such areas as district planning, hospital services, regulation of the commercialization of health services, the regulation of traditional and complementary medicine, and participation. At regional level, the Regional Office for the Americas continued to make progress in the implementation of primary health care-based health systems in accordance with the Montevideo Declaration, as well as of the Productive management methodology for health services. In the Western Pacific Region, the Regional Strategy for Health Systems, based on the values of primary health care, was adopted in October 2010. In the European Region, work on clarifying concepts of public health and health systems, and identifying essential public health services for Europe was initiated. In all regions, the support given to countries for the organization of health services in line with primary health care principles was intensified. ■

PERFORMANCE INDICATORS

CURRENT STATUS

10.1.1 Number of Member States that have regularly updated databases on numbers and distribution of health facilities and health interventions offered

ON TRACK

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.

AT RISK

Globally, the indicators for the Organization-wide expected result are on track or ahead of schedule and will need to be revised in view of the growing demand for support. If available resources are reduced in the upcoming months, the same level of support could not be provided, and the 2012–2013 target for indicator 10.2.1 would not be met.

A framework document on national health policies, strategies and plans was discussed during the regional committees and formed the basis of a report that was considered by the Executive Board at its 128th session. As a result, a resolution on policy dialogue will be submitted to the Sixty-fourth World Health Assembly for consideration. The Joint Assessment of National Strategies approach, as well as tools to support countries and partners in national planning processes, such as the Country Planning Cycle Database, the WHO toolkit for building country health policies, strategies and plans and a glossary, were developed. A global learning programme on national health policies, strategies and plans was launched in June 2010. The staff of 25 priority country offices received training and have developed road maps in line with the national planning cycle in their countries. Progress was made in 26 countries in assessing health system performance. Direct support was provided to countries for health planning and policy dialogue reviews in all regions, however, the level of support provided by the Regional Office for South-East Asia needs to be intensified. Support was also provided to countries in the context of the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Alliance for Vaccines and Immunisation and the Health System Funding Platform. ■

PERFORMANCE INDICATORS

CURRENT STATUS

10.2.1 Number of Member States that have in the last five years developed a comprehensive national health planning processes in consultation with stakeholders	ON TRACK
10.2.2 Number of Member States that conduct 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	ON TRACK

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.

AT RISK

Globally, progress on meeting the indicators for the Organization-wide expected result was ahead of schedule, spurred on by the Accra agenda for action and the International Health Partnership. However, the indicator only measures the beginning of the harmonization and alignment process, and Member States are calling for it to be extended to cover all Member States that benefit from external aid. Should resources for the Organization-wide expected result stagnate or decrease, WHO will have to scale down its engagement in donor harmonization and alignment and enhancing country ownership, thereby diminishing the likelihood of further progress.

During the current biennium, the Regional Offices for Africa, South-East Asia and the Western Pacific focused attention on the coordination of donors and their alignment with national priorities and plans; as did the Regional Office for Europe with regard to Eastern Europe. The Regional Office for the Americas placed emphasis on harmonizing national capacities with international aid, and on working with aid providers from the region. Such work needs to be intensified in the Eastern Mediterranean Region.

The International Health Partnership, in which WHO and the World Bank jointly serve as the secretariat, has played a major role in coordinating donor assistance and changing the behaviour of both countries and agencies. During the past two years, the number of signatories has grown from 24 to 49, of which 38 are Member States. The main aim of the Partnership is to align more partners with national health strategies. Progress on commitments to alignment are monitored annually by an independent consortium known as IHP+ Results. WHO also co-leads the OECD/DAC Task Team on Health as a Tracer Sector, which is responsible for documenting the progress made in aid effectiveness in the health sector. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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

ON TRACK

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.

ON TRACK

Progress was made in the following areas: self assessments of the health information systems in the African, Eastern Mediterranean, South-East Asia and Western Pacific Regions; development of strategic plans for health information systems in the African, South-East Asia and Western Pacific Regions; implementation of household surveys in health and health facility reporting systems in the South-East Asia Region; improved data quality in the European Region. The progress made was partly attributable to: tools and financial support provided by the Health Metrics Network Framework; the introduction of information and communications technology; multi-country activities; and tools produced by the regional offices and headquarters.

Overall, however, the progress made was modest and critical gaps remain, especially in areas such as birth and death registration in terms of an accurate cause of death, and the generation of reliable health statistics from facility reporting systems. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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

ON TRACK

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.

ON TRACK

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. Specific examples include, the launch of an observatory in the Region of the Americas; updating the comprehensive Health for All database in the European Region; supporting countries in designing a web portal in the African Region; and designing theme pages at headquarters with input from the regions. Most countries have statistical profiles that are available from WHO databases, but there is still too much reliance on modelling to fill data gaps, especially for low-income countries.

WHO continues to engage with countries through surveys on adult health and aging (six and eight countries, respectively), facility assessments (10 countries), strengthening of vital statistics systems (eight countries), and comprehensive analyses to inform health sector reforms and reviews (eight countries). Regarding equity, work in headquarters and regional offices continued to incorporate the social determinants of health and health equity approaches in programme strategies. ■

PERFORMANCE INDICATORS	CURRENT STATUS
10.5.1 Proportion of countries for which high quality profiles with core health statistics are available from its open-access databases	ON TRACK
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	ON TRACK
10.5.3 Effective research for health coordination and leadership mechanisms established and maintained at global and regional levels	ON TRACK

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

AT RISK

The functions of Research and Cooperation were relocated in order to ensure the alignment of functions and to plug financial gaps. Regions focused their attention and activities on three key areas: strengthening national health research systems, establishing better linkages between evidence and policy, and facilitating the sharing of health research information.

Following the rejuvenation of the Advisory Committee on Health Research in the European Region, the mapping of national health research systems is planned and will serve as the basis for supporting Member States in enhancing their systems in line with internationally-agreed minimum standards (indicator 10.6.1). Four countries in the South-East Asia Region have achieved the indicator target. The Regional Office for the Western Pacific established a regional ethics review committee in order to strengthen capacity in the region, and to provide technical support and advice to Member States.

The Regional Offices for Africa and the Eastern Mediterranean re-confirmed their commitment to implementing the Evidence-Informed Policy Networks (EVIPNet) initiative. The Regional Office for the Eastern Mediterranean took steps to establish EVIPNet teams in Member States, as well as the necessary regional platforms, and also contributed to global activities under the initiative. Nine African Member States established functional EVIPNet teams.

The Regional Office for the Americas placed particular emphasis on the dissemination and sharing of health research information through the establishment of the Health Research Web, and on continuing the collaboration with national commissions on health research.

The Regional Office for Europe is considering using its research for health programme to monitor progress on indicator 10.6.2. In the South-East Asia Region, two countries achieved the target for the indicator.

All regions are actively involved in the implementation of the WHO Strategy on Research for Health. In general, the activities carried out by the regional offices have complemented the guidance and directions provided by headquarters. ■

PERFORMANCE INDICATORS

CURRENT STATUS

10.6.1 Proportion of low- and middle-income countries in which national health-research systems meet internationally agreed minimum standards

ON TRACK

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)

ON TRACK

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

ON TRACK

The Global Observatory for eHealth survey carried out in 2009 did not include the adoption of knowledge management policies by Member States in order to bridge the digital “know-how” gap, hence the indicator does not apply. A total of 24 countries in the African Region adopted knowledge management policies. In the European Region, 33 countries reported having a national eHealth policy or strategy, and 31 indicated they were partially implementing such a policy or strategy.

The HINARI Access to Research in Health Programme is on track, although its technological infrastructure requires attention as the programme is introduced in more institutions worldwide. The annual target of articles that are downloadable was achieved during the first half of the biennium. The majority of countries benefiting from HINARI were in Africa. The Global Health Library and Global Institutional Repository also played a part in achieving the expected result. Member States of the South-East Asia Region developed policies and strategies for eHealth and knowledge management; access to health information continued to widen through the electronic library maintained by the regional office.

The second Global Survey of eHealth was completed with responses from 114 countries. Following analysis of the data, two full reports are awaiting publication. They will complement the eHealth Global Atlas, which includes profiles of the 114 countries, and was published on the web. The Regional Committee for Africa adopted resolution AFR/RC60/R3 on eHealth solutions in the African Region, which will constitute a framework for eHealth development in the region. Work began on the preparation of guidance and policy documents covering online safety, use of eHealth information for public health purposes, and a guide for research ethics committees. The Health Academy was introduced in six countries. The ePortuguese Virtual Health Library and other networking activities were developed in Portuguese speaking countries. The PAHO Health Information Platform was established and is operational, as is the Open Portal of the Regional Health Observatory. The Regional Office for the Eastern Mediterranean continued to support the regional network of medical editors. The Regional Office for the Western Pacific began to develop an eHealth programme following identification a new health informatics collaborating centre. The eHealth Intelligence report expanded its coverage and outreach activities. Two eHealth programmes, namely, the Africa Health Infoway and Sharing eHealth Intellectual Property, had to be shelved. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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	ON TRACK
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	ON TRACK
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	ON TRACK

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

AT RISK

Although the indicators have been achieved, a lack of funding may hamper promotion of the Global Code of Practice on the International Recruitment of Health Personnel in regions and countries. Efforts are being made to mobilize resources and the outcome will determine whether the goals set for the Organization-wide expected result will be fully achieved.

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. Normative work on developing guidelines, including for a transformative scale-up of education, will continue. The provision of technical assistance to countries in their health workforce planning processes, and for implementing global guidelines, will be considered in relation to the resources available.

All regions reported progress in countries in the collection and analysis of data on the health workforce, and efforts are continuing to strengthen information systems on the subject in countries. In particular, the Regional Office for South-East Asia is updating its country health workforce profiles. 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.

New tools for health workforce planning in health facilities, including workload indicators for staffing needs, and new methodologies for measuring inequalities in the health workforce, were well received as they facilitate the planning process.

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 implementation of the Code of Practice are being prepared. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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 **ON TRACK**

10.8.2 Number of Member States with an national policy and planning unit for human resources for health **ON TRACK**

¹ Resolution WHA63.16

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.

AT RISK

At the mid-term, all the indicators had been achieved. However, the Organization-wide expected result is reported as being at risk owing to a reduction in funding that could lead to staff cutbacks. Fundraising activities are being undertaken to plug the funding gap.

WHO and its partners, including the Global Health Workforce Alliance, the European Commission and the United States Agency for International Development, directed technical assistance and investment towards at least 41 countries experiencing a health workforce crisis, for use in health workforce planning, improvement of information systems, including health workforce observatories, educational programmes for professionals, task shifting, and retention strategies. 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. A masters degree programme promoted by WHO and implemented by a consortium of universities is being implemented in 14 African countries.² Although the above initiatives have led to achievement of the indicators for multi-year plans and investment plans, they will not be adequate for dealing with the crisis.

Malawi's Emergency Human Resources Programme for addressing the health workforce crisis revealed the need for massive investment in countries. Investment in the health workforce has been shown to have an impact on health outcomes, but sustainability is a problem. Based on the amount of direct investment in Malawi between 2004 and 2009, it is estimated that a further US\$ 43.5 million will be needed during the next five years to sustain the gains made so far. In that regard, the target of a 25% reduction in the number of countries called for in the Medium-term strategic plan 2008–2013 (14 out of 57) is being reconsidered in view of the effort and investment being directed towards health workforce development and health systems. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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 **ON TRACK**

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 **ON TRACK**

² Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Congo, Democratic Republic of the Congo, Ethiopia, Mali, Mozambique, Rwanda, Senegal and South Africa.

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.

AT RISK

The world health report 2010 – health system financing: the path to universal coverage contained contributions from all regions. More than 61 countries received technical support from WHO in the area of health system financing, but demand continues to grow, as well as for information about what has worked in other countries. Although, globally, the target number of countries supported should be met, three regions reported being at risk of not achieving the regional goals. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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

ON TRACK

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

ON TRACK

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.

AT RISK

The system of health accounts is being revised to include inputs from all Organizational levels, and a Unified Health Model, designed to assess the costs and health impact of scaling up health interventions, is in the last stage of development with United Nations partners. Representatives of more than 40 countries were trained in the use of a range of tools. However, three regions reported that the Organization-wide expected result is “at risk” owing to financial constraints. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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, organization and efficiency of service delivery, including contracting, or the incidence of financial catastrophe and impoverishment	ON TRACK
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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	ON TRACK
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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.

AT RISK

All levels of WHO engaged in partnerships in order to advocate for more funds for health, engage in technical and analytical work and provide technical and policy support to countries. The partnerships include: the International Health Partnership, the Providing for Health initiative and several regional networks. In consultation with countries, WHO continued to report on key health expenditure indicators, with active input from all regions, and to issue annual updates. Capacity building exercises have been conducted in over 30 countries, especially in relation to tracking expenditures. One region reported such activities as being at risk owing to financial constraints. ■

PERFORMANCE INDICATORS	CURRENT STATUS
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 protect consistent with primary health care	ON TRACK
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	ON TRACK

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.

ON TRACK

A total of 40 revised tools were prepared in connection with the WHO Guidelines on Hand Hygiene and a second Global Hand Hygiene Day was held on 5 May 2010. Some 4000 hospitals registered to use the Safe Surgery Saves Lives checklist, and three regional surgery workshops were conducted in the Region of the Americas, the European Region and the Eastern Mediterranean Region. The findings of research on core competencies for patient safety were released and the *WHO patient safety curriculum guide for medical schools* was published.

In the African Region, patient safety focal points in Burundi, Mozambique, Namibia and Zambia initiated activities in connection with patient safety policy frameworks. Formation of the first partnerships under the African Partnerships for Patient Safety initiative is continuing in six African countries. Technical assistance was provided to six countries in the Region of the Americas to improve the quality of care and patient safety. The Regional Office for Europe provided support to the European Union network for patient safety, a Delphi exercise on measures for patient safety in data-poor hospitals in selected countries, a pulse oximetry project in Republic of Moldova, and translation of the *WHO patient safety curriculum guide for medical schools* in Romania. The Regional Office for South-East Asia focused on implementation of hand hygiene tools, dissemination of the Safe Surgery Saves Lives checklist to all Member States in the Region, and conducting workshops in India, Indonesia and Malaysia in connection with Global Hand Hygiene Day, for which 999 health care facilities in the Region registered. India and Nepal launched pilot projects on the *WHO patient safety curriculum guide for medical schools* and India is also piloting the Trauma Care checklist and Safe Child Birth checklist. Some 2000 institutions in the Western Pacific Region signed the hand hygiene pledge; a safe surgery workshop held in Hanoi was attended by representatives from Cambodia, the Lao People's Democratic Republic, Mongolia and Viet Nam. ■

PERFORMANCE INDICATORS

CURRENT STATUS

10.13.1 Key tools, norms and standards to guide policy development, measurement and implementation disseminated and their use supported	ON TRACK
10.13.2 Number of Member States participating in global patient safety challenges and other global safety initiatives, including research and measurement	ON TRACK

SUMMARY OF FINANCIAL IMPLEMENTATION

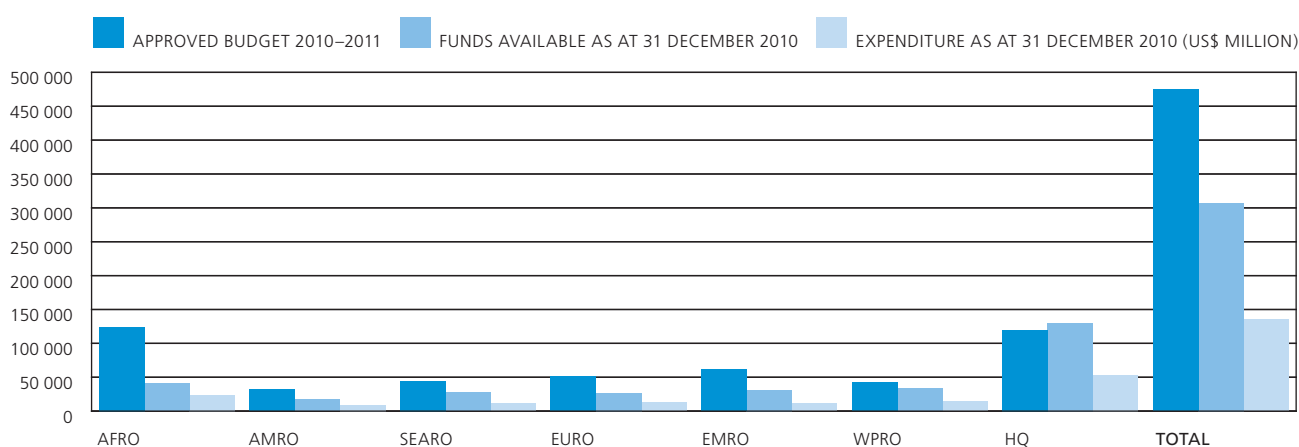
(AS AT 31 DECEMBER 2010)

The total approved budget for the strategic objective was US\$ 474 million (since adjusted to US\$ 509 million), of which US\$ 420 million (88%) was for base programmes and US\$ 54 million (12%) for special programmes and collaborative arrangements, such as the World Alliance for Patient Safety, the Health Metrics Network and the Global Health Workforce Alliance.

As of late December 2010, funding of US\$ 307 million had been made available through assessed and voluntary contributions. Of that, US\$ 241 million (56% of the approved budget) was for WHO base programmes and US\$ 66 million (122% of the approved budget) for special programmes and collaborative arrangements. Of the available funds, US\$ 135 million (29% of the approved budget and 44% of available funds) had been implemented by the end of 2010. Implementation for base programmes was US\$ 110 million (46% of available funds for base programmes) and for special programmes and collaborative arrangements US\$ 25 million (39).

Strategic objective 10 covers a range of activities related to health systems and health knowledge and information. Donor interest in those activities has not been uniform. While headquarters appears to be well funded, the funding is concentrated in partnerships and a few core departments. Some departments are experiencing serious funding shortfalls for the biennium. Funding from the approved budgets for regional offices has also been uneven. In actual fact, the budgets were “aspirational” and funding versus implementation in 2008–2009 (a typical baseline) is in reality quite good: 77% for the Regional Office for Africa, 89% for the Regional Office for the Eastern Mediterranean and 86% for the Regional Office for Europe. ■

2010–2011 (US\$ 000)		AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	TOTAL
Approved programme budget 2010–2011		124035	32224	44321	50528	60968	42441	119687	474204
Funds available as at 31 December 2010 ^a	AC	18652	15762	20914	7181	17632	15634	28105	123880
	VC	21729	1605	6923	19717	13589	17571	101837	183173
	TOTAL	40381	17367	27837	26898	31221	33205	129942	307053
Funds available as % of approved budget		33%	54%	63%	53%	51%	78%	109%	65%
Expenditure as at 31 December 2010		23816	8871	11603	13081	10915	14073	53302	135661
Expenditure as a % of approved budget		19%	28%	26%	26%	18%	33%	45%	29%
Expenditure as a % of available funds		59%	51%	42%	49%	35%	42%	41%	44%



^a Total funds available includes US\$ 201,000 of funds which were undistributed as of 31 December 2010.

PRIORITY RESULTS FOR 2011

For Organization-wide expected result 10.5 on knowledge and evidence for health decision making, the results to which priority will be allocated remain the same namely strengthening country health information systems by supporting the monitoring and review component of national health-sector strategic plans in countries; Health observatories: initial focus on country, regional and global level, but increasing focus on country level and development of standards for health information, including data collection, compilation, analysis and quality control, dissemination, and use of information technology.

Under Organization-wide expected result 10.6 on national health research, WHO will facilitate under the leadership of regional offices of national implementation of EVIPNET, and advocacy to encourage Member States to comply with the recommendation to dedicate at least 2% of the health budget to research to bring national health research up to a standard that meets internationally agreed minimum standards.

In the area of knowledge management and eHealth policies, Organization-wide expected result 10.7, WHO will work on the development of the Global Observatory for eHealth to function as an interactive system for reporting progress, policy and strategy development and monitoring activities in Member States for knowledge management and eHealth; the enhancement of HINARI as a public-private partnership by reinventing the programme parameters and revitalizing partnerships with publishers; and by engaging institutions in eligible countries in the promotion and use of the system and in providing feedback on challenges.

In addition, allocation of resources will support global collaborative and corporate projects that incur minimum expenses and provide maximum benefits, such as the Global Health Library, institutional repositories for information retrieval and Global Information Full Text. The Secretariat will also work on the development of global eHealth policies and models for national strategies and the necessary toolkits in order to reduce global investment in reinventing the same tools.

In the areas of health workforce information systems under Organization-wide expected result 10.8 and health workforce development under Organization-wide expected result 10.9, WHO will continue to undertake normative and technical assistance functions in the areas of health workforce information systems and maintenance of a global database; promote the education, training and retention of health personnel to ensure sufficient numbers, quality, suitability and equitable distribution; implement the Global Code of Practice on the International Recruitment of Health Personnel as mandated by resolution WHA63.16. The intensity of activities in these areas will be adjusted according to the level of human and financial resources available to implement them.

The Secretariat will further encourage investment in health workforce development in countries, particularly in planning, managing and regulating processes related to training, distribution, retention and migration, and maximize synergies within WHO and with partners in order to make a difference, particularly in countries experiencing a health workforce crisis.

For Organization-wide expected result 10.13 on health financing priorities include the development of a long-term strategy for setting priorities and modes of collaboration in order to increase the visibility and impact of patient safety-related activities; to engage regional offices in creating regional programmes for patient safety so as to foster national programme development and support the implementation of tools and standards in regions and countries. ■

IDENTIFICATION OF SPECIFIC ACTIVITIES AND RESULTS THAT WILL BE REDUCED OR NO LONGER DELIVERED

In response to the financial constraints, expenditure has been reduced and fundraising stepped up for Organization-wide expected result 10.5 on knowledge and evidence for health decision making. However, such funding tends to be unpredictable and is generally earmarked. The results at greatest risk of not being achieved are those connected with WHO's monitoring role, its work on standards, classification and data collection, and provision of technical assistance to countries for strengthening their health information systems.

Within a scenario of reduced financing, the focus of strategic objective 10 will be to maintain WHO's core functions in policy and norms development, in monitoring and evaluation while a number of programmatic activities are likely to be affected including technical assistance to countries for the strengthening of health information systems.

Under Organization-wide expected result 10.7 on knowledge management and eHealth policies, two programmes will be no longer delivered: the Africa Health Infoway and Sharing of eHealth Intellectual Property. ■

SO11

TO ENSURE IMPROVED ACCESS, QUALITY AND USE OF MEDICAL PRODUCTS AND TECHNOLOGIES



PROGRESS TOWARD THE ACHIEVEMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

OF THE THREE ORGANIZATION-WIDE EXPECTED RESULTS FOR THIS STRATEGIC OBJECTIVE, ONE WAS "ON TRACK" AND TWO "AT RISK"

OVERVIEW

The vaccine prequalification procedure was revised in 2010. Seven vaccine quality standards were established. The national regulatory agencies in 13 countries were assessed. Egypt and Iran (Islamic Republic of) were found to be performing in conformity with WHO indicators. All 12 countries in the Global Network for Surveillance of Newly Prequalified Vaccines received financial and technical support to strengthen countries' capacity to monitor the safety of vaccines used in their immunization programmes.

For medicines, comprehensive technical support was given to 92 Member States. The Regional Office for the Western Pacific developed a regional framework for improving access to essential medicines. The 50th Directing Council of PAHO adopted resolution CD50.R8 on Health and human rights. The Regional Office for Africa completed an assessment of the structure and performance of regulatory agencies in 26 countries. Standardized country profiles for the pharmaceutical sector are jointly being prepared by WHO, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Bank in 73 low- and middle-income countries. A total of 21 quality specifications for new essential medicines (for example, paediatric HIV) were developed, as well as 16 quality assurance guidelines. Eight biological reference standards for blood, blood products and in-vitro diagnostics were finalized, as well as the first global good manufacturing practice standard for blood establishments. In 2010, 85% to 90% of antiretroviral and artemisinin-based combination therapies procured by the large funding agencies were from prequalified sources, with <3% quality failure. The WHO Model Formulary 2010 was issued, covering all essential medicines on the WHO Model List of Essential Medicines, and serving as a model and starting point for national formularies.

In 2010, the Prequalification of Diagnostics Programme became fully operational with the first diagnostic product prequali-

fied. The first Global Forum on Medical Devices brought together key stakeholders to share knowledge on available medical devices, guidelines, tools, strategies, policies and best practices, and to determine future needs. WHO technical working groups reviewed the process and development of a prioritization document, and a fast track procedure was initiated. In response to the call for innovative technologies, 15 new and innovative technologies were identified for use in low- and middle-income countries.

WHO's normative functions in vaccines, medicines and technologies are essential for the pharmaceutical industry and for national regulators, and especially for those in low- and middle-income countries. Yet, due to the continual erosion of WHO's assessed contributions this whole area of work has now reached the stage where some global normative functions that are not specifically supported by individual donors are being abandoned, such as WHO's work for International Narcotics Control Board, or have become extremely vulnerable, for example, the medicine safety and pharmacovigilance programme, WHO's anti-counterfeit medicine programme and its work on the quality norms of blood and blood products.

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 anti-counterfeit medicine programme, 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 several resolutions on the subject. ■

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

ON TRACK

Model procedures for evaluating vaccine clinical trials are being prepared by the Developing Countries' Vaccine Regulators Network, the African Vaccine Regulators Forum and the ASEAN Vaccine Chapter. A training course on good clinical practice inspections was developed by the Developing Countries' Vaccine Regulators Network, and training was organized in Indonesia and South Africa.

Numerous countries in the South-East Asia and Western Pacific Regions established or updated their national medicine policies. The WHO/Health Action International medicine price and availability surveys were conducted in over 60 countries and policy guidance for medicine pricing in low- and middle-income countries is being prepared. Governance and anti-corruption programmes are running in 26 countries. Standardized country profiles for the pharmaceutical sector are being prepared jointly by WHO, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Bank in 73 low- and middle-income countries. WHO is the global clearing house for all United Nations medicine-related country assessments and country-level policy documents in the area of pharmaceuticals. For example, over 1000 national medicine policies and national essential medicines lists are now available on the WHO public web site. The Regional Office for the Western Pacific produced a regional framework for improving access to essential medicines, and a regional price information exchange mechanism.

The blood transfusion safety programme continues to support countries in strengthening their capacity to develop national policies and plans for establishing and improving their national blood systems by promoting universal access to safe blood transfusion. The first Global Forum on Medical Devices brought together key stakeholders to share knowledge on available medical devices, guidelines, tools, strategies, policies and best practices, and to determine future needs. Many countries developed national laboratory policies and plans. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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	ON TRACK
11.1.2 Number of Member States receiving support to design or strengthen comprehensive national procurement or supply systems	AT RISK
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	AT RISK
11.1.4 Publication of a biennial global report on medicine prices, availability and affordability, based on all available regional and national reports	ON TRACK

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.

AT RISK

Four written and three measurement standards for vaccines were established. Progress was made in the standardization of another eight vaccines (for acellular pertussis, BCG disease, dengue, DTP, malaria and combined vaccines based on DTP, oral polio vaccine and inactivated poliovirus vaccine). The revision of the vaccine prequalification procedure was completed in 2010. The national regulatory agencies in Egypt and Iran (Islamic Republic of) were officially assessed and found to be performing in conformity with WHO indicators. Assessments of national regulatory agencies and follow-up were carried out in 13 countries. A computerized tool for national regulatory assessment was expanded to include pre-visits.

The first report on the assessment of regulatory agencies in 26 African countries was published. Many countries have assessed and strengthened their medicine regulation systems, often through participation in the United Nations Prequalification programme, which is managed by WHO. Globally, 21 quality specifications for new essential medicines, including paediatric HIV, were designed, as well as 16 quality assurance guidelines; these standards are essential for generic manufacturing. Eight biological reference standards for blood, blood products and in-vitro diagnostics were finalized, as well as the first global good manufacturing practice standard for blood establishments. Adverse drug reactions were collected from nearly 100 countries that maintain a database of some six million reports on adverse drug reactions with active case findings for new HIV and malaria medicines. The United Nations Prequalification programme prequalified 36 new products for AIDS, tuberculosis, malaria and reproductive health and trained 1211 regulators and manufacturers through 70 training courses in all six regions. In 2010, 85% to 90% of antiretroviral and artemisinin-based combination therapies procured by the large funding agencies came from prequalified sources, with <3% quality failure. The PAHO Strategic Fund continued to procure essential medicines for Member States in the region.

In the African Region, 41 countries collected data on blood safety indicators. The Essential & Emergency Surgical Care global database collected data on infrastructure, the surgical workforce, skills, equipment and standardized guidelines from 30 low- and middle-income countries. In 2010, the injection safety and infection control project documented the impact of its activities on the burden of disease, as well as the major contribution of injection safety interventions to achieving the Millenium Development Goals on infant and maternal mortality and HIV transmission. In 2010 the Prequalification of Diagnostics Programme became fully operational with the first diagnostic product prequalified. WHO technical working groups reviewed the process and development of a prioritization document, and a fast track procedure was initiated. ■

PERFORMANCE INDICATORS	CURRENT STATUS
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	ON TRACK
11.2.2 Number of assigned International Nonproprietary (generic) Names for medical products (cumulative)	ON TRACK
11.2.3 Number of priority medicines, vaccines, diagnostic tools and items of equipment that are prequalified for United Nations procurement	ON TRACK
11.2.4 Number of Member States for which the functionality of the national regulatory authorities (NRA) has been assessed or supported	ON TRACK

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 planning programmes.

AT RISK

All 12 countries in the Global Network for Post-Surveillance of Newly Prequalified Vaccines received financial and technical support to strengthen countries' capacity to monitor the safety of vaccines used in their immunization programmes. However, by the end of 2010, only five out of 11 countries had submitted, on schedule, data on adverse events following immunization, and fewer than 10% had provided sufficient core data. Significant efforts will be required to address the lack of quality reporting.

Numerous countries in the South-East Asia and Western Pacific Region were supported in updating their national lists of essential medicines. The Regional Office for Europe held a regional workshop on regulating medicine promotion. The WHO Model Formulary 2010 was issued, covering all essential medicines on WHO's Model List of Essential medicines and serving as a model and starting point for national formularies. The WHO Model List of Essential Medicines for Children and the first WHO Model Formulary for Children were issued for guiding countries' decisions on selection, procurement and reimbursement in connection with essential medicines. Preparatory work was carried out for World Health Day 2011 whose theme is antimicrobial resistance and its global spread. A lack of funding prevented any significant work being carried out on promoting rational use of medicines by prescribers and consumers.

Consultations with stakeholders, national authorities, and educational programmes have reinforced advocacy on universal access to the safe, efficient and ethical transplantation of cells, tissues and organs. In 2010, progress was made in the sensitive area of organ donation from deceased donors. Through the WHO call for innovative technologies, 15 new and innovative technologies were identified for use in low- and middle-income countries. Eight medical devices in the category of commercialized products and seven in the category of non-commercialized products were selected. A compendium was produced listing and describing the 85 innovative technologies received. WHO continues to monitor the performance of over 300 national reference laboratories through the provision of external quality assessment schemes for a range of laboratory markers, including HIV, hepatitis B, hepatitis C, haematology, blood films, CD4, clinical chemistry and coagulation. The maintenance manual for laboratory equipment was used in regional training programmes. ■

PERFORMANCE INDICATORS

CURRENT STATUS

11.3.1 Number of national or regional programmes receiving support for promoting sound and cost-effective use of medical products or technologies **IN TROUBLE**

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 **ON TRACK**

SUMMARY OF FINANCIAL IMPLEMENTATION

(AS AT 31 DECEMBER 2010)

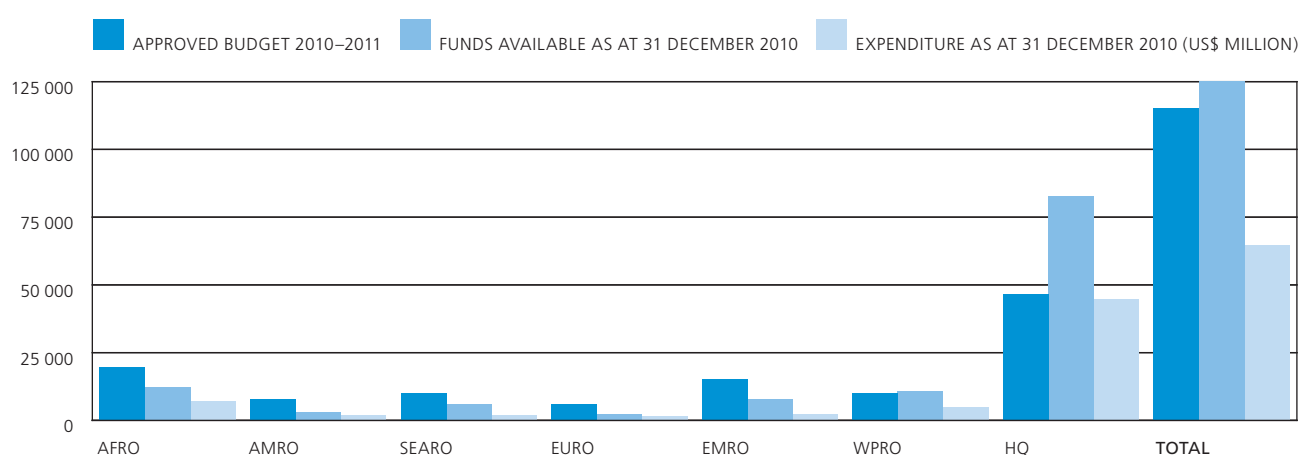
The total approved budget for the strategic objective was US\$ 115 million (since adjusted to US\$ 170 million, including US\$ 30 million for special programmes and collaborative arrangements for work on prequalification of medicines and the International Nonproprietary Name programme).

As at end of December 2010, funding of US\$ 125 million (74%) had been made available through assessed and voluntary contributions. Of that, US\$ 91 million (73% of available resources) was for WHO base programmes and US\$ 34 million (27% of available resources) for special programmes and collaborative arrangements. Globally, of the available funds, US\$ 65 million (56% of the approved budget and 52% of available funds) had been implemented by the end of 2010.

Available resources in headquarters amount to 178% of the approved budget because the original budget of US\$ 46 million did not take account of the costs and funding required for the vaccine, medicine and diagnostics prequalification programme. That has been corrected in the revised budget for headquarters, which was US\$ 98 million as at 31 December 2010 (US\$ 68 million for base programmes and US\$ 30 million for special programmes and collaborative arrangements). On the revised basis, expenditure of US\$ 45 million in headquarters represents 54% of available funds and 46% of the revised budget.

Implementation of regional and country programmes was below 50%, mainly because no specified funds were made available for them, except in the Western Pacific Region as a result of successful fundraising efforts. ■

2010–2011 (US\$ 000)		AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	TOTAL
Approved programme budget 2010–2011		19663	7731	10002	5952	15069	10227	46483	115127
Funds available as at 31 December 2010 ^a	AC	5177	1405	3280	705	3182	2776	9593	26118
	VC	7031	1478	2635	1561	4813	7964	73352	98957
	TOTAL	12208	2883	5915	2266	7995	10740	82945	125075
Funds available as % of approved budget		62%	37%	59%	38%	53%	105%	178%	109%
Expenditure as at 31 December 2010		7142	1964	1937	1531	2479	4978	44772	64803
Expenditure as a % of approved budget		36%	25%	19%	26%	16%	49%	96%	56%
Expenditure as a % of available funds		59%	68%	33%	68%	31%	46%	54%	52%



^a Total funds available includes US\$ 123,000 of funds which were undistributed as of 31 December 2010.

PRIORITY RESULTS FOR 2011

At least half the activities and results under the strategic objective are related to the development and implementation of global quality standards for vaccines, medicines and essential technologies. While the global medical industry, and especially the generic industry in low- and middle-income countries, is heavily dependent on WHO's global standards and uses them extensively, the economic and medical importance of the work is not adequately recognized by WHO's governing bodies. As a result, the assessed contributions for the work were reduced and unspecified funds moved to underfunded country programmes in other technical areas, leaving work that is relevant for all Member States, and which should be authoritative and independent, highly dependent on the funding decisions of a few individual donor countries and large foundations, or even unfunded. At the same time, nearly all regional offices reported that the demand for technical advice and support from the Member States far exceeded their human and financial resources. ■

IDENTIFICATION OF SPECIFIC ACTIVITIES AND RESULTS THAT WILL BE REDUCED OR NO LONGER DELIVERED

Some global normative functions, which are not specifically supported by individual donors, such as WHO's work for the International Narcotics Control Board and the anti-counterfeit medicine programme, are either being abandoned or their staff reduced to one professional officer each due to lack of flexible funding. Unless additional funds are made available, these functions are likely to disappear in the next biennium.

Promoting the rational use of medicines and combating antimicrobial resistance is also underfunded, despite its potential medical and economic benefits.

Nearly all regional offices report that the demand from Member States for technical support under the strategic objective far exceeds their human and financial resources. ■

SO12

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



PROGRESS TOWARD THE ACHIEVEMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

OF THE FOUR ORGANIZATION-WIDE EXPECTED RESULTS FOR THIS STRATEGIC OBJECTIVE, ALL WERE "ON TRACK"

OVERVIEW

The introduction and leadership of the Global Policy Group (composed of the Director-General, the Deputy Director-General and the six Regional Directors) proved to be a successful coordination mechanism, and a coherent approach to developing greater consistency and coherence in the WHO Secretariat's delivery across the three levels of the Organization. It also resulted in regular policy and strategic coordination among peer groups at senior management level and, at regional level, between Regional Directors and Heads of Country Offices, thereby further enhancing policy coherence.

Strategic guidance was provided by several key reports such as the *World Health Report 2010* on universal coverage and the first report on neglected tropical diseases, *Working to overcome the global impact of neglected tropical diseases*.

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 and presented to the 128th session of the Executive Board for subsequent consideration by the Sixty-fourth World Health Assembly.

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, and the meetings of the International Health Regulations Review Committee.

In response to previous requests made to the Secretariat, great efforts were made to ensure that documentation issuance was provided early or on-time for the major governance meetings. For the 126th Executive Board the percentage of late documents was reduced to 3%, from 33% in 2009, and for Sixty-third World Health Assembly, the percentage of late documents was reduced to 22%, from 29% in 2009. This effort was replicated in relation to the Regional committees.

At the regional level, leadership and direction, were strengthened through the recruitment of senior personnel, the streamlining or restructuring of technical and administrative areas, regular and systematic reviews of organization-wide policies, a regional forum for dialogue among Member States and the main partners to promote health and encouragement of the active engagement of Member States in the preparation and conduct of the regional committees and other high-level meetings.

Country cooperation strategies, and effective WHO country presence, made good progress, including through renewed country cooperation strategies and alignment of WHO technical collaboration in countries of all six regions to national strategies and priorities. Heads of WHO country offices were selected from the global roster of successful candidates through a competitive selection process and have been provided with an induction training course to further develop their skills and competencies. The exchange of experiences in the context of harmonization and alignment 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. Guidelines and tools on harmonization and alignment were developed and disseminated in all countries and country and regional training and orientation courses were supported to further develop the capacity of country teams.

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.

WHO's engagement in a series of high level United Nations General Assembly events and resolutions has resulted in improved positioning and alignment of global health priorities and WHO's strategic objectives. In particular, this has led to the development of new ways of working cross-sectorally and engaging partners in health. One example is leadership on writing the 2010 United Nations Secretary-General's report on the topic of foreign policy and global health that culminated in a third United Nations General Assembly resolution on the subject.³

Further coordination with the United Nations to support the inclusion of health policy and synergy of business practices has been advanced through WHO serving as the Vice-Chair of the United Nations Development Group, as well as senior staff leading or staffing a number of United Nations Development Group, Chief Executives Board initiatives (such as Social Protection Floor), High Level Committee on Programmes, High Level Committee on Management working groups and Regional United Nations Development Group. WHO continued engagement with the United Nations Economic and Social Council and, inter alia, prepared the 2010 United Nations Secretary-General's report on the 2009 United Nations Economic and Social Council's high-level forum discussion on global public health.

Guidance facilitating WHO's engagement with the United Nations Development Assistance Framework and the United Nations Expanded Funding Windows has led to an increase of over 10% in funds for WHO compared to 2009. WHO country teams ensured leadership of the Global Health Cluster of the United Nations Country Team. Coordination of United Nations efforts on health at country level has improved and WHO leadership on health actions has been recognized by the United Nations system and the United Nations Development Group.

Engagement by regional offices with United Nations Regional Coordination Mechanisms and with other United Nations agency regional directors served to strengthen synergies and alignment, and to maximize contributions to the health development agenda at regional and country levels. 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. Regional offices are increasingly engaged in work with the United Nations and with various intergovernmental organizations, such as the Association of South-East Asian Nations, the African Union, the European Union, the Organization of American States and the Organization of the Islamic Conference. Collaboration with the European Commission, the European Parliament and the Council of the European Union on the process supported the articulation of the European Union's role in global health policy, with key references to WHO in terms of global governance and leadership in its normative work and guidance functions.

The WHO web site was redesigned to make it more user friendly, with improvements to make the site easier for persons with special needs. The number of visits noted across all the Organization's web sites (global and regional) continued to increase as content and language versions being posted increased. The use of social media was introduced and has contributed to reaching more users. Training on writing for the web, web editing and publishing was provided. Use of traditional media channels was made, such as newsletters and audiovisual production, in certain regional settings in order to enhance the sharing of health knowledge.

Over 250 proposals for WHO collaborating centres were reviewed and decisions were made as appropriate. The alignment of their workplans with WHO priorities is at a record high level. Several training opportunities on policies and procedures were offered and a manual on knowledge networks with a special focus on WHO's needs was developed, and two related workshops were organized.

Greater collaboration between WHO's regional libraries and the headquarters' library led to further efficiencies and cost savings, thus benefitting staff of the Organization worldwide.

The monthly issues of *The Bulletin of the World Health Organization* were published on schedule in both printed and electronic versions in English and Arabic. Abstracts of articles were provided in all the official languages. *The World Health Report* was produced in multiple formats and in all official languages. *The Eastern Mediterranean Health Journal* and the *Pan American Journal of Public Health* continued to publish high quality biomedical and public health research on a periodical basis. The quarterly *African Health Monitor* was published in English and French. Permission granted to external partners to translate WHO publications allowed for increased availability of a range of WHO publications in more than 70 languages.

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. ■

³ United Nations General Assembly Resolution A/RES/63/33

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

ON TRACK

The introduction and regular convening of the Global Policy Group improved coherence across the three levels of the Organization. Discussions on the future of WHO financing were launched through a consultation with Member States, and proposals for developing a WHO programme of reform were prepared and presented to the 128th session of the Executive Board for consideration by the Sixty-fourth World Health Assembly.

WHO's approach was presented in a coherent manner at international events, such as the United Nations High-level Plenary Meeting on the Millennium Development Goals in September 2010, and global strategic guidance was provided through key reports, including the *World Health Report 2010 – the path to universal coverage*, and the first WHO report on neglected tropical diseases, *Working to overcome the global impact of neglected tropical diseases*.

In addition to the regular 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, and the meetings of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009.

The Secretariat strove to ensure timely issuance of documentation for the main governance meetings at global and regional levels, achieving in most cases greatly improved results.

Strategic efforts to strengthen relations with nongovernmental organizations have yielded good results, including support to harmonize actions in countries. Timely and thorough reviews of nongovernmental organizations in official relations with WHO were implemented, including preparation of new applications presented to the Executive Board Standing Committee on Nongovernmental Organizations, the annual review of one third of the nongovernmental organizations in official relations with WHO (59 of 187), and advice to all levels of the Organization on engaging with such organizations.

Corporate communication actively supported the technical programme areas, including tuberculosis, pandemic influenza and official health days. Through advocacy visits to countries, WHO sought to promote a better understanding of its role and priorities.

The need to strengthen internal oversight services was highlighted by the newly formed Independent Expert Oversight Advisory Committee, addressing the requirements to strengthen oversight services, and include support for investigations of alleged harassment, now being managed by internal oversight services, and the impact of covering high risk areas identified by the new internal oversight services risk assessment model.

The Office of the Legal Counsel, in addition to dealing with the standard corporate governance issues, worked extensively on the area surrounding conflict of interest.

In certain locations, governance was strengthened through regular and ad-hoc Programme Committee meetings. In the European Region the Standing Committee of the Regional Committee strengthened its oversight function, including using the Programme budget as a strategic tool for accountability, specifying the commitments of both Member States and the Secretariat.

Regional participation in policy dialogue continued at a global level, enabling the regional and country offices to effectively implement policy directions and guidance from governing bodies, as well as to synchronize regional and country strategies with the global agenda. ■

PERFORMANCE INDICATORS

CURRENT STATUS

12.1.1 Proportion of documents submitted to governing bodies within constitutional deadlines in the six WHO official languages

ON TRACK

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.

ON TRACK

Renewed country cooperation strategies were formulated in all regions using the new *Country Cooperation Strategies Guide 2010*. The process enabled WHO technical cooperation to fully align to national policies, strategies and plans, and be harmonized with the United Nations Development Assistance Framework as well as other development partner platforms, such as the Sector wide Approach (SWAp) and the International Health Partnership, and country offices reviewed their capacities on the basis of country cooperation strategies' priorities and available resources. Capacities were further strengthened through regional- and country-level training and orientation courses.

In all regions, the country cooperation strategic agenda is being mapped in accordance with the strategic objectives contained in the Medium-term strategic plan, and the results will be used to inform and validate Programme budget 2012–2013 workplans.

For the first time, heads of country offices were selected from a roster of successful candidates through a competitive selection process. Newly recruited heads of country offices from all six regions have received induction training to further develop their skills and competencies.

To further develop the capacity of country teams, the first phase of the WHO Compendium of National Expertise was implemented in order to provide country teams with access to high quality technical expertise in a timely manner. The database of WHO expertise in the African Region was developed and has improved the ability of both country teams and regional partners to identify and use internal expertise.

Tools, guidelines as well as guidance notes on aid effectiveness, the United Nations Development Assistance Framework, and multi-donor trust funds have been developed, disseminated and uploaded onto the web sites for easy access.

Given the differences between Member States in the European Region, a review of the overall approach to collaboration was conducted and a new strategy for country presence is being developed. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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

ON TRACK

12.2.2 Proportion of WHO country offices which have reviewed and adjusted their core capacity in accordance with their country cooperation strategy

ON TRACK

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.

ON TRACK

WHO collaboration with health partnerships, other United Nations agencies, intergovernmental bodies, nongovernmental organizations, the private sector, and other partners, was further strengthened in 2010.

New WHO policies, mechanisms and approaches have improved coherence among stakeholders 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. These include those for global health initiatives and WHO hosted partnerships, engagement with the private sector, high level coordination with the United Nations system and WHO interaction with United Nations Country teams, engagement with nongovernmental organizations, interaction with specific intergovernmental organizations, and new strategic approaches for cross-sectoral partnerships, such as for foreign policy and health.

Adoption of resolution WHA 63.10 on Partnerships by the Sixty-third World Health Assembly resulted in improved management of, and engagement with, hosted partnerships and other forms of collaboration. All of the WHO hosted partnerships comply with the WHO partnerships policy. Similarly, all of the health partnerships that provide funding to countries in which WHO engages work in accordance with the best practice principles for Global Health Partnerships. These include global health initiatives and partnerships external to WHO in which WHO is engaged and those managed by WHO. Examples are the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Alliance for Vaccines and Immunization, the International Drug Purchase Facility (UNITAID), the Partnership for Maternal, Newborn and Child Health, the International Federation of Red Cross and Red Crescent Societies, the Health Metrics Network, the International Health Partnership, Providing for Health initiative, and the Stop TB Partnership.

The WHO Global Policy Group's endorsement of the WHO Private Sector engagement policy framework established new approaches for how all levels of the Organization can collaborate with these entities in order to influence their work as well as for resource mobilization. Processes to ensure due diligence for private sector engagements are consistently timely, of high quality, and sensitive to issues of potential conflicts.

WHO has continued to be a leader in the United Nations "Delivering as One" efforts. WHO served as the Vice-Chair of the United Nations Development Group, with senior staff leading or staffing a number of United Nations Development Group working groups such as the High-Level Committee on Programmes, and the High Level Committee on Management. All Regional Directors participate in the United Nations Regional Director Teams meetings as part of regional United Nations Development Group mechanism. The Harmonization for Health in Africa partnership mechanism with United Nations and bilateral agencies and development banks complements the United Nations Development Group mechanisms and has enabled the provision of harmonized support to the development of national strategic plans, as well as joint advocacy for greater investment in health in the African Region.

To further develop the capacity of country teams and regional offices, tools, guidelines as well as guidance notes on key aspects of United Nations reform and the Chief Executives Board, and for business practices, such as working with United Nations Development Assistance Frameworks, Management and Accountability Framework, and Multi-donor Trust Funds, have been developed and disseminated. Country as well as regional training and orientations have been supported.

A survey of all WHO country offices indicates that as of end 2009, 83% had reported that they were actively engaged in the development of the United Nations Development Assistance Framework, including leading the health component. In 2010, further indications are that WHO is engaged in all United Nations Development Assistance Frameworks where they exist. Under the leadership of WHO, the Global Health Cluster coordinates the actions of the international humanitarian health organizations at both the global/regional and country levels to improve the effectiveness, predictability and accountability of humanitarian health action. ■

Coordination of WHO's engagement in a series of high level United Nations General Assembly events and resolutions has resulted in improved positioning and alignment of global health priorities and WHO's Strategic Objectives. These included coordination of the Director-General's participation in health side events to the Millennium Development Goals Summit and the Director-General's participation in the United Nations General Assembly, the Chief Executives Board and other high level events in New York. Strategic support was provided to the development of the Secretary-General's Global Strategy on Women's and Children's Health. WHO also contributed to United Nations General Assembly resolutions A/RES/64/265 on the prevention and control of non-communicable diseases, and A/RES/64/255 on improving global road safety.

Coherence is further achieved through WHO's engagement in health-related and other relevant meetings at the United Nations, including the High-Level Segment of the United Nations Economic and Social Council, the Commission on Population and Development, the Commission on the Status of Women, the Conference of States Parties to the Convention on the Rights of Persons with Disabilities, the 18th session of the Commission on Sustainable Development, and the Fourth United Nations Conference on the Least Developed Countries.

The engagement by regional offices with United Nations Regional Coordination Mechanisms and the Regional Directors of other United Nations agencies has led to enhanced coordination with United Nations agencies. Regional office engagement with the African Union, the Association of South-East Asian Nations, the European Union, the Organization of American States, the Iberoamerican Summit of Head of States, the Fifth Ministerial Conference on Environment and Health and the Organization of the Islamic Conference have strengthened synergies and alignment in order to derive maximum benefit from contributions to the health development agenda at regional and country levels. A joint Declaration by the European Commission and the WHO Regional Office for Europe was adopted by the Sixtieth Session of the European Regional Committee to consolidate the considerable existing collaboration. Partner Forums on health were held by regional offices to address particular issues such as noncommunicable diseases and promote coordination.

Development of new strategic approaches to engage partners in health included input by WHO into United Nations General Assembly resolution A/RES/63/33 on Global health and foreign policy. Some regional offices developed similar initiatives at regional level with main external partners.

Similarly, new strategic approaches were developed to engage partners in health activities and provide support to harmonize actions. These included tools to map nongovernmental and faith-based organizations, approaches to engage communities, and working with United Nations partners in the Interagency Task Force on Faith and Development. ■

PERFORMANCE INDICATORS

CURRENT STATUS

12.3.1 Number of health partnerships in which WHO participates that work according to the best practice principles for Global Health Partnerships	ON TRACK
12.3.2 Proportion of health partnerships managed by WHO that comply with WHO partnership policy guidance	ON TRACK
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	ON TRACK

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.

ON TRACK

The WHO web site was redesigned, with specific improvements for persons with special needs and with an increase in content and accessibility. The regional health knowledge context saw the Regional Office for Africa re-launch its web site and continue to increase its content based on printed publications in English, French and Portuguese. The Regional Office for the Americas continued to maintain the web site in English and Spanish, while official publications were in addition produced in French and Portuguese. The Regional Office for the Eastern Mediterranean continued to publish the website content in Arabic, English and, in many parts of it, in French. The Regional Office for Europe revamped its web site with improved topic and country sites and generated over 36% increase in number of visits. The Regional Office for the Western Pacific took major steps to improve access to health information using the web as there was a rise in the volume of visitors to its web site from 1.5 million visitors in 2009 to 2.9 million in 2010.

The management of WHO collaborating centres focused on improving the quality of proposals and their screening on time in addition to training on knowledge networks. All regional offices contributed to better management of the designation of WHO collaborating centres and improvement of services through training and virtual networking. In the Regional Office for Europe, work is ongoing to capitalize from the large number of WHO collaborating centres in this region by closer integration of the centres with the work plans of the Secretariat.

Collaboration between WHO's regional libraries and the headquarters' library increased, allowing further efficiencies, and cost savings, thus benefiting staff of the Organization worldwide. In addition, the regional network of WHO librarians supports multilingual information retrieval and sharing across the Organization. Computer-based training tools have been developed to ensure information training, in particular for staff at remote locations. The information services of the Region for the Eastern Mediterranean, especially the Index Medicus and electronic publishing, continued to increase to ensure maximum accessibility to users. The Regional Office for South-East Asia focused on improving quality and access to its information products, especially with its electronic library being made available, which has contributed to better access to medical knowledge in the region. Access to evidence and knowledge for all WHO staff at headquarters, in all regional, country offices and out posted centres was provided through the Global Information Full Text. The Americas developed a technological platform to improve access to evidence and knowledge for Member States and the general public using cost-effective technology such as the Virtual Campus of Public Health and the Virtual Library of Public Health.

Timely and regular publishing of WHO flagship publications, such as the *Bulletin of the World Health Organization* and *The world health report* continued. WHO information products were widely disseminated. The WHO Ethics Review Committee continued its work in an efficient manner. ■

PERFORMANCE INDICATORS

CURRENT STATUS

12.4.1 Average number of page views/visits per month to the WHO headquarters' web site	ON TRACK
12.4.2 Number of pages in languages other than English available on WHO country and regional offices' and headquarters' web sites	ON TRACK

SUMMARY OF FINANCIAL IMPLEMENTATION

(AS AT 31 DECEMBER 2010)

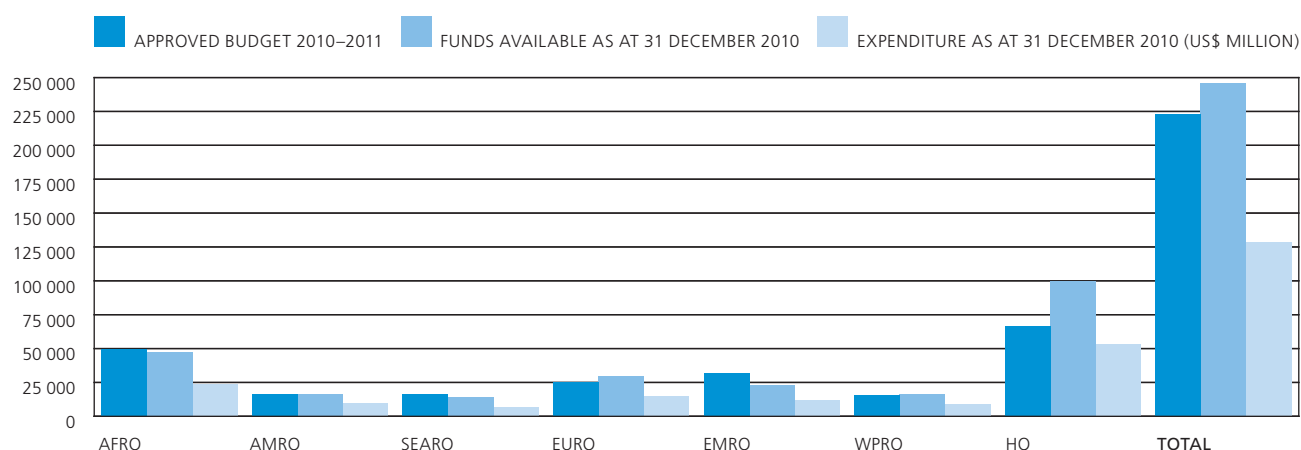
The WHA approved budget for strategic objective 12 was US\$ 223 million. Available funding by the mid-term was US\$246 million (110% of the approved budget), of which US\$ 190 million were from assessed contributions and US\$ 56 million from voluntary contributions. Implementation across all locations as at 31 December 2010 was US\$ 129 million which corresponds to 58% of the approved budget and 52% of the available resources.

The high availability of resources in headquarters of 149% against the approved programme budget is because the originally approved budget for headquarters did not include subsequent shifts of major work components, such as language services from strategic objective 13.

There is a current total estimated gap of US\$ 12 million, if the implementation rate of strategic objective 12 is maintained, through the biennium compared to funds available.

Regular monitoring of the situation at regional and budget centre levels will be important to ensure the optimal use of the funds within the strategic objective. ■

2010–2011 (US\$ 000)		AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	TOTAL
Approved programme budget 2010–2011		49 735	16 710	16 503	25 572	31 659	15 779	66 759	222 717
Funds available as at 31 December 2010	AC	42 345	14 256	10 101	20 800	19 482	11 647	71 699	190 330
	VC	4 724	2 163	3 775	9 005	3 301	4 652	27 871	55 491
	TOTAL	47 069	16 419	13 876	29 805	22 783	16 298	99 570	245 821
Funds available as % of approved budget		95%	98%	84%	117%	72%	103%	149%	110%
Expenditure as at 31 December 2010		23 907	9 793	6 807	14 592	11 936	8 855	52 983	128 873
Expenditure as a % of approved budget		48%	59%	41%	57%	38%	56%	79%	58%
Expenditure as a % of available funds		51%	60%	49%	49%	52%	54%	53%	52%



PRIORITY RESULTS FOR 2011

Major offices will manage their own internal reallocation or re-programming exercises throughout 2011 in order to ensure appropriate realignment of funding across the departments and regional and county offices concerned, as well as optimal programme delivery during the biennium. ■

PLANS TO ACHIEVE EFFICIENCIES AND COST REDUCTIONS

- Further coherence and complementarity in the area of resource mobilization;
- Operational efficiencies in the areas of governing bodies at global and regional levels, translation, interpretation, graphics services, publications, travel and communication, including telephone expenses and exploring the feasibility of developing an integrated approach to managing web sites;
- Timely fund management and effective financial monitoring;
- Implementation of the WHO reform agenda to the extent additional resources effectively support such efforts;
- Closer link between the Country Cooperation Strategies, the Medium-term strategic plan and the Programme Budget 2012–2013 workplan development, including the monitoring of their implementation;
- Continue to work in partnerships, including with non traditional partners, on the basis of new mechanisms of collaboration, and striving for improved harmonization and coherence, including through support to effective WHO engagement in the United Nations Development Assistance Framework roll-out. ■

IDENTIFICATION OF ACTIVITIES AND RESULTS THAT WILL BE REDUCED OR NO LONGER DELIVERED

All the Organization-wide expected results are rated as “on track”. No major office is facing challenges that cannot be overcome by a strategic reallocation of resources. WHO has been requested to establish new intergovernmental working groups and expert committees, for which new sources of funding would need to be found so as not to deflect resources away from core planned operations, where a funding gap of US\$ 12 million remains to be filled.

It is crucial to ascertain how much additional overall funding can be expected in 2011 in order to be able to make informed decisions on which activities to abandon or defer. ■

SO13

TO DEVELOP AND SUSTAIN WHO AS A FLEXIBLE, LEARNING ORGANIZATION, ENABLING IT TO CARRY OUT ITS MANDATE MORE EFFICIENTLY AND EFFECTIVELY



PROGRESS TOWARD THE ACHIEVEMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

OF THE SIX ORGANIZATION-WIDE EXPECTED RESULTS FOR THIS STRATEGIC OBJECTIVE, FIVE WERE "ON TRACK" AND ONE "AT RISK"

OVERVIEW

The draft Programme budget 2012–2013 was discussed by the regional committees, as well as by the Programme, Budget and Administration Committee during the 128th session of the Executive Board. The Programme budget 2008–2009 performance assessment was delivered to the Sixtieth-third World Health Assembly on time.

A corporate resource mobilization strategy was discussed and endorsed by the Global Policy Group and a draft plan of action was prepared in consultation with the global resource mobilization team and the headquarters resource mobilization team.

The introduction of the Global Management System was completed in all regional offices except the Regional Office for the Americas. As a result of its implementation, consistency in service delivery, transparency, financial reporting and income analysis have improved across the Organization. Introduction of the Global Management System in other regional offices in 2010, and detailed planning for its introduction in early 2011 in the Regional Office for Africa, was achieved through close collaboration between the regional offices concerned and headquarters.

Funding mechanisms for the Capital Master Plan and in connection with security were explored, and an Independent Expert Oversight and Advisory Committee was established. A new cost recovery mechanism, known as the post occupancy charge, was implemented, and a global roster for heads of WHO country offices introduced, which has prompted proposals for global rosters for other generic positions.

An unqualified audit opinion on the first biennial financial statement was produced under the General Management System, and the enterprise risk management framework was institutionalized at headquarters and its expansion to the regions initiated.

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. ■

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.**

ON TRACK

The draft Programme budget 2012–2013 was discussed by the regional committees and by the Programme, Budget and Administration Committee at the 128th session of the Executive Board. All country office workplans for the biennium 2010–2011 were peer-reviewed by headquarters and the Regional Offices for Africa, the Americas, South-East Asia and the Western Pacific. The Regional Office for the Eastern Mediterranean is planning a peer review, but the Regional Office for Europe will not be undertaking such an exercise.

Mapping of Organization-wide expected result 12.2 on country cooperation strategies was further developed and strengthened. Operational planning linkages were created during preparation of the Programme budget 2012–2013. Mapping was conducted in all regions. The exercise included a full review of the country cooperation strategic agenda and the structuring of its elements into main components and sub-components that were then mapped to the Medium-term strategic plan, strategic objectives and Organization-wide expected results. The information gathered will be used to develop operational plans at all levels of the Organization in 2012–2013. The preparation process for the Programme budget 2012–2013 was simplified to reduce the associated workload of the strategic objective networks and budget centers.

The Programme budget 2008–2009 performance assessment with improved evaluation of indicators was delivered to the Sixty-third World Health Assembly on time.

Operational planning for 2012–2013 was redesigned, with adequate review points for senior management to provide direction.

The Mid-term review of implementation of the Programme budget 2010–2011 and the Interim assessment of the Medium-term strategic plan 2008–2013 are both on track and the findings will inform a senior management review and prioritization process before being finalized for consideration by the World Health Assembly. ■

PERFORMANCE INDICATORS

CURRENT STATUS

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

ON TRACK

13.1.2 Office Specific Expected Results (OSERs) for which progress status has been updated within the established timeframes for periodic reporting

ON TRACK

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.

ON TRACK

The financial management reporting tool has been redesigned in graphic format and its use should be more vigorously promoted. The budget analysis conducted in October 2010 was well received.

Advice on resource and award management policies and practices and proposals for resource allocation of corporate resources were put forward, including proposals to manage assessed contributions in an integrated budget. A corporate resource mobilization strategy was discussed and endorsed by the Global Policy Group, and a draft plan of action was prepared in consultation with the global resource mobilization team and the headquarters resource mobilization team.

Resource mobilization and external relations efforts, including contributions to the UNDP Multi-donor Trust Fund and meetings with donors, were strengthened, including 12 bilateral meetings with Member States, stakeholders, and other key donors, for example, contributors to the core voluntary contributions account, the Bill & Melinda Gates Foundation and USAID.

Support was provided for the Director-General's consultation on WHO reform in January 2010, the associated web consultations and the follow-up discussions in the regional committees and during preparation of the documents for consideration by the Executive Board.

The required accounting, income recording, treasury management, health insurance and pension services were all performed by the end of 2010 to the agreed service standard. The statutory financial report, including a "clean" external audit opinion was presented to Member States. Progress was made in implementation of the International Public Sector Accounting Standards, and related training was carried out in regional offices. Preparations, including a risk analysis on financial conversion, were carried out for the introduction of the Global Management System in the Regional Office for Africa. ■

PERFORMANCE INDICATORS

CURRENT STATUS

13.2.1 Degree of compliance of WHO with International Public Sector Accounting Standards

ON TRACK

13.2.2 Amount of voluntary contributions that are classified as fully and highly flexible

ON TRACK

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.

ON TRACK

In April 2010, a global roster was introduced for heads of WHO country offices, in line with the decision taken by the Global Policy Group. In the intervening period, over 30 vacancies have been advertised to those who appear on the roster.

In September 2010, WHO issued a revised policy on the prevention of harassment within the Organization, following extensive consultations. The policy includes input from representatives of the WHO Staff Association, senior management and other administrative personnel at headquarters and in the regional offices.

Curricula were prepared for the global human resources learning programmes and workshops were held in the Regional Offices for the Americas and the Western Pacific and at headquarters.

In 2010, implementation of the updated version of the performance management and development system in all regions became mandatory. Staff are required to identify relevant competencies and outline an individual development plan in consultation with supervisors. An assessment of training needs in relation to the “Fit for the Future” initiative has turned out to be an essential tool for identifying and providing training programmes suited to staff members’ learning requirements.

An occupational health and safety committee was established and trained in conjunction with the new WHO global occupational health and safety policy. Progress was made towards the harmonization of regional medical services.

In late 2010, customized “prevention” databases were launched by PAHO, the Regional Office for Europe and the International Agency for Research on Cancer. The WHO policy on the employment of persons with disabilities, in line with the United Nations Convention on the Rights of Persons with Disabilities and its Optional Protocol, was implemented worldwide. ■

PERFORMANCE INDICATORS

CURRENT STATUS

13.3.1 Proportion of offices with approved human resources plans for a biennium	ON TRACK
13.3.2 Number of staff assuming a new position or moving to a new location during a biennium (delayed until biennium 2010–2011)	ON TRACK
13.3.3 Proportion of staff in compliance with the cycle of the Performance Management Development System	ON TRACK

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.

ON TRACK

Wherever possible, WHO delivered information technology services to staff and partners according to Information Technology Infrastructure Library standards. Information technology projects that allow WHO to follow and promote best industry practices, including on information security, business continuity and information technology service continuity, are being developed. In addition, current information and communications technology policies are being reviewed and made relevant.

At the end of 2010, the Global Management System had been introduced in all major offices 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. ■

PERFORMANCE INDICATORS

CURRENT STATUS

13.4.1 Number of information technology disciplines implemented Organization-wide according to industry-best-practices benchmarks

ON TRACK

13.4.2 Proportion of offices using consistent real-time management information

ON TRACK

13.5 Managerial and administrative support services¹ necessary for the efficient functioning of the Organization provided in accordance with service-level agreements that emphasize quality and responsiveness.

AT RISK

In 2010, the Global Management System began to run more smoothly following its initial introduction in 2008 as staff in the Global Service Centre became familiar with the nature of WHO's role and with the system. As a result, service delivery targets were met despite a 30% rise in transactions occasioned by the expansion of Global Centre Services to the Regional Offices for the Eastern Mediterranean, Europe and South-East Asia.

Focused pre-introduction support was given to the Regional Office for Africa in order to smooth the transition from legacy system to the Global Management System. This is particularly important as the introduction of Global Service Centre services in the Regional Office for Africa on 1 January 2011 is expected to increase the volume of transactions by 25%.

The Global Service Centre undertook to enhance the quality of data, processes and systems, as well as carry out compliance activities, including co-development of standard operating procedures, data quality exercises (particularly in human resources) and travel compliance quality checks.

The Organization-wide expected result was rated as "at risk" because of the additional work required to address internal weaknesses in coordination between the Global Service Centre and its client offices in such areas as encumbrance management, travel recoveries and personal account reconciliations. ■

PERFORMANCE INDICATORS

CURRENT STATUS

13.5.1 Proportion of services delivered by the global service centre according to criteria in service-level agreements

ON TRACK

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

ON TRACK

Infrastructure support services were provided in order to measure the resources available for sustaining an appropriate level of satisfaction at headquarters. Some infrastructure projects, such as the renovation of meeting room C, were completed in 2010 in addition to the regular maintenance of buildings.

At headquarters, evacuation exercises were finalized for the main building (967 people), buildings L and M (538 people) and building D (446 people). Evacuation exercises for buildings X and C were postponed during 2010 and will be reinstated in 2011. ■

PERFORMANCE INDICATORS

CURRENT STATUS

13.6.1 Degree of satisfaction with quality of services in all major offices resulting from the provision of effective infrastructure support	ON TRACK
13.6.2 Proportion of offices that have conducted regular building evacuation exercises	ON TRACK

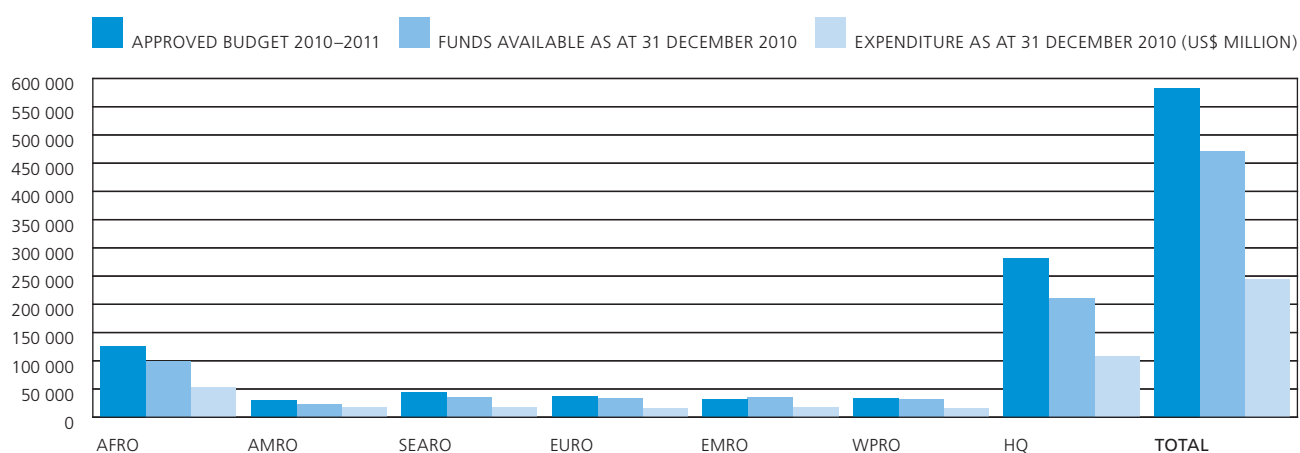
SUMMARY OF FINANCIAL IMPLEMENTATION

(AS AT 31 DECEMBER 2010)

The total budgeted costs for strategic objective 13 were US\$ 582 million, composed of US\$ 524 million for strategic objective 13, plus additional costs under strategic objective 13bis of US\$ 58 million financed through a separate cost recovery mechanism (see summary table 6, Proposed programme budget 2010–2011, page 84). Available funds as at 31 December 2010 for costs relating to strategic objectives 13 and 13bis were US\$ 465 million, which include US\$ 272 million from assessed contributions, US\$ 85 million from voluntary contributions (mainly programme support charges) and US\$ 108 million made available through the post occupancy charge. The Director-General endorsed the introduction of the post occupancy charge, with effect from January 2010, as a mechanism in WHO's new cost recovery strategy to address the shortfall in the financing of the strategic objective. The income from the post occupancy charge contributes to those enabling and supportive functions that are directly related to staffing, namely, human resources management and administration, staff development and learning, information and communications technology

(infrastructure, user support and applications management), payroll administration, and conducive working environment, including some United Nations common security costs. Charges made in respect of those services have been applied to salary costs throughout the Programme budget and are therefore held under strategic objective 13 bis, outside the Programme budget, to avoid double-accounting. Of the available funds, US\$ 245 million (52%) were implemented as at 31 December 2010. ■

2010–2011 (US\$ 000)		AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	TOTAL
WHA approved programme budget SO13		125 187	29 550	44 508	36 593	31 008	32 910	224 131	523 887
<i>Additional budget SO13 bis</i>								58 200	58 200
Consolidated budget		125 187	29 550	44 508	36 593	31 008	32 910	282 331	582 087
Funds available as at 31 December 2010	AC	65 058	14 290	22 017	18 820	19 014	16 982	122 507	278 688
	VC	20 828	4 843	8 663	7 289	6 855	9 411	27 437	85 325
	TOTAL	99 754	23 299	36 144	33 495	35 364	32 029	211 458	471 544
Funds available as % of approved budget		80%	79%	81%	92%	114%	97%	75%	81%
Expenditure as at 31 December 2010	SO13	44 140	14 859	14 910	11 120	12 563	12 602	78 382	188 576
	SO13bis	8 467	2 752	2 724	4 354	5 761	3 111	28 949	56 116
	TOTAL	52 606	17 611	17 633	15 474	18 324	15 712	107 331	244 692
Expenditure as a % of approved budget		42%	60%	40%	42%	59%	48%	38%	42%
Expenditure as a % of available funds		53%	76%	49%	46%	52%	49%	51%	52%



PRIORITY RESULTS FOR 2011

WHO will continue to support WHO's strategic and operational planning for 2012–2013, including final preparations for presentation of the Proposed programme budget 2012–2013 to the Sixty-fourth World Health Assembly, and planning for the next General Programme of Work and Medium-term strategic plan. WHO will also support the Organization-wide efforts in programme evaluation and monitoring and evaluation of implementation of the Programme budget, and coordination of WHO's resource mobilization activities and management of the major donors of core voluntary contributions.

The Secretariat will complete preparations for implementation of the International Public Sector Accounting Standards, will complete the reform of staff health insurance governance arrangements and will further develop the process for assessing and prioritizing major capital expenditure projects across the Organization. In addition, work will continue on sustainable funding and on security as well as on the updating of the WHO e-Manual to ensure that all staff across the Organization have easy access to relevant policies and procedures.

Finally the revision of the strategic planning and the budget process, and practices connected with human resources, contract types and entitlements will continue, as part of the Director-General's reform agenda.

IDENTIFICATION OF SPECIFIC ACTIVITIES AND RESULTS THAT WILL BE REDUCED OR NO LONGER DELIVERED

Efforts in headquarters and most regions will continue to identify and reduce duplication and overlap of work in general management and administration.