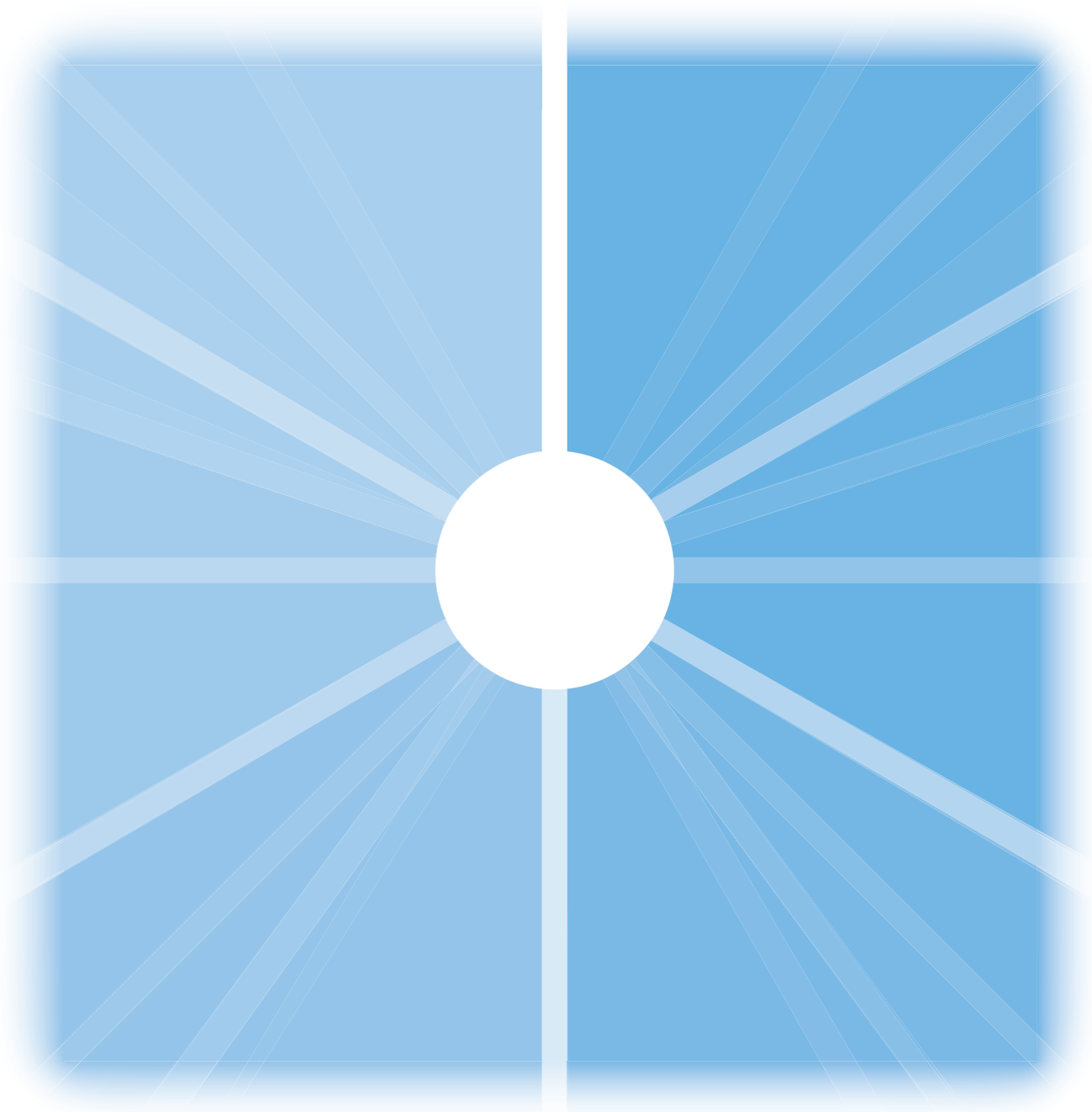


PROGRAMME BUDGET 2010-2011
PERFORMANCE ASSESSMENT REPORT



PROGRAMME BUDGET 2010-2011
PERFORMANCE ASSESSMENT REPORT

Rounding convention: Due to the presentation of the financial figures in US\$ 000 or US\$ millions there may be a slight discrepancy between the total shown, and the total when calculated by adding the figures as printed.

WHO/PRP/12.1

© World Health Organization 2012

The designation employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Printed in Geneva, Switzerland, May 2012.

FOREWORD BY THE DIRECTOR-GENERAL

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

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

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

The biggest shift during the biennium came with high-level political acknowledgement of the multiple threats, also to economies, posed by the rise of chronic noncommunicable

diseases. This acknowledgement included recognition of the need for collaboration among multiple sectors of government and multiple agencies well beyond health. Progress in developing protocols for implementing provisions of the WHO Framework Convention on Tobacco Control demonstrated that full cooperation, in the name of health, with ministries of finance, trade, labour, and agriculture as well as law enforcement bodies is entirely feasible and profoundly fruitful.

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

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

The Commission on Information and Accountability for Women's and Children's Health broke new ground in terms of global health governance. Its strategy of improving basic information capacity within countries as the bedrock of accountability has served as a model for developing targets and indicators for monitoring progress in combating noncommunicable diseases. After years of intense negotiations, Member States adopted a framework that sets out obligations for the sharing of

influenza viruses and of benefits, like vaccines and medicines, during an influenza pandemic. A Review Committee, set up under the International Health Regulations (2005), assessed WHO performance during the 2009 influenza pandemic and issued recommendations aimed at improving the global response to similar events in the future. As yet another instrument to improve performance and accountability, an Independent Monitoring Board was established to oversee progress in polio eradication. The Board's six-monthly assessments have been frank, critical, and taken very seriously by countries as well as by WHO and its partners in the Polio Eradication Initiative.

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



Dr Margaret Chan
Director-General

TABLE OF CONTENTS

PERFORMANCE ASSESSMENT OVERVIEW	7
SUMMARY OF FINANCIAL IMPLEMENTATION	8
ACHIEVEMENTS BY STRATEGIC OBJECTIVE	15
SO 1 Communicable diseases	17
SO 2 HIV/AIDS, Tuberculosis and Malaria	32
SO 3 Chronic noncommunicable conditions	51
SO 4 Child, adolescent, maternal, sexual and reproductive health, and ageing	64
SO 5 Emergencies and disasters	78
SO 6 Risk factors for health	92
SO 7 Social and economic determinants of health	101
SO 8 Healthier environment	111
SO 9 Nutrition and food safety	127
SO 10 Health systems and services	141
SO 11 Medical products and technologies	171
SO 12 WHO leadership, governance and partnerships	181
SO 13 Enabling and support functions	189
ANNEX	198

PERFORMANCE ASSESSMENT OVERVIEW

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

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

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

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

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

FULLY ACHIEVED

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

PARTLY ACHIEVED

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

NOT ACHIEVED

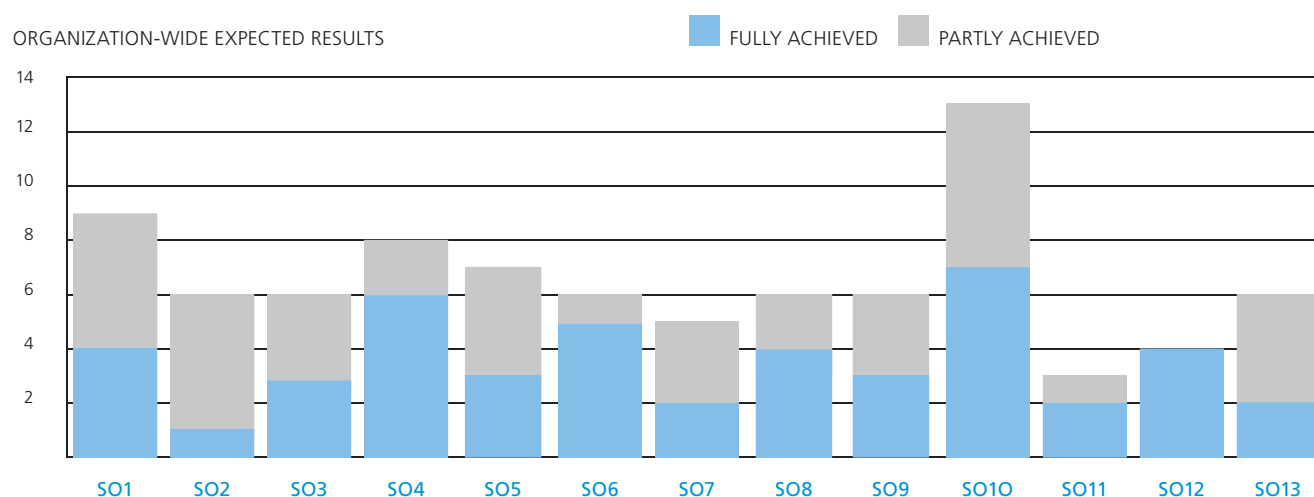
No indicator target for the Organization-wide expected result was met.

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

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

STRATEGIC OBJECTIVE	ORGANIZATION-WIDE EXPECTED RESULTS		
	FULLY ACHIEVED	PARTLY ACHIEVED	TOTAL
SO1 Communicable diseases	4	5	9
SO2 HIV/AIDS, Tuberculosis and Malaria	1	5	6
SO3 Chronic noncommunicable conditions	3	3	6
SO4 Child, adolescent, maternal, sexual and reproductive health, and ageing	6	2	8
SO5 Emergencies and disasters	3	4	7
SO6 Risk factors for health	5	1	6
SO7 Social and economic determinants of health	2	3	5
SO8 Healthier environment	4	2	6
SO9 Nutrition and food safety	3	3	6
SO10 Health systems and services	7	6	13
SO11 Medical products and technologies	2	1	3
SO12 WHO leadership, governance and partnerships	4	0	4
SO13 Enabling and support functions	2	4	6
Total	46	39	85

ORGANIZATION-WIDE EXPECTED RESULTS



SUMMARY OF FINANCIAL IMPLEMENTATION

The biennium 2010–2011 presented challenges in the form of lower than expected voluntary contributions, especially in the Base programmes segment of the budget, combined with unexpected cost increases in some offices arising from large currency movements. The combination of these two factors

created financial constraints and meant that areas of the budget, particularly in the regions, were not as well financed as had been planned, and were, therefore, unable to achieve their target implementation, while at the same time costs increased disproportionately at headquarters.

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

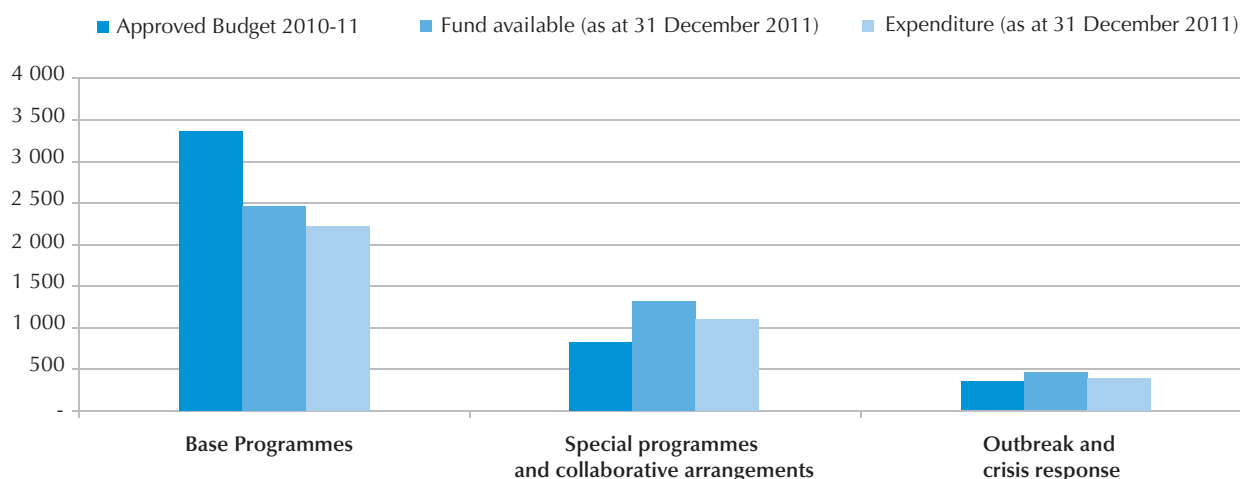
The Secretariat responded to the changes in the financial situation in various ways: a realistic Programme budget 2012–2013 was developed based on forecasts of income and expenditure; headquarters underwent a strategic programmatic and financing

review in which staffing levels were reduced; some high-volume administrative functions in Geneva were reassigned to Kuala Lumpur; some staff numbers were also cut in other offices, particularly in the African Region; many cost-cutting efforts, including changes in travel policies, were implemented; and attention was focused on the reform agenda, including management and financing reforms. In addition, in 2011, at the programme level, prioritization and selective implementation of activities took place, referred to in many of the strategic objective summaries.

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

SEGMENT	APPROVED BUDGET 2010–2011	FUNDS AVAILABLE AS AT 31 DECEMBER 2011		FUNDS AVAILABLE AS % OF APPROVED BUDGET	EXPENDITURE AS AT 31 DECEMBER 2011	EXPENDITURE AS % OF APPROVED BUDGET	EXPENDITURE AS % OF FUNDS AVAILABLE	
US\$ million								
		Assessed contributions	Voluntary contributions	Total				
Base programmes	3 368	934	1 537	2 472	73%	2 221	66%	90%
Special pro- grammes and collaborative arrangements	822	4	1 312	1 315	160%	1 108	135%	84%
Outbreak and crisis response	350	1	456	457	131%	388	111%	85%
Total*	4 540	939	3 305	4 244	93%	3 717	82%	88%
Encumbrances						149		
Budget utilization						3 866		

* The total of US\$ 3 717 million in the column for expenditure as at 31 December 2011 excludes expenditures relating to in-kind and in-service contributions for Programme budget 2010–2011 of US\$ 483 million. With the inclusion of these contributions, expenditure was US\$ 4 199 million (as shown in Schedule 2 of the Audited Financial Report). In addition to the expenditure shown above, US\$ 149 million in encumbrances were incurred as firm commitments with suppliers. Including encumbrances, the total budget utilization was US\$ 3 866 million (before adding in-kind and in-service expenditures).



WHO's approved Programme budget for 2010–2011 was US\$ 4 540 million, of which US\$ 944 million was to be financed from assessed contributions, and the balance of US\$ 3 600 million was to be financed by voluntary contributions.

The total funds available and planned for the biennium were US\$ 4 240 million or 93% of the approved budget.

This was composed of income received in 2010–2011 from assessed and voluntary contributions of US\$ 2 800 million (excluding in-kind contributions), as well as income from 2008–2009 planned for 2010–2011 of US\$ 457 million, and funds carried forward from 2008–2009 of US\$ 943 million.

The breakdown of financial approved budgets 2010–2011 and 2012–2013 is as follows:

	FOR BUDGET 2010–2011	FOR BUDGET 2012–2013
US\$ million		
Income unimplemented in 2008–09	943	
Income received in 2008–2009 and planned for 2010–2011	457	
Income received in 2010–2011 (US\$ 3.8 billion)	2 844	1 000
Total	4 244	

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

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

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

WHO's approved Programme budget 2010–2011 total of US\$ 4 540 million is divided into segments, consisting of US\$ 3368 million for Base programmes (74% of the Programme budget), US\$ 822 million (18% of the Programme budget) for Special programmes and collaborative arrangements and US\$ 350 million (8% of the Programme budget) for Outbreak and crisis response.

In 2010–2011, WHO improved its ability to track financing and expenditure according to the three budget segments, and the tables presented in this document provide a management

analysis of the budget from this perspective. The three segments offer a useful lens through which to view the budget, in particular to understand the reasons for different levels of financing for different areas of the approved budget. There is also considerable collaboration across the budget areas, with funding from Special programmes and collaborative arrangements occasionally supporting activities under Base programmes, and funding in the Outbreak and crisis response area sometimes supporting activities that relate both to crisis response and preparedness.

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

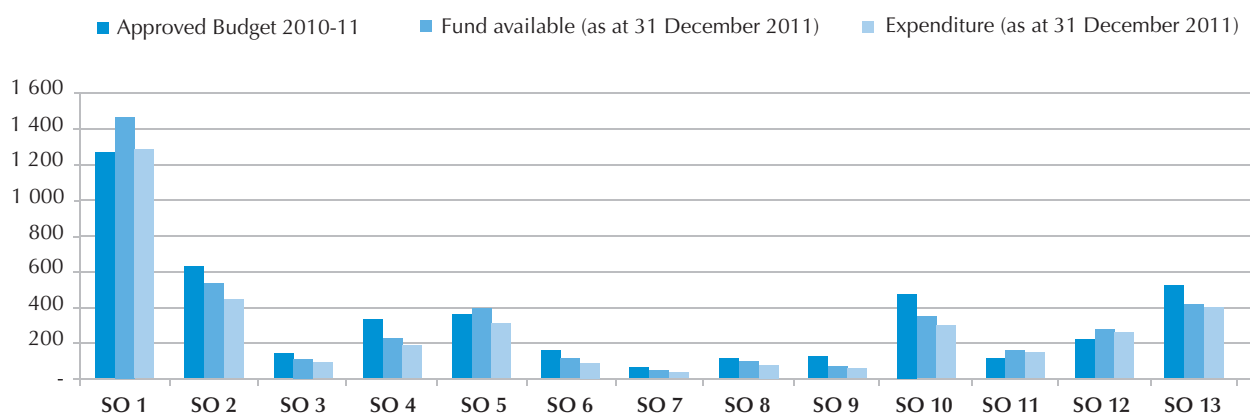
The financing for the Special programmes and collaborative arrangements segment is frequently influenced by work with partners in various types of collaborative arrangements, for activities that meet WHO's objectives and yet may be driven by factors beyond the Organization's immediate control. Financing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

Financing for the Outbreak and crisis response segment of the budget is mainly driven by emergencies and outbreaks, which are, by their nature, unpredictable. The budget for these areas is approved at a minimal level at the beginning of the biennium, and then financing is made available in response to circumstances as they arise. Financing received above the approved budget in Outbreak and crisis response was mainly related to pandemic (H1N1) under strategic objective 1, although

in the Eastern Mediterranean Region, significant increases in financing were also recorded under strategic objective 5 for activities related to the civil unrest of the “Arab Spring” in Egypt, Libya, the Syrian Arab Republic and Yemen, as well as to flooding in Pakistan. In the Region of the Americas, increases in Outbreak and crisis response funding under strategic objective 5 stemmed primarily from WHO’s response to the earthquake in Haiti, and to flooding in the Philippines in the Western Pacific Region.

Programme budget 2010–2011, financial implementation, by strategic objective, all segments

STRATEGIC OBJECTIVE	APPROVED BUDGET 2010–2011	FUNDS AVAILABLE AS AT 31 DECEMBER 2011			FUNDS AVAILABLE AS % OF APPROVED BUDGET	EXPENDITURE AS AT 31 DECEMBER 2011	EXPENDITURE AS % OF APPROVED BUDGET	EXPENDITURE AS % OF FUNDS AVAILABLE
US\$ million								
		Assessed contributions	Voluntary contributions	Total				
SO 1	1 268	72	1 400	1 472	116%	1 290	102%	88%
SO 2	634	42	494	535	84%	446	70%	83%
SO 3	146	38	74	112	77%	98	67%	87%
SO 4	333	50	172	222	67%	190	57%	86%
SO 5	364	16	377	393	108%	312	86%	80%
SO 6	162	31	78	109	67%	94	58%	86%
SO 7	63	16	26	42	67%	37	59%	88%
SO 8	114	31	63	94	82%	83	73%	88%
SO 9	120	18	51	70	58%	62	52%	89%
SO 10	474	125	223	348	73%	298	63%	86%
SO 11	115	27	131	158	137%	137	119%	87%
SO 12	223	198	71	269	121%	264	119%	98%
SO 13	524	276	144	420	80%	405	77%	97%
Total	4 540	939	3 305	4 244	93%	3 717	82%	88%



Programme budget 2010–2011, financial implementation, by strategic objective, Base programmes

STRATEGIC OBJECTIVE	APPROVED BUDGET 2010–2011	FUNDS AVAILABLE AS AT 31 DECEMBER 2011		FUNDS AVAILABLE AS % OF APPROVED BUDGET	EXPENDITURE AS AT 31 DECEMBER 2011	EXPENDITURE AS % OF APPROVED BUDGET	EXPENDITURE AS % OF FUNDS AVAILABLE	
US\$ million								
		Assessed contributions	Voluntary contributions	Total				
SO 1	542	70	310	380	70%	355	66%	93%
SO 2	556	40	314	354	64%	294	53%	83%
SO 3	146	38	73	111	76%	96	66%	86%
SO 4	292	49	124	172	59%	149	51%	86%
SO 5	109	15	50	65	59%	47	43%	72%
SO 6	149	31	63	94	63%	81	54%	86%
SO 7	63	16	26	42	66%	37	58%	88%
SO 8	113	31	62	93	82%	82	73%	88%
SO 9	116	18	46	64	55%	58	49%	90%
SO 10	420	125	161	286	68%	250	59%	87%
SO 11	115	27	94	121	105%	103	90%	86%
SO 12	223	198	71	269	121%	264	119%	98%
SO 13	524	276	144	420	80%	405	77%	97%
Total	3 368	934	1 537	2 472	73%	2 221	66%	90%

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

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

During 2010–2011, several adjustments were made under strategic objectives 12 and 13 to better harmonize the planning of expenditures in country offices with the two strategic objectives. As a result, strategic objective 13 shows under-implementation against the original approved budget, and strategic objective 12 shows over-implementation. However, taken together, implementation was at 91% of the approved budget. This net under-implementation is in part due to budget reductions in strategic objective 13 in order to effect a transfer outside the programme budget where funding was made available through the post occupancy charge (see summary table 6, page 84 of the 2010-2011 Programme budget). Through the mechanism of the post occupancy charge, direct costs for administration of programmes were charged to all strategic objectives in the Programme Budget. This amounted to an additional US\$139 million for the administration of contracts, security, information technology infrastructure, and staff development, in addition to the costs of SO13 shown under the programme budget.

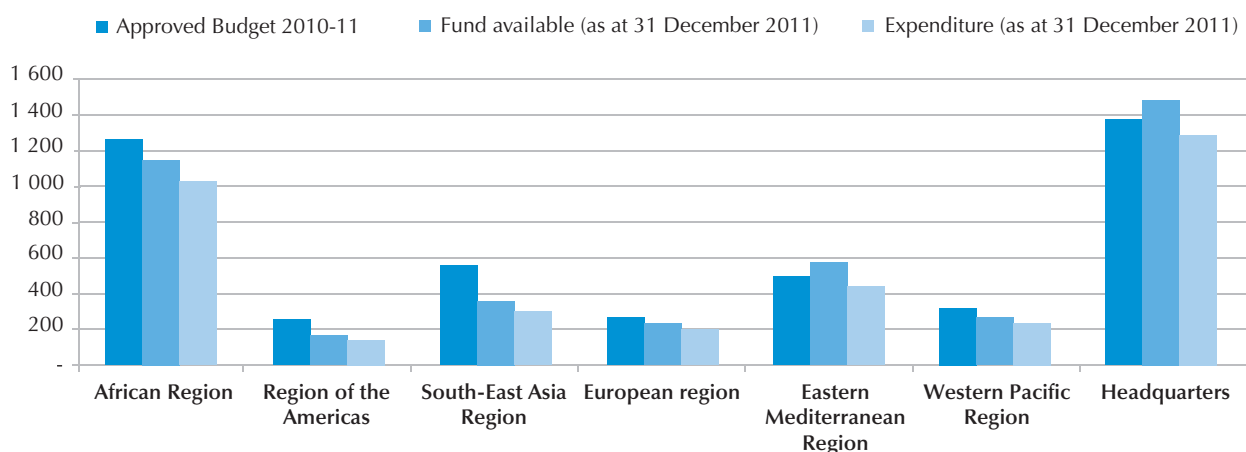
Under strategic objective 1, implementation in relation to the approved budget was 102% due to the elevated levels of implementation for certain elements in both Outbreak and crisis response (mainly for H1N1 vaccines) and Special programmes and collaborative arrangements (mainly for poliomyelitis eradication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

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

Programme budget 2010–2011, financial implementation by location, all segments

LOCATION	APPROVED BUDGET 2010–2011	FUNDS AVAILABLE AS AT 31 DECEMBER 2011			FUNDS AVAILABLE AS % OF APPROVED BUDGET	EXPENDITURE AS AT 31 DECEMBER 2011	EXPENDITURE AS % OF APPROVED BUDGET	EXPENDITURE AS % OF FUNDS AVAILABLE
US\$ million								
		Assessed contributions	Voluntary contributions	Total				
African Region	1 263	209	931	1 139	90%	1 026	81%	90%
Region of the Americas	256	80	78	158	62%	154	60%	97%
South-East Asia Region	545	102	267	369	68%	314	58%	85%
European Region	262	62	161	223	85%	199	76%	89%
Eastern Mediter- ranean Region	515	90	477	567	110%	449	87%	79%
Western Pacific Region	310	78	194	272	88%	251	81%	92%
Headquarters	1 389	318	1 179	1 498	108%	1 324	95%	88%
Total	4 540	939	3 305*	4 244*	93%	3 717	82%	88%

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



Programme budget 2010–2011, financial implementation by location, Base programmes

LOCATION	APPROVED BUDGET 2010–2011	FUNDS AVAILABLE AS AT 31 DECEMBER 2011		FUNDS AVAILABLE AS % OF APPROVED BUDGET	EXPENDITURE AS AT 31 DECEMBER 2011	EXPENDITURE AS % OF APPROVED BUDGET	EXPENDITURE AS % OF FUNDS AVAILABLE
US\$ million							
		Assessed contributions	Voluntary contributions	Total			
African Region	926	209	316	524	57%	478	91%
Region of the Americas	245	80	40	121	49%	118	98%
South-East Asia Region	394	101	143	244	62%	210	86%
European Region	239	62	128	190	80%	170	90%
Eastern Mediter- ranean Region	391	90	139	229	58%	176	77%
Western Pacific Region	293	78	166	244	83%	224	92%
Headquarters	881	315	604	919	104%	844	92%
Total	3 368	934	1 537 *	2 471*	73%	2 221	90%

* includes US\$ 1 million of voluntary contributions not yet distributed to the major offices

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

In Special programmes and collaborative arrangements, expenditure varied between 86% and 382% of the approved

budget in the regions, due mainly to increases in poliomyelitis eradication efforts; by comparison, in headquarters, budget implementation by Special programmes and collaborative arrangements was only 108% of the budget. Of the increase in financing above the approved budget, 94% was for the regions and 6% for headquarters. Most of the financing for Special programmes and collaborative arrangements above the expected budget level was to support poliomyelitis eradication and vaccination activities with the GAVI Alliance under strategic objective 1, as well as support provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria, for strategic objective 2.

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

ACHIEVEMENTS OF STRATEGIC OBJECTIVES AND ORGANIZATION-WIDE EXPECTED RESULTS

REFERENCE

1 See also document A65/29, paragraph 10.

The remainder of the report provides a detailed assessment for each strategic objective covering:

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

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

SO1

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



ASSESSMENT OF THE ORGANIZATION-WIDE EXPECTED RESULTS

Of the nine Organization-wide expected results for this strategic-objective, four were «fully achieved» and five «partly achieved».

Overview

Communicable diseases are one of the greatest potential barriers to global health. Excluding HIV/AIDS, tuberculosis and malaria, they account for 20% of deaths in all age groups, 50% of child deaths and 33% of deaths in the least developed countries.

While progress continues to be made towards the prevention, surveillance and control of communicable diseases, there have been some major challenges in carrying out surveillance and response, enhancing research capacity and developing, validating and making available new knowledge, intervention tools and strategies.

Several global and regional strategies are being implemented, such as the Global Immunization Vision and Strategies (GIVS), the Reach Every District (RED) approach, the Integrated Diseases Surveillance Strategy in the African Region and regional strategies on the elimination of neglected diseases.

In the South-East Asia and Western Pacific Regions, the Asia Pacific Strategy for Emerging Diseases, the Asia Pacific Strategy for Strengthening Health Laboratory Services, the regional strategic framework for prevention and control of zoonoses, a bi-regional Strategic Plan for the Prevention and Control of Dengue in Asia Pacific and others, provided the mechanisms for working together in a strategic manner in several major areas of work: capacity building for emerging infectious diseases, meeting the core capacity requirements under the International Health Regulations (IHR) 2005, and pandemic preparedness. The International Health Regulations (2005) remain the overarching legal framework for all Member States.

1.1

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

Partly Achieved

Extending immunization coverage to more children was a key achievement during the biennium. An estimated 109.4 million children under one year old were vaccinated with three doses of diphtheria-tetanus-pertussis vaccine compared to 106 million in 2008. The number of countries reaching 90% or more immunization coverage with diphtheria-tetanus-pertussis vaccine rose to 130 countries compared to 120 in the previous biennium. An increase in uptake of new and underused vaccines was achieved. Pneumococcal and rotavirus vaccines were introduced in 55 and 28 countries respectively.

Pneumococcal and rotavirus together are responsible for half the deaths from vaccine preventable diseases of children under five years and current and future progress is expected to contribute greatly to reducing overall child mortality. Pneumococcal vaccine was introduced in 55 countries (including one country where the vaccine was partially introduced) in this biennium, compared to 31 countries in 2008–2009. Rotavirus vaccine was introduced in 28 countries, up from 19 in the previous biennium, and human papillomavirus (HPV) vaccine in 37 countries (including four in parts of the country only), up from 22 countries in the previous biennium.

Haemophilus influenza type B (Hib) vaccine had been introduced in 169 countries by the end of 2010, compared to 136 in 2008. Global coverage with three doses of Hib vaccine increased from 28% in 2008 to 42% in 2010, reaching 92% in the Region of the Americas, with outstanding progress in the African Region where Hib coverage increased from 39% in 2008 to 62%, and the Eastern Mediterranean Region, with an increase in coverage from 29% to 58%. Coverage in the South-East Asia and Western Pacific Regions is 9% and 10%, respectively.

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

WHO continued to support Member States by convening ministry of health immunization specialists and other partners in order to identify innovative ways of strengthening immunization services in countries by means of several platforms, including global measles management meetings and global meetings on new vaccines, which are held annually.

In 2011, for the first time, about 180 countries across the African Region, the Region of the Americas and the Eastern Mediterranean, European and Western Pacific Regions took part in simultaneous Immunization Weeks, demonstrating unprecedented collaboration between the regions in building awareness of the value of immunization. In the Region of the Americas all Latin American and Caribbean countries participated, and the effort was integrated in other health interventions. The Eastern Mediterranean launched the first Vaccination Week in 2010, with the unprecedented participation of all countries in the Region. The European Immunization Week 2010 was conducted in 47 countries in 2010 and 52 in 2011. The African and Western Pacific Regions successfully joined in 2011, and the South-East Asia Region will participate starting in 2012. The South-East Asia Region also held ministerial meetings and passed a regional committee resolution declaring 2012 the Year of Intensification of Routine Immunization (resolution SEA/RC64/R3) in order to heighten political awareness and encourage Member States to renew their commitment.

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

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
1.1.1 Number of Member States with at least 90% national vaccination coverage (DTP3).	126	135	130
1.1.2 Number of Member States that have introduced <i>Haemophilus influenzae</i> type b vaccine in their national immunization schedule.	136	160	169

1.2

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

Partly Achieved

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

WHO has coordinated the global roll-out and scaling up of the new bivalent oral polio vaccine, which led to the stopping of transmission in India. As one of the major actors in the Global Polio Eradication Initiative, WHO has also been supporting a full research agenda on accelerating eradication in order to eliminate vaccine-derived polio cases, as well as research to secure eradication. The Secretariat also processed, analysed and distributed information on the global poliomyelitis situation.

This Organization-wide expected result was only partly achieved despite significant progress in India, a reduction of global cases in 2011, and the rapid and effective response to new outbreaks. On-going transmission in priority countries, especially Nigeria and Pakistan, continues to threaten global eradication. Only 80% (instead of the 90% targeted) of the final country reports show interruption of wild poliovirus transmission and the acceptance of containment of wild poliovirus stocks by the relevant regional commission for the certification of poliomyelitis eradication. Development of post oral poliovirus vaccine cessation plans is pending awaiting review of the oral poliovirus vaccine cessation strategy and a World Health Assembly resolution, hence the current measurement of 0%.

In 2010–2011, enhanced advocacy, supported by publication of the findings of the Independent Monitoring Board of the

Global Polio Eradication Initiative, generated new international political will and commitment to improve and sustain support for stopping poliomyelitis transmission. However, a significant effort is still needed to translate these commitments into support. Improving the quality of oral poliomyelitis vaccine campaigns has proved more problematic than expected, particularly in endemic and re-established transmission countries.

While Angola and Sudan appear to have improved and sustained campaign quality to the levels required to interrupt transmission, this has not yet been achieved in Chad and the Democratic Republic of Congo. Campaign quality in key areas of northern Nigeria and in transmission zones in Pakistan remains sub-optimal, and this is further complicated in parts of Pakistan and Afghanistan by compromised access due to conflict. Innovative mechanisms for improving quality are being explored, including outsourcing to nongovernmental organizations in key areas. A key lesson learnt is that enhanced national and sub-national advocacy, coupled with additional technical support in priority areas, is critical for improving WHO support to these countries.

In terms of technical support, prioritization of needs is required. Given the high demand for support missions, there is close coordination with other departments and agencies to provide additional support, as well as increased synchronization of the work of technical staff and consultants in order to obtain the maximum impact from consultant deployments in priority countries. Additional technical support will also be required in 2012 to meet the evolving programmatic need for more rapid information from an expanded range of data sources. This will require re-structuring and increased standardization of the current data system, technical support to guide the development of the system and to cope with the demand for more rapid output, management of the entire surveillance, data and laboratory system which requires constant attention, and maintaining the standard for accuracy.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
1.2.1 Percentage of final country reports demonstrating interruption of wild poliovirus transmission and containment of wild poliovirus stocks accepted by the relevant regional commission for the certification of poliomyelitis eradication.	87% for interruption of transmission; 81% for containment	90%	80%
1.2.2 Percentage of Member States using trivalent oral poliovirus vaccine that have a timeline and strategy for eventually stopping its use in routine immunization programmes.	0%	50%	0%

1.3

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

Partly Achieved

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

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

WHO has provided technical assistance to Member States with the aim of providing access for all populations to interventions for the prevention, control, and elimination of neglected communicable diseases, including zoonotic diseases. In the African Region, a regional neglected tropical diseases multi-year strategic plan for 2011–2015 was finalized. The European Region reported that technical and financial support had been provided for conducting operational research on visceral leishmaniasis in Georgia, and for a WHO country-level consultation on outcomes of an epidemiological study on dengue fever in Croatia.

In the Regional Office for the Americas, seven countries adopted programmes or strategies for the surveillance, prevention,

control or elimination of neglected diseases. In addition, significant progress has been made with regard to diseases targeted for preventive chemotherapy: trachoma, lymphatic filariasis, schistosomiasis, soil-transmitted helminths and onchocerciasis. Most recently, onchocerciasis was eliminated in Colombia, for which national health authorities have requested certification. In the Eastern Mediterranean Region, Morocco and Sudan benefited from WHO support on sound pesticide management. In the South-East Asia Region, technical support was provided to the Ministry of Health and Family in the Maldives for organizing a national training workshop on clinical recognition, case management and control of emerging diseases including zoonoses. Sri Lanka was supported to organize a meeting of major stakeholders and develop a national plan for rabies elimination based on the regional strategic framework. In the Western Pacific Region, WHO verified the interruption of lymphatic filariasis transmission in the Solomon Islands WHO provided technical and/or financial support for deworming against soil-transmitted helminthiasis, where the global target for deworming 75% of school-age children was achieved.

Despite considerable progress, this Organization-wide expected result was considered to be partly achieved as the reporting on the elimination of leprosy at sub-national level was incomplete at the time of reporting. The global momentum for control of neglected tropical diseases has led to an increase in the number of partners supporting Member States in implementation of the programmes, through various parallel funding mechanisms. Coordination among these partners is still weak in some areas. This is having a particular impact on capacity to track implementation and achievement in the case of some neglected tropical diseases, as is insecurity, inaccessibility and a rapid turnover of health personnel at all levels in high-burden countries (Somalia and South Sudan in particular). Lack of political commitment and the lower priority status of neglected tropical diseases control were among the obstacles in some endemic countries. Lack of access to quality-assured medicines and diagnostics for neglected tropical diseases is also affecting programmes in some areas, leading to difficulties in maintaining achievements.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
1.3.1 Number of Member States certified for eradication of dracunculiasis.	175	179	180
1.3.2 Number of Member States that have eliminated leprosy at sub-national levels.	78	95	Not available
1.3.3 Number of reported cases of human African trypanosomiasis for all endemic countries.	9 503	8 500	8 000
1.3.4 Number of Member States having achieved the recommended target coverage of population at risk of lymphatic filariasis, schistosomiasis and soil-transmitted helminthiasis through regular anthelmintic preventive chemotherapy.	15	20	23

1.4

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

Fully Achieved

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

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. A total of 180 Member States have established case-based, laboratory confirmed rash and fever surveillance. Virological surveillance for measles proved to be beneficial in identifying the sources of measles outbreaks and tracking virus transmission within and between regions.

All levels of WHO 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). A total of 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.

Implementation of the Integrated Disease Surveillance and Response strategy in the African Region was shown to be at different stages in the 46 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 Western Pacific Region, the Asia Pacific Strategy for Emerging Diseases 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 diseases surveillance and monitoring systems. In the South-East Asia Region, the countries reached the indicator target.

The following are common obstacles that prevent the implementation of effective surveillance systems in Member States. At national level they are: suboptimal normative and legislative frameworks; competing priorities and/or emerging priorities (e.g. natural disasters); shortcomings of human resources policy (high staff turnover at national level, understaffed peripheral levels, suboptimal technical competencies); and context-specific interpretation and operationalization of the concept of intersectoral and interdisciplinary surveillance. Strengthening of human resources is key to effective surveillance on communicable diseases. Training sessions on specific diseases and surveillance functions were held at national, subregional, and regional levels aimed at improving technical capacity in the short term and promoting key principles. To improve the quality of its coordinated surveillance networks, WHO works with ministries of health to strengthen the WHO global HPV laboratory network (LabNet) by supporting the development of norms and standards, and providing and conducting training sessions for laboratory professionals in order to ensure adherence to standard procedures.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
1.4.1 Number of Member States with surveillance systems and training for all communicable diseases of public health importance for the country.	85	150	150
1.4.2 Number of Member States for which WHO/UNICEF joint reporting forms on immunization surveillance and monitoring are received on time at global level in accordance with established time-lines.	148	150	151

1.5

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

Fully Achieved

Progress has been made in regions and countries on a variety of new intervention tools and strategies, with new knowledge being disseminated by institutions in developing countries through sustained support from WHO. For example, a best practice guidance framework document for testing genetically modified mosquitoes for safety and efficacy was developed, supported and tested in countries. Tools, such as qPCR as a biomarker of Chagas disease were standardized and validated, and a simplified system for dengue case classification was developed and evaluated in 18 countries before being adopted and widely used in Latin America, and, increasingly, in Asia. A conjugated meningococcal A vaccine targeted at the control of epidemic meningitis in Africa obtained licensure and was WHO-prequalified. The vaccine was developed by the meningitis vaccine programme, a partnership between WHO and PATH, a catalyst for global health, and has been successfully introduced in several countries in the meningitis belt (Burkina Faso, Mali and Niger), attaining very high coverage. In collaboration with partners, typhoid vaccine introduction strategies have been developed.

Capacity building through fostering developing countries' leadership in fighting neglected diseases of poverty and in vaccine development has continued. From 2010 to 2011, a number of small grants supported in-country research studies, some of which have been published in peer-reviewed journals. A majority of the institutions of publications' first authors are

from developing countries. Progress made in building countries' capacity included, the establishment of a training and technology transfer hub for vaccine adjuvants, and provision of training and technology to two developing countries. Regional training centres for training local researchers and research managers in good research practices have been established in institutions in four WHO regions, with support from headquarters. The establishment of the African Network for Drugs and Diagnostics Innovation (ANDI), which became a legal entity in October 2010, represents a new approach to innovation in drugs and diagnostics.

Activities led by headquarters and the regional offices have provided technical cooperation for enhancing country research capacity and developing, validating and making available and accessible new knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases. Workshops on research design, methodology and proposal writing in order to strengthen the research capacity of young researchers and disease-control programme managers were organized. Technical support was provided to countries to develop implementation strategies for leprosy elimination, to review the conjugate Meningitis A clinical trial application, and to support joint inspection of clinical trial sites through to clinical evaluation and registration of the vaccine. WHO support was also provided to countries for the publication of articles on climate change research.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
1.5.1 Number of new and improved tools or implementation strategies, developed with significant contribution from WHO, introduced by the public sector in at least one developing country.	6	9	17
1.5.2 Proportion of peer-reviewed publications based on WHO-supported research where the main author's institution is in a developing country.	>55%	55%	71%

1.6

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

Partly Achieved

One of the main challenges WHO faced this biennium was achieving the core capacities required by the International Health Regulations (2005) for the establishment and strengthening of alert and response systems for epidemics and other public health emergencies of international concern. A comparison of the status of the International Health Regulations (2005) core capacities in countries reporting in 2010 and 2011 shows overall progress across all core capacities. The most noticeable progress was in surveillance and preparedness. There is also evidence that countries have made use of the different phases of pandemic (H1N1) 2009 in assessing the functioning of the Regulations, as well as in strengthening their technical capacities, including in laboratories. Human resource capacity at designated points of entry and for chemical events detection and response remains low.

Tools to support countries in assessing their core capacities and monitor progress were developed. Technical guidance documents and their related tools, which assist Member States in setting policies, strategies and operational plans facilitating the implementation of the International Health Regulations (2005) were developed and disseminated. Workshops to train National International Health Regulations Focal Points were organized and event communications exercises held in some regions.

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

The Review Committee on the Functioning of the International Health Regulations (2005) met in the context of the global response to pandemic (H1N1) 2009, completed its work and presented the results of its review to the Sixty-fourth World Health Assembly. Its main findings were that although the Regulations had contributed towards preparing the world to cope better with public health emergencies, it was still ill-prepared to respond to a severe pandemic or any other public health emergency on a global scale. The specific recommendations

of the Review Committee for scaling up implementation of the Regulations have guided the Organization in further strengthening the International Health Regulations (2005) framework.

All regions pinpointed insufficient knowledge of the obligations of the Regulations as an obstacle to achieving its requirements in countries. WHO will need to facilitate the transfer of expertise and guidance to the operational level, and facilitate the exchange of experiences and best practice in implementation of the Regulations.

Although both indicators for this Organization-wide expected result were achieved, the Region of the Americas and the European and the South-East Asia Regions only partly achieved the results because of difficulties in assessing and developing national core capacities under the International Health Regulations (2005).

Actions undertaken to address the obstacles include: training courses and awareness-raising activities; intensifying collaboration between the relevant programmes in-house; and initiating multi-sectoral International Health Regulations (2005) implementation processes in Member States to facilitate their implementation. Formally established networking of National Focal Points with WHO International Health Regulations Contact Points has ensured that links with the international community are in place and ready for rapid information sharing, carrying out joint risk assessments and harmonizing the response in the event of a public health emergency of international concern. Subregional activities on exchange of experience and good practice have led to greater ownership of implementation of the Regulations in countries. This has also facilitated resource mobilization activities and mutual support between Member States, and has helped to redress obstacles hindering implementation of the Regulations. Advocacy during Regional Committee meetings on implementation, as well as on critical needs for public health laboratories and promotion of the one health concept, has served to address the challenges to achieving this Organization-wide expected result.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
1.6.1 Number of Member States that have completed the assessment and developed a national action plan to achieve core capacities for surveillance and response in line with their obligations under the International Health Regulations (2005).	At least 95	115 ¹	129
1.6.2 Number of Member States whose national laboratory system is engaged in at least one external quality-control programme for epidemic-prone communicable diseases.	140	120 ²	121

1.7

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

Partly Achieved

WHO supported on-going reviews and revisions of preparedness plans and standard operating procedures based on pandemic lessons learnt. WHO also continued to support international and regional specialist networks, including the Global Influenza Surveillance Network, networks for infection control and the emerging and dangerous pathogens laboratory network. In addition, emergency response teams were established at national and subregional level. WHO issued new technical guidelines on respiratory diseases, surveillance of, and response to, influenza, and clinical management of dengue cases.

Integrated strategies for detection and control were developed in many regions, and especially for vector interventions in Iran, Iraq, Saudi Arabia, Sudan and Yemen. National capacities for detection of, and preparedness for, public health threats were enhanced globally, particularly in Member States in the African Region, the Region of the Americas and the Eastern Mediterranean Region. A significant reduction in meningitis cases was recorded in three high-risk countries, namely, Burkina Faso, Chad and Niger, possibly in connection with the introduction of the new trivalent vaccine. Many countries have increased their focus on strategies and capacities for the control of dengue.

WHO offered routine technical collaboration to detect, contain and respond to major epidemic and pandemic-prone diseases through its regional offices and headquarters. In the

African Region, in particular, International Coordinating Group (ICG) responses to yellow fever and meningitis included technical advice, logistics services and medical supplies, as well as support for donor mobilization in acute situations and preventive vaccination campaigns. WHO supported regional and subregional training courses on infection prevention and control measures in the Eastern Mediterranean and South-Eastern Asia Regions to reduce nosocomial infection and improve the safety of health-care workers. All regions supported increased intersectoral and cross-border coordination through inter-ministerial meetings and national and international consultations, focusing on such issues as zoonotic diseases and outbreak and response. Besides its work in dengue, influenza and cholera, the Regional Office for the Americas is strengthening country capacities and ensuring the Region's preparedness for the possible introduction of the chikungunya virus.

Although this Organization-wide expected result was on track at the mid-term, it was partly achieved at the end of the biennium because only 158 of the 165 Member States targeted had national preparedness plans and standard operating procedures in place for readiness and response to major epidemic-prone diseases. Obstacles to achievement included Member States' limited capacity for, and, in some cases, political commitment to, timely international or intersectoral collaboration, as well as shortages of human, financial and logistical resources to implement strategies, especially for integrated vector control.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
1.7.1 Number of Member States having national preparedness plans and standard operating procedures in place for readiness and response to major epidemic-prone diseases.	139	165	158
1.7.2 Number of international coordination mechanisms for supplying essential vaccines, medicines and equipment for use in mass interventions against major epidemic and pandemic-prone diseases.	8	8	8
1.7.3 Number of severe emerging or re-emerging diseases for which prevention, surveillance and control strategies have been developed.	8	8	8

1.8

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

Fully Achieved

All six WHO regional offices are now using the WHO Event Management System (EMS)³ in 129 WHO locations with the involvement of 169 teams and 597 users. Its use has facilitated the timely exchange of information and management of acute public health events across WHO, especially in cross-border and multi-regional events.

Between 1 January 2010 and 31 December 2011, 885 unique events were entered in the Event Management System, of which 432 were substantiated as acute public health risks (48.8%), 196 (22.1%) were real events that did not meet the criteria for an outbreak, 107 (12.1%) were discarded after investigation as false rumours, and 31 (3.5%) were unverifiable; the final designation is missing for 119 events (13.4%). Between 1 January 2001 and 31 December 2011, a total of 3 993 unique events were entered into the System, of which 2 600 (65%) were substantiated acute public health risks, the majority being attributed to infectious disease outbreaks, including zoonoses. Overall appropriation of the Event Management System in the regions has exceeded expectation and the activity has now entered a new phase, focusing on maintenance, enhanced analytical, mapping and visualization tools for decision support.

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 (GOARN). WHO's field response to major events and outbreaks included the cholera outbreaks in Haiti

and Pakistan and providing field missions in the aftermath of the Pakistan floods, which resulted in outbreaks of vector-borne illnesses, such as Crimean Congo haemorrhagic fever and dengue. Operational reviews of Global Outbreak Alert and Response Network missions were completed for the dengue outbreaks in Pakistan and the cholera event in Haiti. Recommendations stemming from the Network's independent evaluation presented in 2011 were instrumental in the re-engaging of its Steering Committee, which carried out the groundwork for the strategy and direction to be pursued by the Network and its operational support team. Working groups within the Steering Committee were formed to address key areas of concern and plans of action were developed targeting improved leadership in outbreak response. During the next biennium, the strategic focus will be on developing International Health Regulations (2005) core capacity in the areas of preparedness and follow-up and expanding the classic Global Outbreak Alert and Response Network field of action that previously concentrated solely on Response.

A WHO manual entitled *Rapid risk assessment of acute public health events* produced with the collaboration of all regional offices, selected country offices and food safety and chemical safety programmes was finalized. A review and revision of risk assessment training was carried out based on lessons learnt from previous training courses and the risk assessment manual. The revised curriculum will be the basis for training-of-trainers courses involving WHO staff and selected trainers from Member States commencing in 2012.

INDICATOR	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
1.8.1 Number of WHO locations with the global event-management system in place to support coordination of risk assessment, communications and field operations for headquarters, regional and country offices.	74	90	129

1.9

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

Fully Achieved

All regions reported effective notification of potential public health threats from countries. National control efforts were undertaken, supported by WHO in many cases. They included: cholera in Cameroon, Cap Verde, Chad, Democratic Republic of Congo, Dominican Republic, Ghana, Haiti, Niger and Nigeria; dengue in Bahamas, Brazil, Colombia, El Salvador, Guatemala, Honduras, Panama, Pakistan, Peru and Venezuela; and plague and hantavirus 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.

Collaboration between the human and animal health sectors was established in Afghanistan, Iraq, Pakistan, South Sudan, Sudan and Egypt for improving public health preparedness and response to zoonotic diseases. Preparedness efforts, including strengthening laboratory capacity and developing protocols against possible occurrences of *E. coli* took place as a result of the outbreak in the European Region.

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 was presented to the Sixty-fourth World Health Assembly. One of its conclusions was that countries should scale up implementation of the International Health Regulations (2005).

Effective preparedness and response planning, including vaccine deployment plans, was critical in controlling outbreaks. Daily event-based surveillance and information sharing mechanisms for communication within the Organization and with Member States enabled more effective event coordination. Rapid situation analysis, risk assessment, coordinated health responses and facilitated resource mobilization, performed through partnership mechanisms and predefined arrangements for identification and deployment of technical resources and logistics/supplies, led to more effective timely event response. Partnership collaborations were required to mobilize resources locally, regionally and internationally when local institutions lacked the capacity to mount fully integrated responses. Regional application of the Global Outbreak Alert and Response Network for deployment of technical resources proved very successful and will be continued in 2012. Multi-sectoral and South-South cooperation proved extremely valuable and effective in public health emergency response.

INDICATOR	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
1.9.1 Proportion of Member States' requests for assistance that have lead 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.	Not available	99%	99%

SUMMARY OF FINANCIAL IMPLEMENTATION

The approved budget for strategic objective 1 was US\$ 1 268 million, of which US\$ 542 million were 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.

As at 31 December 2011, US\$ 1471 million were funds available under this strategic objective, of which US\$ 380 million were distributed to Base programmes, US\$ 962 million to Special programmes and collaborative arrangements and US\$ 129 million to the Outbreak and crisis response segment.

Strategic objective 1 is relatively well resourced, with funding available equal to 116% of the approved budget but this available funding is uneven across segments.

Available funding for Base programmes is only 70% 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 154%

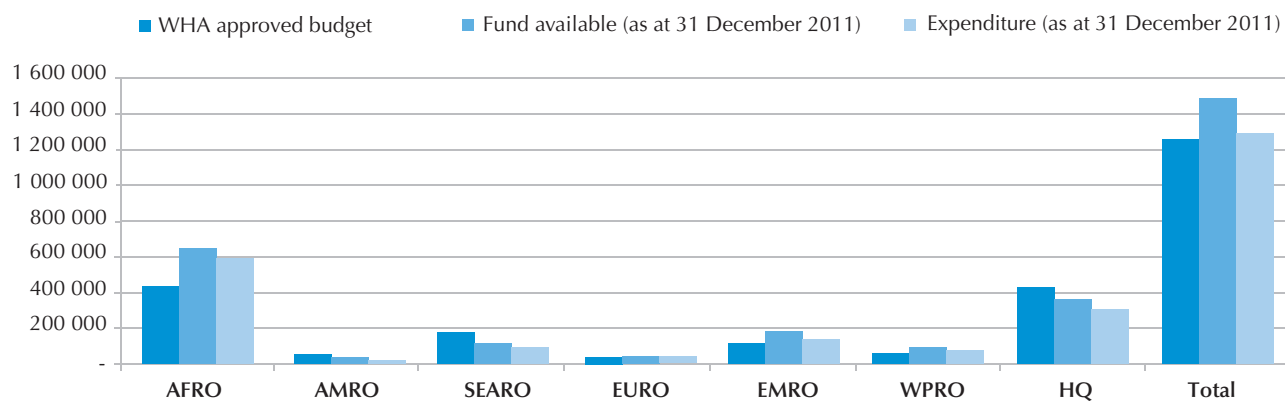
and 129%, respectively. In the cases where available resources exceeded the approved budget, budget adjustments have taken place to enable implementation in these two segments.

Overall implementation for all segments in relation to the approved budget was 102% owing to the high component of both Outbreak and crisis response (mainly for pandemic H1N1 2009) and Special programmes and collaborative arrangements (mainly poliomyelitis eradication and the GAVI Alliance). In Base programmes, implementation of strategic objective 1 was 66% of the approved budget, or 93% of available financing. In addition, in headquarters strategic objective 1 accounted for most of the in-kind expenditures recorded for H1N1 vaccines, more than US\$ 400 million.

Implementation (expenditure) against the Programme budget in Base programmes has been very low in all major offices with the exception of the Western-Pacific Region and headquarters at less than 70%. This is due to the low available resources which did not match the expectations in financing the approved programme budget for the base programmes. Implementation against funds was well above 80% in most major offices.

All Segments

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	424 120	30 450	180 357	28 560	134 357	48 485	422 024		1 268 353
Funds Available									
AC	16 842	9 085	7 348	1 533	6 066	6 462	24 246		71 581
VC	630 386	12 655	131 510	28 503	175 168	56 976	346 676	18 215	1 400 088
Total	647 228	21 739	138 858	30 036	181 233	63 438	370 922	18 215	1 471 669
Funds Available as % of approved budget	153%	71%	77%	105%	135%	131%	88%		116%
Expenditure	589 659	20 550	119 521	25 362	155 431	57 588	321 390		1 289 501
Expenditure as % of approved budget	139%	67%	66%	89%	116%	119%	76%		102%
Expenditure as % of funds available	91%	95%	86%	84%	86%	91%	87%		88%



Base programmes

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	155 203	24 950	80 907	22 510	88 110	34 345	135 919		541 944
Funds Available									
AC	16 842	9 085	7 348	1 533	6 066	6 462	23 077		70 412
VC	70 132	3 947	40 867	13 103	31 084	40 212	110 589		309 933
Total	86 973	13 031	48 215	14 636	37 149	46 674	133 666		380 344
Funds Available as % of approved budget	56%	52%	60%	65%	42%	136%	98%		70%
Expenditure	87 654	12 233	39 970	11 642	28 358	41 805	133 784		355 446
Expenditure as % of approved budget	56%	49%	49%	52%	32%	122%	98%		66%
Expenditure as % of funds available	101%	94%	83%	80%	76%	90%	100%		93%

Special programmes and collaborative arrangements

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DIS- TRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	255 417	3 500	95 250	5 050	43 547	9 840	213 805		626 409
Funds Available									
AC	-	-	-	-	-	-	1 169		1 169
VC	541 515	6 531	85 058	13 621	140 935	10 338	144 756	18 215	960 968
Total	541 515	6 531	85 058	13 621	140 935	10 338	145 925	18 215	962 137
Funds Available as % of approved budget	212%	187%	89%	270%	324%	105%	68%		154%
Expenditure	484 006	6 339	74 331	11 208	121 920	9 357	104 681		811 843
Expenditure as % of approved budget	189%	181%	78%	222%	280%	95%	49%		130%
Expenditure as % of funds available	89%	97%	87%	82%	87%	91%	72%		84%

Outbreak and crisis response

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DIS- TRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	13 500	2 000	4 200	1 000	2 700	4 300	72 300		100 000
Funds Available									
AC	-	-	-	-	-	-	-		-
VC	18 740	2 177	5 585	1 779	3 149	6 426	91 331	-	129 187
Total	18 740	2 177	5 585	1 779	3 149	6 426	91 331	-	129 187
Funds Available as % of approved budget	139%	109%	133%	178%	117%	149%	126%		129%
Expenditure	17 999	1 978	5 220	2 512	5 153	6 426	82 925		122 212
Expenditure as % of approved budget	133%	99%	124%	251%	191%	149%	115%		122%
Expenditure as % of funds available	96%	91%	93%	141%	164%	100%	91%		95%

REFERENCES

- 1 The target by 2011 for indicator 1.6.1 was revised to reflect latest estimates as per new monitoring system introduced in 2010.
- 2 The target by 2011 for indicator 1.6.2 was revised to reflect latest estimates as per new monitoring system introduced in 2010.
- 3 WHO has developed a comprehensive “event management system” to manage critical information about outbreaks and ensure accurate and timely communications between key international public health professionals, including WHO regional offices, country offices, collaborating centres and partners in the Global Outbreak Alert and Response Network.

DETAILS OF INDICATOR ACHIEVEMENT

1.1.1 African Region: Algeria, Angola, Botswana, Burkina Faso, Burundi, Cap Verde, Congo, Eritrea, Gambia, Ghana, Malawi, Mauritius, Sao Tome and Principe, Seychelles, Sierra Leone, Togo, United Republic of Tanzania. **Region of the Americas:** Antigua and Barbuda, Argentina, Bahamas, Belize, Brazil, Chile, Cuba, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Trinidad and Tobago, United States of America, Uruguay. **Eastern Mediterranean Region:** Bahrain, Egypt, Iran (Islamic Republic of), Jordan, Kuwait, Libya, Morocco, Oman, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia. **European Region:** Albania, Andorra, Armenia, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Lithuania, Luxembourg, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, Maldives, Myanmar, Sri Lanka, Thailand. **Western Pacific Region:** Australia, Brunei Darussalam, Cambodia, China (People's Republic of), Cook Islands, Fiji, Japan, Kiribati, Malaysia, Marshall Islands, Mongolia, Nauru, New Zealand, Niue, Republic of Korea, Singapore, Tonga, Viet Nam.

1.1.2 African Region: Angola, Benin, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, Zambia, Zimbabwe. **Region of the Americas:** Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States of America, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Bahrain, Djibouti, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, United Arab Emirates, Yemen. **European Region:** Albania, Andorra, Armenia, Austria, Belarus, Azerbaijan, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Nepal, Sri Lanka. **Western Pacific Region:** Australia, Brunei Darussalam, Cambodia, Cook Islands, Fiji, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, New Zealand, Niue, Palau

(Republic of), Papua New Guinea, Philippines, Samoa, Solomon Islands, Tonga, Tuvalu, Viet Nam.

1.2.1 African Region: Botswana, Burundi, Gambia, Kenya, Lesotho, Malawi, Mauritius, Sao Tome and Principe, Seychelles, Sierra Leone, Swaziland, Uganda, United Republic of Tanzania. **Region of the Americas:** Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States of America, Uruguay, Venezuela (Bolivarian Republic of) and, in addition, Puerto Rico. **Eastern Mediterranean Region:** Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen. **European Region:** Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand. **Western Pacific Region:** Australia, Brunei Darussalam, Cambodia, China (People's Republic of), Cook Islands, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, New Zealand, Niue, Palau (Republic of), Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

1.3.1 African Region: Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Comoros, Congo, Equatorial Guinea, Eritrea, Gabon, Gambia, Guinea, Guinea Bissau, Lesotho, Liberia, Madagascar, Malawi, Mauritania, Mauritius, Mozambique, Namibia, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States of America, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen. **European Region:** Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Brunei Darussalam, Cambodia, China (People's Republic of), Cook Islands, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, New Zealand, Niue, Palau (Republic of), Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

1.3.4 African Region: Burkina Faso, Burundi, Malawi, Mali. **Region of the Americas:** Belize, Ecuador, El Salvador, Honduras, Mexico, Nicaragua. **Eastern Mediterranean Region:** Afghanistan. **European Region:** Kyrgyzstan. **South-East Asia Region:** Maldives, Sri Lanka. **Western Pacific Region:** Cook Islands, Kiribati, Lao People's Democratic Republic, Niue, Samoa, Tonga, Tuvalu, Vanuatu, Viet Nam.

1.4.2 African Region: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.

Region of the Americas: Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Brazil, Colombia, Cuba, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Nicaragua, Paraguay, Saint Kitts and Nevis, Saint Lucia, Uruguay, Venezuela (Bolivarian Republic of).

Eastern Mediterranean Region: Afghanistan, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, Yemen.

European Region: Andorra, Armenia, Azerbaijan, Belarus, Croatia, Cyprus, Czech Republic, Estonia, Finland, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Malta, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Tajikistan, Turkmenistan, United Kingdom of Great Britain and Northern Ireland, Uzbekistan.

South-East Asia Region: Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Timor-Leste.

Western Pacific Region: Brunei Darussalam, Cambodia, China (People's Republic of), Cook Islands, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, New Zealand, Niue, Palau (Republic of), Papua New Guinea, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

1.5.1 The tools produced during this reporting period are available upon request.

1.5.2 The list of peer reviewed publications are available upon request.

1.7.1 African Region: Algeria, Angola, Benin, Botswana, Burkina Faso, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.

Region of the Americas: Argentina, Barbados, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Ecuador, El Salvador, Grenada, Honduras, Jamaica, Mexico, Nicaragua, Panama, Peru, Saint Lucia, Trinidad and Tobago, United States of America, Uruguay, Venezuela (Bolivarian Republic of).

Eastern Mediterranean Region: Bahrain, Egypt, Iran (Islamic Republic of), Jordan, Lebanon, Morocco, Oman, Pakistan, Saudi Arabia, Sudan, Syrian Arab Republic, Yemen.

European Region: Austria, Azerbaijan, Belarus, Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan.

South-East Asia Region: Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste.

Western Pacific Region: Australia, Brunei Darussalam, Cambodia, China (People's Republic of), Cook Islands, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, New Zealand, Niue, Palau (Republic of), Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Viet Nam.

1.8.1 The list of WHO locations are available upon request.



To combat HIV/AIDS, tuberculosis and malaria



ASSESSMENT OF THE ORGANIZATION-WIDE EXPECTED RESULTS

Of the six Organization-wide expected results for this strategic-objective, one was «fully achieved» and five «partly achieved».

Overview

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

Progress has continued in extending HIV-related services. The global incidence of HIV infection has stabilized and begun to decline in many countries with generalized epidemics, and an estimated 2.5 million lives have been saved since 1995. The number of people falling ill with tuberculosis has been declining since 2006, and TB mortality has fallen by 40% since 1990, and an estimated additional 7 million lives have been saved since 1995. There have been remarkable gains in the scale-up

of malaria control measures. During 2010 and 2011, in the African Region, about 220 million insecticide treated mosquito nets were distributed and 78 million people protected through indoor residual spraying.

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

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.

Partly Achieved

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

The global health sector strategy on HIV/AIDS 2011–2015 was endorsed by Member States and disseminated during the biennium. Regional strategies were then adopted. In addition, new guidance was prepared, including on antiretroviral therapy for adults and children, prevention of mother-to-child transmission, infant feeding and updated tuberculosis/HIV guidance. Regional strategies for dual elimination of mother-to-child transmission of HIV and syphilis were launched or endorsed by Member States in 3 regions.

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

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

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

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

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

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

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

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
2.1.1 Number of low and middle income countries that have achieved 80% coverage for (a) antiretroviral therapy and (b) the prevention of mother-to-child transmission services.	Not available	a) 15 and b) 20	a) 8 and b) 13
2.1.2 Proportion of endemic countries that have achieved their national intervention targets for malaria.	35%	60%	50%
2.1.3 Number of Member States that have achieved the targets of at least 70% case detection and 85% treatment success rate for tuberculosis.	42	46	45
2.1.4 Number of countries among the 27 priority ones with 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.	2	4	5
2.1.5 Proportion of high burden Member States that have achieved the target of 70% of persons with sexually transmitted infections diagnosed, treated and counselled at primary point-of-care sites.	Not available	70%	Not available

2.2

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

Partly Achieved

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

An increasing number of countries have strengthened their AIDS coordination mechanisms, and integrated previously separated planning and funding streams into consolidated HIV plans. As a result, donors are moving towards funding National Strategy Plans rather than individual projects.

By the end of 2011, the number of countries with comprehensive HIV policies and medium term plans increased to 158.

Under the guidance of the Regional Offices, Country offices provided a wide range of technical and policy support to state- and non-state counterparts, supported by headquarters as appropriate. In the African Region, eighteen countries were supported to develop or update their HIV/AIDS strategic and operational plans, while sixteen countries had their health sector HIV/AIDS programmes reviewed. At the end of 2011, a total of 39 countries in the region had updated HIV/AIDS strategic plans. In the European Region fourteen countries were supported in the evaluation of their national HIV/AIDS programmes, and seven countries received support to develop, adapt and adopt HIV normative documents to the local context. In the South East-Asia region, 7 countries were supported to develop national HIV plans and 3 countries were supported in reviewing the national HIV programmes. Six countries were supported in updating the national HIV prevention and treatment guidelines. In the Western-Pacific Region, countries were supported to expand and strengthen the linked response between HIV and SRH and other programmes including TB.

For tuberculosis, Stop TB's TBTEAM is a technical assistance mechanism managed by WHO and involving all regional offices and major TB technical partners which was significantly strengthened during the biennium. The focus is on country leadership in stewarding the technical support it needs for development of response plans, adaption of policies and for implementation. With WHO office and TBTEAM support, Member States moved to update strategies and plans especially in keeping with urgent needs for expanding access to early TB diagnosis as well as MDR-TB management and TB-HIV joint action. Examples of regional action: The Consolidated Action Plan to Prevent and Combat M/XDR-TB in WHO European Region 2011-2015 endorsed at the 61st EURO Regional Committee. The Plan was developed in consultation with the Member States, civil society organizations, communities and other stakeholders. 15 high burden countries have developed national MDR-TB response plans. SEARO has a 2006-2015 regional plan and also a new 2011-2015 MDR-TB plan. WPRO's regional plan was updated and programmatic management of MDR-TB was established in all four countries with high TB burden as well as MNG and Laos. In EMRO, 17 countries developed new plans to 2015. Laboratory strengthening and improved supranational reference laboratory networks were a priority for technical assistance for all regions and with Headquarters' global coordination support.

For malaria, Member States embraced the use of the WHO tool for malaria programme reviews, released in 2010, as the basis for developing up-to-date strategic plans for malaria. With technical support from WHO and other partners and in collaboration with the Roll Back Malaria Partnership, Member States were able to update national strategic plans for malaria to incorporate the latest evidence-based guidance. More than 20 countries conducted Malaria Programme Reviews during the biennium. With regard to specific policies, 27 countries in the African Region and 42 in other WHO Regions adopted the WHO recommendation to provide insecticide-treated mosquito nets for all persons at risk from malaria, not only pregnant women and children. A total of 82 countries, of which 38 are in the African Region, distributed insecticide-treated mosquito nets free of charge. A total of 73 countries, including 36 in the African Region, recommended indoor residual spraying for malaria control.

The Organization-wide expected result saw significant progress in technical assistance and cooperation which was intensified in line with the demands of financing mechanisms and in order to accelerate implementation and measurement of impact. Nevertheless, the Organization-wide expected result was rated as partly achieved, due to the fact that data for indicator 2.2.2 on “proportion of high-burden countries monitoring provider initiated HIV testing and counselling in sexu-

ally transmitted infection and family planning services” are available only from the Region of the Americas, the European, South East Asia and Western Pacific mainly due to insufficient resources for STI surveillance at the global, regional, and country level. In addition, the Eastern Mediterranean Region faced constraints during the latter half of the period, given security and other challenges.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
2.2.1 Number of targeted Member States with comprehensive policies and medium-term plans in response to HIV, tuberculosis and malaria.	HIV: 103/131 TB: 90/95 Malaria: 70/70	HIV: 115/131 TB: 118/118 Malaria: 70/70	HIV: 158 TB: 119 Malaria:92
2.2.2 Proportion of high-burden countries monitoring provider initiated HIV testing and counselling in sexually transmitted infection and family planning services.	55%	60%	Not available
2.2.3 Number of countries among the 63 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.	18	30	43

2.3

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

Partly Achieved

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

In the area of HIV/AIDS, many countries were able to further reduce HIV treatment commodity costs by pooling procurement of drugs and diagnostics and/or negotiating for additional reductions in the process of active pharmaceutical ingredients and finished formulations. The weighted median price of the most widely used first-line regimens was US\$ 121 per person per year in 2010, 12% lower than the average weighted median price of the most widely used first-line regimens in 2009. Based on its "AIDS Medicines and Diagnostics Services" (AMDS) partnership, WHO was able to provide technical support and capacity building in procurement and supply management (PSM) to at least 74 countries. During the biennium, tools and guidelines were also produced or updated, and products which support access to commodities were developed. The WHO's essential medicines list was updated to include 20 antiretroviral drugs including fixed doses combinations. WHO has so far prequalified a total of 202 HIV related drugs, 178 of which are ARV drugs.

Expanding access to second-line TB drugs and to new effective TB diagnostics were priorities for WHO and the Stop TB Partnership/Global Drug Facility (GDF) and WHO-hosted Global Laboratory Initiative, and WHO prequalification of medicines mechanism during the biennium. The Global Drug Facility continued strong support for direct procurement of first-line TB drugs most often with national and other donor resources, WHO, GDF and other partners initiated new analyses and collaborations, including with the Clinton Health Initia-

tive, the Bill & Melinda Gates Foundation, USAID and others to address the bottlenecks for regular affordable supply of second-line drugs. The WHO developed a roll-out plan for Xpert MTB/RIF diagnostic test and guided efforts during 2011 for early procurement in 47 countries. It created databases and regular sharing of information on scale-up. All regional offices guided adoption of policy and appropriate use of the test.

In the area of malaria, major gains were made in increasing access to malaria diagnostic testing and effective treatment with quality-assured antimalarial medicines. These efforts were facilitated by the release of key guidance documents, including on malaria diagnostic testing, treatment of malaria, and on good procurement practices for rapid diagnostic tests and medicines. Guidance on the treatment of severe malaria was updated, and the Essential Medicines Department prequalified one supplier of parenteral artesunate. There are now 18 drugs prequalified for the treatment of malaria. WHO continued to work with FIND, the U.S. Centers for Disease Control and Prevention and the Special Programme for Research and Training in Tropical Diseases to run the malaria rapid diagnostic tests product testing programme, which released its third report in 2011. The programme has resulted in a steady increase in the proportion of rapid diagnostic tests procured by Member States that meet minimum WHO performance criteria. A total of 63 countries reported receiving WHO technical support to expand access to antimalarial medicines. A total of 37 out of 43 malaria-endemic countries in the African Region and 53 out of 63 endemic countries in other WHO Regions reported having adopted a policy of providing parasitological diagnosis for all age groups. A total of 84 countries and territories have now adopted artemisinin-combination therapies for first-line treatment of *P. falciparum* malaria.

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

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
2.3.1 Number of new or updated global norms and quality standards for medicines and diagnostic tools for HIV/AIDS, tuberculosis and malaria.	25	40	41
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.	226	300	300
2.3.3 Number of targeted countries receiving support to increase access to affordable essential medicines for HIV/AIDS, tuberculosis and malaria whose supply is integrated into national pharmaceutical systems (the number of targeted countries is determined for the six-year period).	HIV: 35 TB: 107 Malaria: 43	HIV: 38 TB: 107 Malaria: 77	HIV: 73 TB: 111 Malaria: 64
2.3.4 Number of Member States implementing quality-assured HIV/AIDS screening of all donated blood.	93	105	109
2.3.5 Number of Member States administering all medical injections using sterile single use syringes.	183	180	180

2.4

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

Partly Achieved

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

For HIV, WHO has produced/updated a number of global guidance documents for strengthening country HIV surveillance and reporting systems, including: surveillance among most at risk populations; population size estimate; and use of assays for recent infection to estimate HIV incidence. Regional and country offices provided targeted technical support for increasing Member States capacity to generate, analyze, report and use strategic information. WHO was involved in the UNAIDS regional capacity building workshops for updating epidemic estimates. The Secretariat provided technical support for the strengthening of HIV surveillance and monitoring systems including HIVDR systems. In the European Region, 53 Member States contribute to the joint WHO/ECDC HIV/AIDS surveillance network. The European Region and regional offices of UNAIDS, UNICEF together with ECDC reached consensus on a common regional HIV/AIDS monitoring and evaluation indicator set for: Global AIDS Response Progress Reporting (former UNGASS); Universal Access in the Health Sector Reporting and the Dublin Declaration Reporting. By March 2012, countries will have reported HIV monitoring and evaluation data in a single coordinated process against a harmonized list of regionally relevant indicators.

Tuberculosis monitoring and evaluation continued with very high level of reporting for Member States on TB epidemi-

ology, programme performance and financing. In this last biennium, significant improvements were made in the coverage of MDR-TB surveillance as well as in overall country-level surveys for overall TB impact measurement. This work was guided by WHO, including all regional offices and a Global Task Force on TB Impact Measurement, and Member States often with Global Fund financing. Major nationwide surveys were conducted in several regions including particularly WPRO, SEARO and AFRO. The results together with regional consultations to review case notification, death registration and prevalence survey data led to major improvements in WHO's TB incidence, prevalence and mortality estimates, including use of direct vital registration in 90 countries. A quality-enhancing TB surveillance checklist was developed with a range of partners and is being pilot-tested in 10 countries. Countries supported by WHO for prevalence survey conduct included among others China, Cambodia, Ethiopia, Nigeria and Thailand. On-going work with India will help guide further assessments there.

Member States continued to provide a very high level of reporting to WHO with regard to malaria financing, policy adoption, intervention coverage and impact. The institution of standard reporting forms allowed the production of individual Country Profiles for all 99 Member States with on-going malaria transmission as part of the *World Malaria Report 2011*. To complement routine data, WHO provided assistance to six countries to conduct rapid impact assessments during the biennium. WHO worked with the Roll Back Malaria Partnership to include a specific target for malaria surveillance. WHO, together with partners, updated guidance on malaria surveillance for both control and elimination settings. The documents will be formally released on World Malaria Day 2012. In 2010, WHO released a global report on the status of antimalarial drug resistance based on WHO's database of antimalarial drug efficacy, including 3932 studies, reported by Member States, as well as data from published articles.

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

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
2.4.1 Number of Member States providing WHO with annual data on surveillance, monitoring or financial allocation data for inclusion in the annual global reports on control of HIV/AIDS, tuberculosis or malaria and the achievement of targets.	HIV: 109 TB: 198 Malaria: 107	HIV: 120 TB: 198 Malaria: 107	HIV: 157 TB: 208 ¹ Malaria: 105
2.4.2 Number of Member States reporting drug resistance surveillance data to WHO for HIV/AIDS, tuberculosis or malaria.	HIV: 54 TB: 114 Malaria: 81	HIV: 65 TB: 125 Malaria: 107	HIV: 61 TB: 127 Malaria: 73 ²

2.5

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

Fully Achieved

WHO hosts the Stop TB Partnership, the International Drug Purchase Facility (UNITAID) and the Roll Back Malaria Partnership, and is a UNAIDS cosponsor and board member of the Global Fund to Fight AIDS, Tuberculosis and Malaria. It also reinforced its role in other collaborative arrangements, where, by doing so, it could improve support for Member States in achieving the targets set out in the Medium-term strategic plan 2008–2013, as well as the Millennium Development Goals.

The visibility for WHO in the global HIV discourse increased significantly during the biennium. Key advocacy events were organized around launches of revised guidelines and the Universal Access report, most notably during the 18th International AIDS Conference in Vienna (AIDS 2010). Upon the request of the 63rd WHA, and directly involving more than 90 Member States, the HIV Department led the development of a draft “Global HIV Health Sector Strategy 2011–2015” that aims to provide overall guidance to countries in developing focused HIV responses in the context of broader health systems development. Regional strategies were developed in European, South-East Asia and Eastern-Mediterranean Regions, and existing strategies are under review in the Region of the Americas and the African Region. The HIV Programme enhanced its convening role in several key partnerships, and WHO positioned itself successfully as co-leads in evolving policy initiatives on: Treatment 2.0 and Elimination of Vertical Transmission of HIV; and health care worker access to HIV and TB interventions (in collaboration with ILO and UNAIDS). In 2011, WHO convened a global group of HIV leaders to revisit the WHO HIV guidelines architecture and develop a guidelines development roadmap for the coming years.

In tuberculosis, WHO continued its deep engagement with a wide range of partners and partnerships at global, regional and country level to advance strategies, resource mobilization, implementation and evaluation. It worked with the Stop TB Partnership Secretariat and working groups to develop the updated Global Plan to Stop TB, 2011–2015 which laid out the consensus around priorities in implementing the Stop TB Strategy, the financial needs, sources and current gaps including for new TB diagnostics, drugs and vaccines. WHO, the Stop TB Partnership/Global Drug Facility, Global Fund, and develop-

ment agencies, member states and experts developed revised and regionalized mechanisms to support scale-up of MDR-TB treatment. The WHO-hosted TB-HIV Working Group focused with WHO Regional Offices on design of regional strategies for TB-HIV intervention. The WHO-managed Global Laboratory Initiative has driven a UNITAID 26 country project to expand use of new TB diagnostics, and in setting a roadmap for scale up of the new Xpert test. WHO offices collaborated closely in the Stop TB Research Movement, work on Public-Private Mix collaborations in service delivery, an expanded agenda with partners for addressing childhood TB, and two major consultations with civil society, NGOs and member states on further collaboration for effective TB care.

In the area of malaria, WHO remained fully engaged in the Roll Back Malaria Partnership, whose secretariat is hosted at WHO. WHO worked with the Partnership in updating its global objectives, targets, milestones, and priorities for 2011–2015. WHO co-chaired a number of key Roll Back Malaria mechanisms, including the Harmonization Working Group, the Monitoring and Evaluation Reference Group, the Case Management Working Group, and the Vector Control Working Group. At the request of the United Nations Secretary-General’s Special Envoy for Malaria, WHO convened and continues to host an artemisinin-combination therapy supply task force to address concerns about tighter than usual supplies of artemisinin-combination therapies. In the African Region, WHO remained engaged in the Roll Back Malaria sub-regional networks. In the South-East Asia and Western Pacific Regions, WHO continued to play a key role in coordinating responses to the emerging threat of antimalarial drug resistance. In the Region of the Americas, WHO continued to play a primary coordination role, and was engaged in the development of the malaria component of Salud Mesoamerica 2015. In the European Region, WHO leadership and coordination continued to be central in efforts to reach the objective, set forth in the Tashkent Declaration, of elimination of malaria from the WHO European Region by 2015.

WHO continued to build the capacity of those applying for Global Fund grants, including national disease control programmes. As a result, financing was made available for increas-

ing universal access to services as well as surveillance, monitoring, evaluate and impact measurement . 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. Member States and WHO at country level have continued to engage with a widening array of affected persons, communities, civil society and private sector partners.

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

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
2.5.1 Number of Member States with functional coordination mechanisms for HIV/AIDS, tuberculosis and malaria control.	HIV: 108 TB: 95 Malaria: 77	HIV:118 TB: 110 Malaria: 70	HIV: 152 TB:122 Malaria: 72
2.5.2 Number of Member States involving communities, persons affected by the diseases, civil-society organizations and the private sector in planning, design, implementation and evaluation of HIV/AIDS, tuberculosis and malaria programmes.	HIV: at least 99 TB: 87 Malaria: 77	HIV: 120 TB: 87 Malaria: 70	HIV: 147 TB: 100 Malaria: 76

2.6

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

Partly Achieved

In general, increased support for research and knowledge management led to the development and adoption of new disease prevention and control strategies, and tools surpassed the initial targets. WHO has been applying more robust tools and processes for ensuring evidence-based policy and strategy development. This involved an expanded array of expert consultations and systematic reviews of evidence in developing the key advancements in policy this last biennium. Major policy guidance is described under OWER 2.1. WHO and the Special Programme for Research and Training in Tropical Diseases (TDR), with numerous partners, published evidence-based results of country-based clinical, epidemiological and operational research. TDR is placing increasing emphasis in its work on capacity building for evidence-based operational research across diseases of poverty.

With a pressing need to increase HIV programme efficiencies, countries are significantly stepping up operational and intervention research. Particular emphasis is placed on research generating knowledge on how to scale-up service for specific groups, such as most at risk populations or pregnant women especially in the African and Eastern-Mediterranean Regions. Some countries have developed HIV research ethics guidelines (India). Based on specific work to support operational research on HTC, in 2010 generic tools for operational research were produced and disseminated to countries. A multi-country intervention research initiative for improving delivery of PMTCT services was launched in The African region in 2011, and the South East Asia and Western Pacific Regions are supporting countries in the development of operational research on "treatment as prevention" approaches.

To further accelerate decline in tuberculosis mortality, incidence and prevalence, WHO and partners are supporting a range of operational research. This includes guidance for field testing of new diagnostics to significantly improve early

and life-saving diagnosis for MDR-TB and HIV-associated TB. Southern Africa is among the sub-regions where such tests are most urgently needed and where WHO is collaborating for rapid sharing of results. Support has been provided for research on more integrated care models with public, private and community-based services. The Stop TB Partnership, WHO and Global Fund, released a guide to TB operational research priorities and approaches. WHO offices, including Headquarters, EURO and WPRO, are engaged in implementing a prioritized agenda of MDR-TB research linked to MDR-TB surveillance and treatment programmes. WHO's HIV and TB staff have jointly supported research helping accelerate implementation of recommended interventions to face the two epidemics.

To ensure timely translation of emerging evidence regarding malaria control into policies that benefit Member States, WHO re-designed the global malaria policy-setting process during the biennium. This resulted in the creation of the Malaria Policy Advisory Group (MPAC), which is closely modelled on the Strategic Advisory Group of Experts (SAGE), which provides recommendations to WHO on immunization. Composed of 15 world-renowned malaria experts appointed in late 2011 from all WHO Regions, the Malaria Policy Advisory Group will meet twice yearly beginning in early 2012. The Advisory Group not only reviews emerging evidence which then forms the basis of new and updated policies, but also identifies evidence gaps where further research is required. During the biennium, WHO was engaged the Malaria Eradication Research Agenda (malERA), a comprehensive exercise in laying out the research required for eventual malaria eradication, as well as the creation of the Malaria Eradication Scientific Alliance (MESA) which tracks and supports the implementation of a prioritized research agenda.

Despite increasing research efforts globally, the African and the South-East Asia Regions reported still significant constraints in research capacity in countries.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
2.6.1 Number of new and improved tools or implementation strategies for HIV/AIDS, tuberculosis or malaria implemented by the public sector in at least one developing country.	1	6	17
2.6.2 Proportion of peer-reviewed publications arising from WHO-supported research on HIV/AIDS, tuberculosis or malaria and for which the main author's institution is based in a developing country.	71%	55%	61%

SUMMARY OF FINANCIAL IMPLEMENTATION

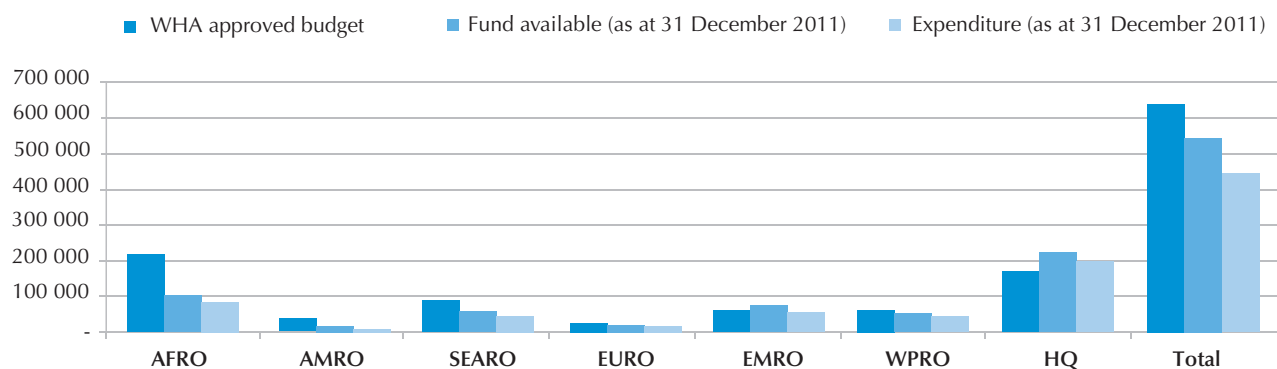
The approved budget envelope of US\$ 634 million is composed of US\$ 556 million for base programmes and US\$ 78 million for special programmes and collaborative arrangements.

As at 31st December 2011, funds available were US\$ 535 million of which US\$ 354 million were for base programmes and US\$ 181 million for special programmes and collaborative arrangements.

For base programmes, total expenditure was US\$ 293 million which represents 53% against the approved budget and 83% against the funds available. Implementation against the approved budget has been particularly low in 5 out of the seven major offices, given the more difficult resource mobilization environment of this last biennium. Implementation against available funds has been more than 80% with the exception of the South East Asia and Eastern Mediterranean Regions.

All Segments

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	208 208	41 449	83 461	29 755	47 540	50 526	172 941		633 880
Funds Available									
AC	10 426	3 175	6 520	1 505	3 802	4 896	11 299		41 624
VC	91 674	6 731	62 137	22 629	55 330	39 766	215 601	-	493 868
Total	102 100	9 906	68 658	24 134	59 133	44 662	226 900	-	535 492
Funds Available as % of approved budget	49%	24%	82%	81%	124%	88%	131%		84%
Expenditure	83 580	9 392	50 639	20 940	45 820	40 802	194 375		445 549
Expenditure as % of approved budget	40%	23%	61%	70%	96%	81%	112%		70%
Expenditure as % of funds available	82%	95%	74%	87%	77%	91%	86%		83%



Base programmes

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	208 208	41 449	83 461	29 755	47 540	50 526	94 941		555 880
Funds Available									
AC	10 426	3 175	6 520	1 505	3 802	4 896	10 136		40 461
VC	90 541	5 890	46 443	21 102	26 795	34 814	88 121	-	313 706
Total	100 967	9 065	52 963	22 607	30 597	39 710	98 257	-	354 167
Funds Available as % of approved budget	48%	22%	63%	76%	64%	79%	103%		64%
Expenditure	82 640	8 738	41 786	19 583	22 389	36 425	81 965		293 525
Expenditure as % of approved budget	40%	21%	50%	66%	47%	72%	86%		53%
Expenditure as % of funds available	82%	96%	79%	87%	73%	92%	83%		83%

Special programmes and collaborative arrangements

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	-	-	-	-	-	-	78 000		78 000
Funds Available									
AC	-	-	-	-	-	-	1 163		1 163
VC	1 132	842	15 695	1 527	28 535	4 952	127 479	-	180 163
Total	1 132	842	15 695	1 527	28 535	4 952	128 642	-	181 326
Funds Available as % of approved budget	-	-	-	-	-	-	165%		232%
Expenditure	945	654	8 854	1 357	23 317	4 377	112 410		151 915
Expenditure as % of approved budget	-	-	-	-	-	-	144%		195%
Expenditure as % of funds available	83%	78%	56%	89%	82%	88%	87%		84%

Outbreak and crisis response

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	-	-	-	-	-	-	-		-
Funds Available									
AC	-	-	-	-	-	-	-		-
VC	-	-	-	-	-	-	-	-	-
Total	-	-	-	-	-	-	-	-	-
Funds Available as % of approved budget	-	-	-	-	-	-	-		-
Expenditure	-5	-	-		115	-	-		110
Expenditure as % of approved budget	-	-	-	-	-	-	-		-
Expenditure as % of funds available	-	-	-	-	-	-	-		-

REFERENCES

- 1 The achievement figure for TB has referred since the beginning of the measurement of this indicator on Member States and other countries and territories.
- 2 There are only 99 countries with on-going malaria transmission, and in only 75 of these it is considered feasible to conduct routine therapeutic efficacy monitoring given the degree of burden. In future bienniums, the target will be adjusted downwards accordingly.

DETAILS OF INDICATOR ACHIEVEMENT

2.1.1a HIV/AIDS: African Region: Botswana, Namibia, Rwanda. **Region of the Americas:** Chile, Cuba, Guyana, Nicaragua. **Western Pacific Region:** Cambodia.

2.1.1b Tuberculosis: African Region: Botswana, Lesotho, Namibia, South Africa, Swaziland. **Region of the Americas:** Argentina, Brazil, Ecuador, Honduras. **European Region:** Belarus, Romania, Ukraine. **South-East Asia Region:** Thailand.

2.1.2 African Region: Benin, Botswana, Burkina Faso, Burundi, Democratic Republic of the Congo, Eritrea, Ethiopia, Kenya, Madagascar, Mali, Namibia, Niger, Rwanda, Senegal, Togo, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Belize, Bolivia (Plurinational State of), Brazil, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname. **South-East Asia Region:** Bangladesh, Bhutan, India, Indonesia, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, China (People's Republic of), Lao People's Democratic Republic, Malaysia, Papua New Guinea, Philippines, Republic of Korea, Solomon Islands, Vanuatu, Viet Nam.

2.1.3 African Region: Algeria, Burundi, Ghana, Kenya, Namibia, Sao Tome and Principe, United Republic of Tanzania, Zambia. **Region of the Americas:** Barbados, Cuba, Dominica, El Salvador, Honduras, Mexico, Nicaragua. **Eastern Mediterranean Region:** Bahrain, Kuwait, Oman, Syrian Arab Republic, Yemen. **European Region:** Albania, Andorra, Bosnia and Herzegovina, Bulgaria, Israel, Montenegro, Romania, Serbia, Slovenia, Sweden, The former Yugoslav Republic of Macedonia, Turkey. **South-East Asia Region:** Bhutan, Democratic People's Republic of Korea, Myanmar, Nepal, Thailand. **Western Pacific Region:** China (People's Republic of), Fiji, Kiribati, Lao People's Democratic Republic, Micronesia (Federated States of), Mongolia, Samoa, Vanuatu.

2.1.4 European Region: Estonia, Georgia, Kazakhstan, Latvia, Lithuania,

2.2.1a HIV/AIDS: African Region: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Bahamas, Barbados, Belize, Dominican Republic, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Jordan, Kuwait, Lebanon, Morocco, Oman, Pakistan, Saudi Arabia, Somalia, Tunisia, Yemen. **European Region:** Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, Estonia, Georgia, Germany, Greece, Hungary, Ireland, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Montenegro, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, Serbia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan,

India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Cambodia, China (People's Republic of), Fiji, Lao People's Democratic Republic, Malaysia, Marshall Islands, Mongolia, Palau (Republic of), Papua New Guinea, Philippines, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

2.2.1b Tuberculosis: African Region: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Belize, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Trinidad and Tobago, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Lebanon, Morocco, Pakistan, Somalia, Sudan, Syrian Arab Republic, Tunisia, Yemen. **European Region:** Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Montenegro, Republic of Moldova, Romania, Russian Federation, Serbia, Tajikistan, The former Yugoslav Republic of Macedonia, Turkmenistan, Ukraine, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, China (People's Republic of), Fiji, Lao People's Democratic Republic, Malaysia, Mongolia, Papua New Guinea, Philippines, Solomon Islands, Viet Nam.

2.2.1c Malaria: African Region: Angola, Benin, Botswana, Burkina Faso, Burundi, Cap Verde, Chad, Comoros, Congo, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Ghana, Guinea Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Belize, Bolivia (Plurinational State of), Brazil, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Djibouti, Iran (Islamic Republic of), Iraq, Oman, Pakistan, Somalia, Sudan, Syrian Arab Republic, Yemen. **European Region:** Azerbaijan, Georgia, Kyrgyzstan, Russian Federation, Tajikistan, Turkey, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, China (People's Republic of), Lao People's Democratic Republic, Malaysia, Papua New Guinea, Philippines, Solomon Islands, Vanuatu, Viet Nam.

2.2.3 African Region: Benin, Botswana, Burkina Faso, Burundi, Cameroon, Congo, Côte d'Ivoire, Equatorial Guinea, Ghana, Guinea, Kenya, Lesotho, Liberia, Malawi, Mozambique, Namibia, Nigeria, Rwanda, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Bahamas, Barbados, Belize, Dominican Republic, Guatemala, Guyana, Haiti, Honduras, Jamaica, Panama, Trinidad and Tobago. **Eastern Mediterranean Region:** Djibouti. **European Region:** Estonia, Russian Federation, Ukraine. **South-East Asia Region:** Thailand. **Western Pacific Region:** Cambodia.

2.3.1 The list of new or updated global norms and quality standards produced during this reporting period are available upon request.

2.3.3a HIV/AIDS: African Region: Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Togo, Zambia, Zimbabwe. **Region of the Americas:** Belize, Bolivia (Plurinational State of), Cuba, El Salvador, Haiti. **Eastern Mediterranean Region:** Iran (Islamic Republic of), Iraq, Lebanon, Morocco, Oman, Somalia, Sudan, Syrian Arab Republic, Tunisia, Yemen. **European Region:** Belarus, Bosnia and Herzegovina, Kyrgyzstan, Montenegro, Slovakia, Switzerland, Tajikistan, Turkmenistan, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, India, Indonesia, Maldives, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Cambodia, Papua New Guinea, Republic of Korea.

2.3.3b Tuberculosis: African Region: Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Bolivia (Plurinational State of), Brazil, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Mexico, Nicaragua, Paraguay, Peru, Uruguay. **Eastern Mediterranean Region:** Afghanistan, Djibouti, Egypt, Iraq, Jordan, Lebanon, Libya, Morocco, Oman, Pakistan, Somalia, Sudan, Syrian Arab Republic, Tunisia, Yemen. **European Region:** Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Romania, Russian Federation, Serbia, Tajikistan, The former Yugoslav Republic of Macedonia, Turkmenistan, Ukraine, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, China (People's Republic of), Fiji, Kiribati, Lao People's Democratic Republic, Marshall Islands, Micronesia (Federated States of), Mongolia, Papua New Guinea, Philippines, Samoa, Solomon Islands, Tuvalu, Viet Nam.

2.3.3C Malaria: African Region: Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Bolivia (Plurinational State of), Brazil, Colombia, Dominican Republic, Ecuador, Guyana, Honduras, Jamaica, Panama, Paraguay, Peru, Venezuela (Bolivarian Republic of). **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste.

2.3.5 African Region: Algeria, Angola, Burundi, Cameroon, Cap Verde, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States of America, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Bahrain, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen. **European Region:** Andorra, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Brunei Darussalam, Cambodia, China (People's Republic of), Cook Islands, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, New Zealand, Niue, Palau (Republic of), Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

2.4.1a HIV/AIDS: African Region: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho,

Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Antigua and Barbuda, Argentina, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Suriname, Trinidad and Tobago, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Lebanon, Morocco, Oman, Pakistan, Somalia, Sudan, Syrian Arab Republic, Tunisia, Yemen. **European Region:** Albania, Armenia, Austria, Azerbaijan, Belarus, Bosnia and Herzegovina, Croatia, Cyprus, Czech Republic, Denmark, Estonia, France, Georgia, Greece, Hungary, Israel, Kazakhstan, Kyrgyzstan, Latvia, Malta, Montenegro, Netherlands, Poland, Republic of Moldova, Romania, Russian Federation, Serbia, Slovakia, Spain, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Ukraine, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Brunei Darussalam, Cambodia, China (People's Republic of), Cook Islands, Fiji, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, New Zealand, Niue, Palau (Republic of), Papua New Guinea, Philippines, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam and, in addition American Samoa.

2.4.1b Tuberculosis: African Region: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Trinidad and Tobago, United States of America, Uruguay, Venezuela (Bolivarian Republic of) and, in addition, Puerto Rico. **Eastern Mediterranean Region:** Afghanistan, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen. **European Region:** Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand. **Western Pacific Region:** Australia, Brunei Darussalam, Cambodia, China (People's Republic of), Cook Islands, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, New Zealand, Niue, Palau (Republic of), Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam and, in addition Tokelau.

2.4.1c Malaria: African Region: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Bahamas, Belize, Bolivia (Plurinational State of), Brazil, Colombia, Costa Rica, Dominica, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Djibouti, Egypt, Iran (Islamic Republic

of), Iraq, Oman, Pakistan, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, Yemen. **European Region:** Armenia, Azerbaijan, Georgia, Kyrgyzstan, Russian Federation, Tajikistan, Turkey, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, China (People's Republic of), Lao People's Democratic Republic, Malaysia, Papua New Guinea, Philippines, Republic of Korea, Solomon Islands, Vanuatu, Viet Nam.

2.4.2a HIV/AIDS: **African Region:** Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Kenya, Lesotho, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Bahamas, Barbados, Belize, Brazil, Colombia, Dominica, Dominican Republic, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Suriname. **Eastern Mediterranean Region:** Iran (Islamic Republic of). **European Region:** Russian Federation, Ukraine. **South-East Asia Region:** India, Indonesia, Thailand. **Western Pacific Region:** Cambodia, China (People's Republic of), Papua New Guinea, Viet Nam.

2.4.2b Tuberculosis: **African Region:** Algeria, Benin, Botswana, Central African Republic, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gambia, Guinea, Kenya, Lesotho, Madagascar, Mauritius, Mozambique, Namibia, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Bahamas, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Paraguay, Peru, United States of America, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Bahrain, Egypt, Iran (Islamic Republic of), Jordan, Kuwait, Lebanon, Morocco, Oman, Qatar, Syrian Arab Republic, Yemen. **European Region:** Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Latvia, Lithuania, Luxembourg, Malta, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand. **Western Pacific Region:** Australia, Brunei Darussalam, Cambodia, China (People's Republic of), Japan, Malaysia, Marshall Islands, Mongolia, New Zealand, Palau (Republic of), Philippines, Republic of Korea, Singapore, Solomon Islands, Vanuatu, Viet Nam.

2.4.2c Malaria: **African Region:** Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Brazil, Colombia, Ecuador, Guyana, Honduras, Nicaragua, Peru, Suriname, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Iran (Islamic Republic of), Pakistan, Somalia, Sudan, Yemen. **European Region:** Tajikistan. **South-East Asia Region:** Bangladesh, Bhutan, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, China (People's Republic of), Lao People's Democratic Republic, Malaysia, Papua New Guinea, Philippines, Solomon Islands, Vanuatu, Viet Nam, Venezuela (Bolivarian Republic of).

2.5.1a HIV/AIDS: **African Region:** Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Canada, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, El Salvador, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines,

Suriname, Trinidad and Tobago, United States of America, Uruguay. **Eastern Mediterranean Region:** Afghanistan, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Saudi Arabia, Syrian Arab Republic, Tunisia, United Arab Emirates. **European Region:** Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, Estonia, Finland, Georgia, Hungary, Ireland, Israel, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Montenegro, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, Serbia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Ukraine, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Cambodia, China (People's Republic of), Fiji, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Palau (Republic of), Papua New Guinea, Philippines, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

2.5.1b Tuberculosis: **African Region:** Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Lucia, Suriname, United States of America, Uruguay. **Eastern Mediterranean Region:** Afghanistan, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Morocco, Oman, Pakistan, Somalia, Sudan, Syrian Arab Republic, Tunisia, Yemen. **European Region:** Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Georgia, Italy, Kazakhstan, Kyrgyzstan, Montenegro, Portugal, Republic of Moldova, Romania, Russian Federation, Serbia, Tajikistan, The former Yugoslav Republic of Macedonia, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, China (People's Republic of), Fiji, Japan, Lao People's Democratic Republic, Mongolia, Papua New Guinea, Philippines, Solomon Islands, Viet Nam.

2.5.1c Malaria: **African Region:** Angola, Benin, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Liberia, Madagascar, Malawi, Mozambique, Namibia, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Belize, Bolivia (Plurinational State of), Brazil, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Venezuela (Bolivarian Republic of). **European Region:** Armenia, Azerbaijan, Georgia, Kyrgyzstan, Russian Federation, Tajikistan, Turkey, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste.

2.5.2a HIV/AIDS: **African Region:** Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Chad, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Antigua and Barbuda, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, , Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States of America, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Djibouti, Egypt, Iran (Islamic Republic of), Jordan, Lebanon, Morocco, Oman, Pakistan, Saudi Arabia, Somalia, Syrian Arab Republic, Tunisia, United Arab Emirates. **European Region:** Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria,

Czech Republic, Denmark, Estonia, Finland, Germany, Kazakhstan, Lithuania, Luxembourg, Montenegro, Netherlands, Norway, Portugal, Republic of Moldova, Romania, Russian Federation, Serbia, Slovenia, Spain, Tajikistan, The former Yugoslav Turkey, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Brunei Darussalam, Cambodia, China (People's Republic of), Fiji, Lao People's Democratic Republic, Malaysia, Marshall Islands, Mongolia, Nauru, New Zealand, Palau (Republic of), Papua New Guinea, Philippines, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

2.5.2b Tuberculosis: African Region: Algeria, Angola, Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Bolivia (Plurinational State of), Brazil, Colombia, Dominica, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Bahrain, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Lebanon, Morocco, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Yemen. **European Region:** Bosnia and Herzegovina, Bulgaria, Kazakhstan, Republic of Moldova, Romania, Serbia, Tajikistan, Turkey. **South-East Asia Region:** Bangladesh, Bhutan, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand. **Western Pacific Region:** Cambodia, China (People's Republic of), Fiji, Lao People's Democratic Republic, Malaysia, Micronesia (Federated States of), Mongolia, Philippines, Republic of Korea, Solomon Islands, Vanuatu, Viet Nam.

2.5.2c Malaria: African Region: Angola, Benin, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Liberia, Madagascar, Malawi, Mozambique, Namibia, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Bahamas, Belize, Bolivia (Plurinational State of), Brazil, Colombia, Costa Rica, Dominica, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Venezuela (Bolivarian Republic of). **European Region:** Armenia, Azerbaijan, Georgia, Kyrgyzstan, Russian Federation, Tajikistan, Turkey, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste.

2.6.1 The list of new or improved tools produced during this reporting period are available upon request.

SO3

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



ASSESSMENT OF THE ORGANIZATION-WIDE EXPECTED RESULTS

Of the six Organization-wide expected results for this strategic-objective, three were «fully achieved» and three «partly achieved».

Overview

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

Global attention to noncommunicable conditions has risen rapidly during this biennium. A High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases was held in September 2011. Representatives from 113 Member States and 34 heads of state or government attended. The result was the Political Declaration on the Prevention and Control of Noncommunicable Diseases (resolution 66/2). The Summit followed and built on the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, held in Moscow in April 2011. The first WHO *Global status report on noncommunicable diseases 2010* was issued at this conference and a further publication on noncommunicable disease country profiles was published immediately before the High-level Meeting.

The *World report on disability* was launched in 2011. It represents a milestone and follows on from the adoption of the Convention on the Rights of Persons with Disabilities (CRPD) in 2008. Subsequent to the global launch of the report, more than 30 national-level policy discussions have been held across all WHO regions on implementation of the recommendations contained in the report. The *Report on mental health and de-*

velopment: targeting people with mental health conditions as a vulnerable group was published during the lead up to the Millennium Development Goals review summit, held in New York in September 2010. The report demonstrates how people with mental health problems are marginalized and face stigma, discrimination and human rights violations in all arenas of their life. It also makes the case for governments and development agencies increase the importance of mental health interventions on the public health agenda and identifies specific actions they can take. This biennium also saw the declaration of the Decade of Action for Road Safety 2011-2020 and its high level launch in over 400 locations in over 100 countries.

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. A WHO report entitled *Scaling up action against non-communicable diseases: How much will it cost?* provides cost estimates for scaling-up “best buy” interventions in low- and middle-income countries. The new *mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized settings* focuses on improving care for persons with mental, neurological and substance abuse disorders, and pilot projects have been initiated in several countries. A WHO guideline document entitled *Preventing intimate partner and sexual violence against women: taking action and generating evidence* and a collection of case studies in trauma care and burns prevention were published to help disseminate knowledge on violence and injury prevention and care.

At the regional level a detailed assessment of countries’ capacity to respond to noncommunicable diseases was undertaken in all Member States during 2010 and further updated in 2011 on the basis of the noncommunicable disease country capacity survey.

During 2010 and 2011, the regional offices focused on providing technical support to Member States. Some regional highlights included: regional high-level consultations in all regions on noncommunicable diseases in preparation for the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases; preparation of regional noncommunicable diseases action plans; a regional community-based rehabilitation strategy and the Strategy for mental health and substance abuse in the Eastern Mediterranean Region 2012-2016 (resolution EM/RC58/R.8) in the Eastern Mediterranean Region; resolu-

tion SEA/RC63.R2 on injury prevention and safety promotion in the South-East Asia Region; and the Strategy and Plan of Action on Epilepsy (resolution CD51.8) in the Region of the Americas. An new project entitled Road Safety in 10 countries was launched in all regions to tackle some of the major risk factors for road traffic deaths and injuries, such as speeding, drinking and driving and the non use of seat belts or helmets. Member States, international partners and the Secretariat have continued to make progress in implementing the Action plan for the prevention of avoidable blindness and visual impairment, 2009-2013.

3.1

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

Fully Achieved

With the support of multiple partners, WHO has advocated for an increased commitment to, and action on, noncommunicable diseases, mental health, violence and injury prevention, and disability. WHO provided technical and administrative support to countries in convening regional meetings to prepare for the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases in September 2011. This has resulted in several global agreements during the biennium, including the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases (resolution 66/2).

The commitment of Member States to tackle noncommunicable diseases, mental health, violence and injury prevention and disability was also evidenced by several other high-level resolutions, including resolution WHA63/13 on the Global Strategy to Reduce the Harmful Use of Alcohol and United Nations General Assembly resolution A/RES/64/255 (2010) declaring a Decade of Action for Road Safety 2011–2020.

WHO hosted the Third Global Meeting of Ministry of Health Focal Points for Violence and Injury Prevention, bringing together around 115 ministry of health focal points from nearly 90 countries, heads of WHO collaborating centres and WHO staff from headquarters and regional and country offices. Participants exchanged ideas and information, learned about the latest products and tools available from WHO, and identified future collaborative activities. The number of Member States with an administrative unit focusing on the prevention and control of noncommunicable diseases raised from 122

to 165. In the African Region, all 46 countries have mental health focal points and Mental Health units at the Ministries of health. While the establishment of worldwide networks of focal points for violence and injury prevention, mental health and noncommunicable diseases has been very successful, these focal points are often tasked with multiple agendas and many receive little or no financial resources for activities. To raise the profile of these technical areas, attention was placed on involving ministries of health at the highest possible level, including at the political level.

In the area of disability, national prevalence data from 193 countries was collected and compiled. The main report is available in three United Nations official languages and the summary report in all six official languages. Awareness-raising events and dialogues on the *World Report on Disability* have been carried out in 33 countries and are continuing.

The mhGAP process has shown to facilitate improvement of mental health services and working towards integrating mental health into general health services and boosted mental health on the public health agenda, which is also reflected by an increased number of member states with a Mental Health budget exceeding 1% of the total health budget. Guidelines were published on how to integrate mental health into primary care. WHO organized the mhGAP Forum in October 2010 and 2011 in which over 20 Member States, several ambassadors and more than 50 partners participated. In addition, WHO was invited to edit the Lancet Series on Global Mental Health 2011, which was launched in October 2011.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
3.1.1 Number of Member States whose health ministries have a focal point or a unit for injuries and violence prevention with its own budget.	156	162	164
3.1.2 <i>The world report on disability and rehabilitation</i> published and launched, in response to resolution WHA58/23.	Draft report prepared	Report published in 6 languages	Report published in 6 languages
3.1.3 Number of Member States with a mental health budget of more than 1% of the total health budget.	90	100	100
3.1.4 Number of Member States with a unit in the ministry of health or equivalent national health authority, with dedicated staff and budget, for the prevention and control of chronic noncommunicable diseases.	75	122	165

3.2

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

Partly Achieved

WHO continued to play a pivotal role in providing guidance on the development, implementation and monitoring of policies and programmes for the prevention and management of noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities and the rehabilitation of those affected by them. In all technical areas there was a substantial increase in the number of countries with relevant policies, legislation, action plans and national budgets, thereby preparing the ground for subsequent implementation and scaling-up of effective interventions.

The number of Member States with national plans for preventing unintentional injuries or violence increased from 83 to 133. WHO has provided several guidance documents on how to prepare national plans for the prevention of violence and unintentional injuries, including the joint preparation of the Global plan for the decade of action on road safety 2011–2020, in collaboration with the United Nations Regional Commissions and other partners. The plan guides Member States in the preparation of national and local plans to implement measures to increase road safety and reduce associated health burden.

Progress continued to be made in the area of noncommunicable diseases with the number of Member States that have adopted a multisectoral national policy on chronic diseases rising from 75 to 121. WHO provided technical assistance to numerous countries to develop, revise and implement noncommunicable diseases policies and plans in line with the strategic objectives of the 2008–2013 Action plan for the global strategy for the prevention and control of noncommunicable diseases. The *Global status report on noncommunicable diseases 2010* reviewed the current status of noncommunicable diseases and

provided a roadmap for reversing the epidemic with a special focus on low- and middle-income countries. An international training course was started by WHO to strengthen the capacity of managers of noncommunicable diseases programmes in ministries of health.

In the area of mental health, the number of countries with mental health policies, plans and laws increased from 51 to 56. The WHO *Report on mental health and development: targeting people with mental health conditions as a vulnerable group* set the key issues and established the way forward for integrating mental health matters into the health and development agenda, including continued support for capacity building through joint international courses on policy, law, human rights and services. Tools, manuals and guidelines were developed and disseminated in the African Region to facilitate the development and implementation of policies and plans.

Some 59 countries in all regions have strengthened their policies and strategies on visual impairment. Annual meetings to support countries in eliminating trachoma and onchocerciasis have been convened or supported by WHO.

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

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
3.2.1 Number of Member States that have national plans to prevent unintentional injuries or violence.	83	88	133
3.2.2 Number of Member States that have initiated the process of developing a mental health policy or law.	51	56	56
3.2.3 Number of Member States that have adopted a multisectoral national policy on chronic noncommunicable diseases.	75	90	121
3.2.4 Number of Member States that are implementing comprehensive national plans for the prevention of hearing or visual impairment.	88	100	59

3.3

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

Partly Achieved

The collection, analysis and use of data on the magnitude, causes and consequences of noncommunicable diseases, mental health, violence and injury prevention, and disability is vital for targeting, preventing and evaluating progress. Overall, Member States have continued to improve their capacity to collect and analyse information in the areas of mental health, road traffic injury prevention and hearing and visual impairment.

A total of 175 countries submitted a full road safety assessment to WHO which was then published in the *Global status report on road safety*. This was the first global comprehensive review highlighting the magnitude of road traffic crashes and describing policies and prevention practices currently being implemented. WHO conducted regional training courses and provided technical support to National Data Coordinators at country level. In addition, the Secretariat analysed the data, compiled the report and organized its launch. The messages contained in the report received wide coverage in the global and national media. Several countries took action to improve road safety after the launch of the report.

National prevalence data on disability was collected and compiled from 193 countries for the World Report on Disability and Rehabilitation. This represents the most comprehensive list of national disability prevalence estimates currently available.

In addition, several key reports monitoring progress around the world, such as the first *Global status report on noncommunicable diseases 2010* and the *Mental health atlas 2011* were published.

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

The lack of a basic infrastructure, such as having no vital registration system or hospital based data system, was also a major obstacle to the collection of valid data across all technical areas. Creating ownership by policy makers at an early stage of the process is important if surveys and other forms of data collection are to have an impact on the development of policies and strategies.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
3.3.1 Number of Member States that have submitted a complete assessment of their national road traffic injury prevention status to WHO during the biennium.	175	175	175
3.3.2 Number of Member States that have a published document containing national data on the prevalence and incidence of disabilities.	158	163	193
3.3.3 Number of low- and middle-income Member States with basic mental health indicators annually reported.	98	110	110
3.3.4 Number of Member States with a national health reporting system and annual reports that include indicators for the four major noncommunicable diseases.	116	136	101
3.3.5 Number of Member States documenting, according to population-based surveys, the burden of hearing or visual impairment.	34	38	47

3.4

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

Fully Achieved

The *mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized settings* based on a comprehensive review of the existing evidence was issued during the biennium. It provides recommendations to facilitate high-quality care at first- and second- level facilities by non-specialist health-care providers. Additional training material accompanying the mhGAP Intervention Guide has been developed and was widely disseminated. The guide quickly became a well-known and frequently used resource. Up to now it has been implemented in eight countries, including those with large populations, such as India and Thailand. A significant number of nongovernmental and private organizations base their interventions on the guidance. It has been translated into all official languages, and also been made available in Hindi, Portuguese and Thai.

Evidence-based guidance was developed for selected essential primary health-care interventions against noncommunicable

diseases in resource constrained settings. Building on guidance developed earlier on applicable and feasible interventions, the focus during the biennium was on cost-effective interventions, so-called best-buys, which are likely to have a high impact, and are being scaled-up quickly in low-resource settings. A noncommunicable diseases research agenda was developed, with a special focus on low- and middle-income countries, and disseminated to all countries in order to provide guidance on prioritizing, capacity building and conducting research on non-communicable diseases in support of its implementation.

Engaging an international multidisciplinary group of experts from low-, middle- and high-income countries was critical in producing evidence-based guidelines. The main difficulty was developing meaningful guidance for settings with wide socioeconomic and cultural variations in different countries. Adaptation and contextualisation of guidelines for individual countries was crucial in overcoming such difficulties.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
3.4.1 Availability of evidence-based guidance on the effectiveness of interventions for the management of selected mental, behavioural or neurological disorders including those due to use of psychoactive substances.	8 interventions published and disseminated	12 interventions published and disseminated	12 interventions published and disseminated
3.4.2 Availability of evidence-based guidance or guidelines on the effectiveness or cost-effectiveness of interventions for the prevention and management of chronic noncommunicable diseases.	4 interventions published and disseminated	5 interventions published and disseminated	6 interventions published and disseminated

3.5

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

Partly Achieved

Countries are becoming increasingly aware of the importance of establishing multisectoral population-wide violence and injury prevention programmes. Demand for guidance and support has been greatest in the areas of road traffic injury prevention, child maltreatment prevention, and drowning. Initiatives to prevent violence against women remain scarce.

The target number of 14 violence and injury prevention guidelines published and widely disseminated was achieved. Several new guidelines were published and widely disseminated. These included *Preventing intimate partner and sexual violence against women: taking action and generating evidence*, *Burn prevention: success stories and lessons learned* and *Mobile phone use: a growing problem of driver distraction*. In addition to direct country support, capacity building for violence and injury prevention included the launch of a series of interactive webinars and TEACH-VIP E-Learning, a comprehensive curriculum for self-paced, self-administered training online.

In the area of mental health, technical assistance and documents were provided for the initiation of community-based projects to reduce suicides and suicidal behaviours. Some 21 Member States have initiated community-based projects to prevent suicides. WHO provided technical support to Brazil, Ethiopia, Fiji, India, Jordan, the Lao People's Democratic Republic, Nigeria, Panama, Thailand, Tonga and Vanuatu, including for the Fourth Asia Pacific Regional Conference of the International Association for Suicide Prevention and the Second Asia Pacific Regional Conference on Psychosocial Rehabilitation, as well as the Twenty-sixth World Congress of the International Association for Suicide Prevention, held in Beijing in 2011.

In the area of blindness and deafness, 78 Member States are including multisectoral approaches in their policies and plans as evidenced by the effort being made to eliminate trachoma and onchocerciasis. WHO has provided technical assistance to assist Member States incorporate multisectoral approaches in national policies and plans. Such approaches have been specifically discussed at national, regional and global meetings convened by the Secretariat.

While progress has been made in most areas, this Organization-wide expected result was assessed to have been "partly achieved" because the number of Member States implementing strategies recommended by WHO for the prevention of hearing or visual impairment did not meet the expected target. A detailed review in 2011 revealed that the initial target was too ambitious, so both the baseline and target were increased by about 30%. The situation arose as a result of further refinement of the criteria and methods used for measuring this indicator, which led to a reduction in the number of Member States assessed as having met the more stringent criteria, as well as the original target not being met.

The multisectoral action required for implementing policies in all these technical areas calls for long-term commitment by all partners, which is difficult to elicit. Articulating and measuring the benefits to be derived from entities outside the health sector engaging in public health is crucial and strong political support for such approaches is important. Better dissemination of success stories would be valuable.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
3.5.1 Number of guidelines published and widely disseminated on multisectoral interventions to prevent violence and unintentional injuries.	10	14	15
3.5.2 Number of Member States that have initiated community-based projects during the biennium to reduce suicides.	17	21	21
3.5.3 Number of Member States implementing strategies recommended by WHO for the prevention of hearing or visual impairment.	88	100	78

3.6

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

Fully Achieved

Technical support continued to be provided to Member States for trauma-care planning and policies and for improving the quality of trauma care. Systems for pre-hospital and hospital-based care for the injured have been established in 70 Member States, largely through WHO's efforts in developing trauma-care guidance. WHO published *Strengthening care for the injured: success stories and lessons learned from around the world*, which documents recent efforts to strengthen care for the injured in a variety of global settings in order to inspire other countries. Two short courses on trauma care system planning and quality improvement were designed, piloted and offered to several countries to help build their capacity. WHO took steps to build consensus on creating a global alliance for the care of the injured, following a request from the 2009 Global Trauma Care Forum held in 2009 in Rio de Janeiro.

The WHO community-based rehabilitation guidelines were developed in collaboration with numerous Member States. After being field tested in 29 countries, they were launched in Asia, Europe and Latin America. WHO provided specific support to community-based rehabilitation programmes in 34 countries and established regional community-based rehabilitation networks covering 86 countries in three regions.

In the area of mental health, eight additional countries have completed an assessment of their mental health systems in the past biennium so that 78 country reports are now available on the mental health evidence and research web site. Technical support was provided in the form of country visits and dissemination of documents for adaptation.

Some 36 countries in all regions are adopting integrated primary health-care strategies for screening for cardiovascular risk and for the integrated management of noncommunicable diseases using WHO guidance. A few have developed plans for national scale-up. Some countries have begun to include essential interventions for noncommunicable diseases in basic health-care packages and to explore innovative mechanisms for financing them.

Progress has been made in providing tobacco cessation support in primary health care in countries during the biennium. According to the *WHO report on the global tobacco epidemic, 2011*, 65 Member States provide tobacco cessation support in primary health care, and at least some cost coverage for tobacco dependence treatment. Training courses for primary health-care providers on brief tobacco interventions and on developing and improving national toll-free tobacco quit line services were conducted in a number of countries.

The WHO manual, *Developing and improving national toll-free tobacco quit-line services* was published and widely disseminated. The WHO capacity building training package for strengthening primary health-care systems for treating tobacco dependence was developed and field tested. Technical assistance was provided for the development of guidelines on demand reduction measures for tobacco dependence and cessation in connection with implementation of Article 14 of the WHO Framework Convention on Tobacco Control, which were adopted by the Conference of Parties (COP) at its fourth session in November 2010.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
3.6.1 Number of Member States that have incorporated trauma-care services for victims of injuries or violence into their health-care systems using WHO trauma-care guidelines.	22	27	70
3.6.2 Number of Member States implementing community-based rehabilitation programmes.	29	34	34
3.6.3 Number of low- and middle-income Member States that have completed an assessment of their mental health systems using the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS).	72	80	80
3.6.4 Number of low- and middle-income Member States implementing primary health-care strategies for screening of cardiovascular risk and integrated management of noncommunicable diseases using WHO guidelines.	51	26 ¹	36
3.6.5 Number of Member States with tobacco cessation support incorporated into primary health care.	55	40	65

SUMMARY OF FINANCIAL IMPLEMENTATION

The approved budget for strategic objective 3 was US\$ 146 million, mainly for Base programmes. Available funding by the mid-term was US\$ 112 million (77% of the approved Programme budget). Implementation as at 31 December 2011 was US\$ 97 million corresponding to 67% of the approved budget and 87% of the available resources.

All major offices, except the Regional Offices for South-Asia and the Eastern Mediterranean, had greater than 70% of funds available against the Programme budget.

The main reason for the low percentage is that resource mobilization for addressing noncommunicable conditions remains difficult. It is hoped that this will change thanks to the strong political commitment in the aftermath of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases.

When looking at expenditure as a percentage of the approved budget, all major offices, with the exception of headquarters, have an implementation of less than 80%. This is because

cause financing did not match the approved budget (pls add). Expenditure against funds available was well over 80% in all major offices.

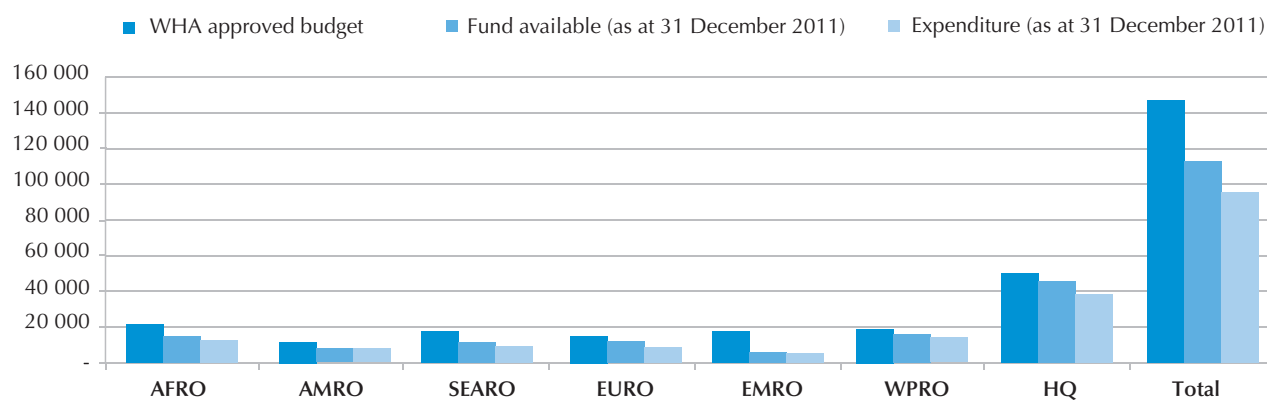
It should be noted that most funds for the strategic objective are specified, not flexible, and, therefore, cannot easily be used to fill gaps across budget centres. Additional fundraising is needed to ensure full implementation of the Programme budget and adequate carry-over for the next biennium.

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.

All Segments

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	19 444	9 180	16 603	14 674	17 594	20 261	48 193		145 949
Funds Available									
AC	8 179	3 863	6 612	2 290	2 520	5 129	9 259		37 852
VC	5 624	3 408	3 325	10 274	4 322	10 843	36 249	360	74 405
Total	13 803	7 271	9 937	12 563	6 842	15 972	45 508	360	112 256
Funds Available as % of approved budget	71%	79%	60%	86%	39%	79%	94%		77%
Expenditure	12 261	7 072	8 917	10 508	6 147	13 903	38 731		97 540
Expenditure as % of approved budget	63%	77%	54%	72%	35%	69%	80%		67%
Expenditure as % of funds available	89%	97%	90%	84%	90%	87%	85%		87%



REFERENCE

- 1 The original baseline of 51 was arrived at before the availability of survey data, based on the global capacity assessment survey which provided more reliable data the target had to be revised to 26.

DETAILS OF INDICATOR ACHIEVEMENT

3.1.1 African Region: Angola, Benin, Botswana, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Niger, Nigeria, Sao Tome and Principe, Seychelles, South Africa, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Antigua and Barbuda, Argentina, Bahamas, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Saint Lucia, Trinidad and Tobago, United States of America, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Bahrain, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Oman, Pakistan, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, United Arab Emirates, Yemen. **European Region:** Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand. **Western Pacific Region:** Australia, Brunei Darussalam, Cambodia, China (People's Republic of), Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, New Zealand, Palau (Republic of), Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Tonga, Vanuatu, Viet Nam.

3.1.3 African Region: Algeria, Eritrea, Ghana, Lesotho, Senegal, Seychelles, United Republic of Tanzania. **Region of the Americas:** Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Brazil, Canada, Chile, Costa Rica, Cuba, Dominica, Ecuador, Grenada, Guatemala, Honduras, Jamaica, Panama, Peru, Suriname, United States of America, Uruguay. **Eastern Mediterranean Region:** Bahrain, Egypt, Iran (Islamic Republic of), Jordan, Lebanon, Morocco, Oman, Saudi Arabia, Syrian Arab Republic, Tunisia. **European Region:** Albania, Andorra, Armenia, Austria, Azerbaijan, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, The former Yugoslav Republic of Macedonia, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Democratic People's Republic of Korea, Maldives, Thailand. **Western Pacific Region:** Australia, China (People's Republic of), Fiji, Japan, Kiribati, Malaysia, Mongolia, New Zealand, Philippines, Republic of Korea, Singapore.

3.1.4 African Region: Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Ghana, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Suriname, Trinidad

and Tobago, United States of America, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen. **European Region:** Andorra, Armenia, Austria, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Ireland, Italy, Kazakhstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Republic of Moldova, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, The former Yugoslav Republic of Macedonia, Turkey, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Cambodia, China (People's Republic of), Cook Islands, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, Niue, Palau (Republic of), Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

3.2.1 African Region: Benin, Burkina Faso, Burundi, Cameroon, Cap Verde, Chad, Congo, Côte d'Ivoire, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Ghana, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Niger, Nigeria, Rwanda, Seychelles, Sierra Leone, South Africa, United Republic of Tanzania, Zambia. **Region of the Americas:** Argentina, Bahamas, Belize, Brazil, Canada, Chile, Colombia, Costa Rica, El Salvador, Guatemala, Honduras, Jamaica, Mexico, Nicaragua, Panama, Peru, United States of America, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Bahrain, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Lebanon, Libya, Morocco, Oman, Saudi Arabia, Sudan, Syrian Arab Republic, United Arab Emirates. **European Region:** Albania, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Malta, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand. **Western Pacific Region:** Australia, Cambodia, China (People's Republic of), Cook Islands, Fiji, Japan, Lao People's Democratic Republic, Malaysia, New Zealand, Papua New Guinea, Philippines, Republic of Korea, Tonga, Vanuatu, Viet Nam.

3.2.2 African Region: Cap Verde, Eritrea, Ethiopia, Gambia, Ghana, Lesotho, Mauritania, Namibia, Nigeria, Sierra Leone, South Africa, Uganda, Zambia. **Region of the Americas:** Antigua and Barbuda, Argentina, Barbados, Belize, Chile, Dominican Republic, Grenada, Nicaragua, Paraguay, Trinidad and Tobago. **Eastern Mediterranean Region:** Egypt, Tunisia. **European Region:** Albania, Armenia, Bosnia and Herzegovina, Bulgaria, Croatia, Latvia, Montenegro, Republic of Moldova, Romania, Serbia, Slovakia, The former Yugoslav Republic of Macedonia. **South-East Asia Region:** Bangladesh, India, Nepal, Sri Lanka, Thailand. **Western Pacific Region:** China (People's Republic of), Cook Islands, Fiji, Kiribati, Lao People's Democratic Republic, Marshall Islands, Micronesia (Federated States of), Nauru, Palau (Republic of), Papua New Guinea, Samoa, Solomon Islands, Tonga, Vanuatu.

3.2.3 African Region: Algeria, Benin, Burundi, Cap Verde, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gabon, Ghana, Kenya, Madagascar, Mali, Mauritania, Mauritius, Mozambique, Nigeria, Seychelles, South Africa, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Barbados, Bolivia (Plurinational State of), Brazil, Canada, Chile, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Jamaica, Mexico, Panama, Paraguay, Peru, Saint Lucia, Trinidad and Tobago, United States of America, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Bahrain, Egypt, Iraq, Lebanon, Oman, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia. **European Region:** Armenia, Belarus, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Poland, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Sweden, Tajikistan, The former Yugoslav Republic of Macedonia, United Kingdom of Great Britain and Northern Ireland. **South-East Asia Region:** Bangladesh, Bhutan, Democratic

People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Cambodia, Cook Islands, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, Niue, Palau (Republic of), Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

3.2.4 African Region: Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, Ghana, Mali, Mozambique, Niger, Rwanda, Seychelles. **Region of the Americas:** Argentina, Belize, Brazil, Canada, Colombia, Cuba, Dominica, Guatemala, Guyana, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Lucia, United States of America, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Bahrain, Iran (Islamic Republic of), Jordan, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, **South-East Asia Region:** Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, China (People's Republic of), Lao People's Democratic Republic, Mongolia, Papua New Guinea, Philippines, Solomon Islands, Viet Nam.

3.3.1 African Region: Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Congo, Democratic Republic of the Congo, Eritrea, Ethiopia, Gambia, Ghana, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Nigeria, Niger, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States of America, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Bahrain, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen. **European Region:** Albania, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Malta, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Brunei Darussalam, Cambodia, China (People's Republic of), Cook Islands, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, New Zealand, Palau (Republic of), Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

3.3.2 African Region: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States of America, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen. **European Region:** Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Republic

of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Brunei Darussalam, Cambodia, China (People's Republic of), Cook Islands, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, New Zealand, Niue, Palau (Republic of), Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

3.3.3 African Region: Algeria, Angola, Botswana, Burkina Faso, Cap Verde, Central African Republic, Comoros, Côte d'Ivoire, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Lesotho, Madagascar, Malawi, Mauritania, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Antigua and Barbuda, Argentina, Belize, Bolivia (Plurinational State of), Brazil, Chile, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Trinidad and Tobago, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Lebanon, Morocco, Pakistan, Syrian Arab Republic, Tunisia. **European Region:** Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Montenegro, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Ukraine, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, China (People's Republic of), Cook Islands, Fiji, Kiribati, Malaysia, Micronesia (Federated States of), Mongolia, Niue, Philippines, Samoa, Tonga, Vanuatu, Viet Nam.

3.3.4 African Region: Democratic Republic of the Congo, Gabon, Ghana, Guinea, Kenya, Lesotho, Madagascar, Malawi, Mauritania, Mauritius, Niger, Senegal, United Republic of Tanzania, Zambia. **Region of the Americas:** Belize, Brazil, Canada, Costa Rica, Cuba, El Salvador, Guyana, Jamaica, Mexico, Nicaragua, Paraguay, Trinidad and Tobago, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Bahrain, Djibouti, Iraq, Kuwait, Lebanon, Libya, Oman, Saudi Arabia, Tunisia, United Arab Emirates. **European Region:** Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Finland, France, Georgia, Germany, Hungary, Italy, Kazakhstan, Latvia, Lithuania, Luxembourg, Malta, Montenegro, Netherlands, Poland, Republic of Moldova, Romania, Russian Federation, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand. **Western Pacific Region:** Australia, Brunei Darussalam, China (People's Republic of), Cook Islands, Fiji, Japan, Kiribati, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, New Zealand, Philippines, Republic of Korea, Tonga, Tuvalu, Viet Nam.

3.3.5 African Region: Benin, Burkina Faso, Cameroon, Eritrea, Ghana, Mali, Niger, Rwanda, Togo, United Republic of Tanzania. **Region of the Americas:** Argentina, Barbados, Brazil, Chile, Colombia, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Mexico, Paraguay, Peru, Saint Lucia, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Iraq, Jordan, Libya, Saudi Arabia, Sudan, Yemen. **South-East Asia Region:** Bangladesh, Bhutan, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, China (People's Republic of), Fiji, Lao People's Democratic Republic, Philippines, Viet Nam.

3.5.1 The list guidelines produced during this reporting period are available upon request.

3.5.2 African Region: South Africa. **Region of the Americas:** Belize, Guyana, Nicaragua, Uruguay. **European Region:** Finland, France, Hungary, Ireland, Kyrgyzstan, Latvia, Norway, Republic of Moldova, Sweden, Uzbekistan. **South-East Asia Region:** India, Sri Lanka. **Western Pacific Region:** China (People's Republic of), Fiji, Tonga, Vanuatu.

3.5.3 African Region: Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Congo, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Ghana, Madagascar, Malawi, Mozambique, Namibia, Rwanda, Sao Tome and Principe, Seychelles, United Republic of Tanzania, Zambia. **Region of the Americas:** Argentina, Barbados, Belize, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Bahrain, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Morocco, Oman, Pakistan, Saudi Arabia. **South-East Asia Region:** Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Cambodia, China (People's Republic of), Fiji, Lao People's Democratic Republic, Mongolia, Papua New Guinea, Philippines, Solomon Islands, Viet Nam.

3.6.1 African Region: Algeria, Benin, Cap Verde, Chad, Ethiopia, Ghana, Liberia, Madagascar, Mali, Mauritania, Mauritius, Mozambique, Niger, Rwanda, Senegal, Sierra Leone, South Africa, Uganda, United Republic of Tanzania, Zambia. **Region of the Americas:** Argentina, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Saint Lucia, Suriname, Trinidad and Tobago, United States of America, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Iran (Islamic Republic of), Iraq, Saudi Arabia, Sudan, Syrian Arab Republic. **European Region:** Azerbaijan, Belarus, Bulgaria, Croatia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Romania, Serbia, Slovakia, The former Yugoslav Republic of Macedonia, Turkey. **South-East Asia Region:** Bhutan, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand. **Western Pacific Region:** Kiribati, Mongolia, Viet Nam.

3.6.2 African Region: Burkina Faso, Ethiopia, Ghana, Kenya, Malawi, Niger, South Africa, Uganda, United Republic of Tanzania, Zimbabwe. **Region of the Americas:** Costa Rica, Guyana, Mexico, Nicaragua. **Eastern Mediterranean Region:** Egypt, Iran (Islamic Republic of), Lebanon, Pakistan. **South-East Asia Region:** Bangladesh, Bhutan, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, China (People's Republic of), Lao People's Democratic Republic, Mongolia, Papua New Guinea, Philippines, Viet Nam.

3.6.3 African Region: Benin, Burundi, Congo, Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, Ghana, Kenya, Mozambique, Nigeria, Rwanda, Seychelles, South Africa, Uganda, Zambia. **Region of the Americas:** Antigua and Barbuda, Argentina, Belize, Bolivia (Plurinational State of), Brazil, Chile, Costa Rica, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Uruguay. **Eastern Mediterranean Region:** Afghanistan, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Lebanon, Morocco, Pakistan, Somalia, Sudan, Syrian Arab Republic, Tunisia. **European Region:** Albania, Armenia, Azerbaijan, Georgia, Kyrgyzstan, Latvia, Republic of Moldova, Tajikistan, The former Yugoslav Republic of Macedonia, Ukraine, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, India, Maldives, Myanmar, Nepal, Thailand, Timor-Leste. **Western Pacific Region:** China (People's Republic of), Fiji, Lao People's Democratic Republic, Mongolia, Philippines, Viet Nam.

3.6.4 Eastern Mediterranean Region: Bahrain, Iraq, Jordan, Kuwait, Oman, Qatar, Tunisia. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, China (People's Republic of), Cook Islands, Fiji, Kiribati, Lao People's Democratic Republic, Malaysia, Micronesia (Federated States of), Mongolia, Nauru, Niue, Palau (Republic of), Philippines, Samoa, Tonga, Tuvalu, Vanuatu, Viet Nam.

3.6.5 African Region: Lesotho, Nigeria, United Republic of Tanzania. **Region of the Americas:** Argentina, Brazil, Canada, Costa Rica, Cuba, Ecuador, Jamaica, Panama, Paraguay, United States of America, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Bahrain, Egypt, Iran (Islamic Republic of), Jordan, Kuwait, Saudi Arabia, United Arab Emirates. **European Region:** Austria, Belarus, Belgium, Bulgaria, Croatia, Czech Republic, Denmark, Finland, France, Germany, Hungary, Ireland, Israel, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Serbia, Slovenia, Spain, Sweden, Switzerland, Turkey, Turkmenistan, United Kingdom of Great Britain and Northern Ireland. **South-East Asia Region:** Democratic People's Republic of Korea, Thailand. **Western Pacific Region:** Australia, Brunei Darussalam, Cook Islands, Japan,

Malaysia, New Zealand, Palau (Republic of), Papua New Guinea, Republic of Korea, Singapore, Solomon Island.

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



ASSESSMENT OF THE ORGANIZATION-WIDE EXPECTED RESULTS

Of the eight Organization-wide expected results for this strategic-objective, six were «fully achieved» and two «partly achieved».

Overview

Action in the political arena was significantly accelerated towards the attainment of Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health). The launching of the United Nations Secretary-General's Global Strategy for Women's and Children's Health in 2010 and the related Commission on Information and Accountability in 2011 marked the high-level political commitment and created additional momentum towards reaching these goals. The Countdown to 2015 also tracks progress towards achievement of the two Millennium Development Goals; WHO serves on its coordinating committee.

Throughout the biennium, emphasis on partnership has been intensified. Commitments made by the G8 group of countries at the summit in Muskoka, Canada, in June 2010,

resulted in significant financial commitments for the joint work of several United Nations partners, including WHO, UNICEF, UNFPA, the World Bank, UNAIDS and UNWomen.

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

4.1

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

Fully Achieved

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

Although national health policies and strategies are moving towards integration, translating this integration into service delivery is complex and demanding. In support of the United Nations Secretary-General's Global Strategy for Women's and Children's Health, WHO placed particular emphasis on supporting policies for integrated service delivery across the life course, approaches to removing barriers to accessing such services, and methods for maintaining or improving the quality of the care provided.

Substantial progress was made in the area of maternal, child and adolescent health during the biennium. All regions have developed or updated their strategies for maternal, newborn and child health, and technical support has been provided for developing or revising relevant policies and strategies in countries.

In the African Region alone, WHO supported 12 countries in reviewing their road maps for maternal and newborn health, and 36 out of 46 countries have prepared comprehensive national strategies with support from WHO. Short programme reviews were conducted in countries in several regions as a means of improving national strategies.

Tools such as the Lives Saved Tool (LiST) and costing tools – most recently OneHeath – have further supported the development of national strategies, particularly in the South-East Asia and Western Pacific Regions. The OneHealth tool for strategic planning was finalized in 2011 and capacity in its use built through workshops at headquarters level, with regional and country participation, and in the Regional Office for the Western Pacific. Three of the workshops focused on maternal

and child health. As part of efforts to build capacity in strategic planning, a workshop on LiST was also conducted at headquarters, with regional and country participation, which was followed up in the Western Pacific Region with work in Solomon Islands. The short programme review methodology covering both maternal and child health was further disseminated and integrated.

In general, progress was made in developing national strategies to achieve universal access to reproductive health services, as well as norms, tools and action plans, especially in relation to improving family planning coverage. Several countries also focused on preparing policy documents and legal frameworks to prevent gender-based violence, and others, particularly in the European Region, formulated sexual health policies. Strategies to prevent cervical cancer and unsafe abortion were also developed. Some countries initiated work on infertility and on the prevention of cervical cancer and unsafe abortion.

Technical support was provided to three countries in the African Region for developing national reproductive health strategic plans for 2010–2014. In addition 12 countries in the Region formulated or adapted national reproductive health or family planning policies, norms and guidelines. A total of 10 countries in the Region of the Americas, five countries in the Eastern Mediterranean Region, four countries in the European Region, 10 countries in the South-East Asia Region and four countries in the Western Pacific Region received support to prepare policies on universal access to sexual and reproductive health.

At global and regional levels, regional frameworks were developed in some regions, aligned with the WHO global reproductive health strategy; in others, the strategy was used to support the development of policies and strategies. Progress towards international development targets in reproductive health was monitored at the Health Assemblies, Regional Committees and related meetings in order to identify where support was needed. The ongoing development and updating of normative guidance products has contributed towards improving the quality of existing policies and plans.

A regional framework for the elimination of paediatric HIV infections and congenital syphilis was drawn up by WHO and its partners in the African Region, with the participation of the Prevention of Parent to Child Transmission (PPTCT) Task Force, the Regional Offices for South-East Asia and the Western Pacific, and government counterparts. Certain countries in Central and Eastern Europe have analysed the integration of HIV and sexual and reproductive health services, focusing on people living with HIV and other key populations.

A total of 72 Member States reported having integrated policies on access to maternal, newborn and child health services, and 63 to sexual and reproductive health services. The majority of these policies were formulated with input and support from WHO. Indicator targets were generally achieved, and in some cases exceeded. Effective collaboration between relevant WHO programmes, between headquarters and regional offices, and with external partners helped in achieving the targets in spite of the limited funding available in this area. Collaboration among

programmes, particularly maternal and child health and health systems at all levels, as well as with external partners, was an important factor in providing high-quality country support. The presence of technical staff in WHO country offices was another facilitating factor. Increased advocacy for political commitment resulted in increased investment by Member States.

However, the provision of technical support for policy and strategy development is dependent on requests from countries and not all countries were ready to develop or revise their policies. Furthermore, the formulation of maternal and child health policies is often not synchronized with national health planning processes. Data and information tend to be lacking in countries as a result of poor health information systems.

WHO continued to advocate for the development, revision and updating of maternal, newborn and child health policies in synchronicity with national health planning processes; it continues to collaborate closely with health-system programmes.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
4.1.1 Number of targeted Member States that have an integrated policy on universal access to effective interventions for improving maternal, newborn and child health.	20	40	72
4.1.2 Number of Member States that have developed, with WHO support, a policy on achieving universal access to sexual and reproductive health.	30	40	63

4.2

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

Fully Achieved

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

To define research priorities for maternal, newborn and child health, WHO and the Alliance for Health Policy and Systems Research convened 11 workshops in the African, Eastern Mediterranean and Western Pacific Regions. An important outcome was a shift in emphasis from clinical research to operations research, with the aim of improving delivery mechanisms for, and removing barriers to access to, effective interventions.

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

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

In the African Region, Benin, Ethiopia, Mali and Senegal, among others, used the results from a study to assess the status of oral rehydration therapy in order to improve strategies for the control of diarrhoea. In the Eastern Mediterranean Region, research was conducted on the management of poisoning in children.

In the South-East Asia Region, research carried out in India supported promotion of the integrated management of neonatal and childhood illness strategy and of using zinc in the management of diarrhoea.

In the Western Pacific Region, the countries that conducted research on maternal and child health issues then used the results in improving the quality of health-care delivery (Lao People's Democratic Republic, Mongolia, Philippines and Viet Nam).

WHO supported eight countries in the African, Eastern Mediterranean and South-East Asia Regions in identifying pri-

orities for research on how to increase coverage of maternal, newborn and child health interventions. A multi-centre study is being supported in the Democratic Republic of Congo, Kenya, and Nigeria to inform policy on the management of neonatal infections. Another multi-centre study, in Ghana and Tanzania, received support to inform policy on neonatal supplementation with vitamin A.

In the Eastern Mediterranean Region, support was provided for the design and implementation of studies in Afghanistan, Lebanon and Pakistan.

In the South-East Asia Region, technical assistance was provided for developing research proposals on child and adolescent health in India and Indonesia. Studies being carried out in Bangladesh and India on newborn, child and adolescent health interventions have also received support. Four sets of guidelines on improved newborn care were drawn up; a set of guidelines on care of newborns and children at first-level referral facilities was updated; and new guidelines were developed on the prevention of pregnancy among adolescent girls. Over 20 systematic reviews and assessments of the available information using the GRADE process were produced to provide the evidence base in order to secure approval of the guidelines by the WHO Research Ethics Review Committee. Guidelines were disseminated and incorporated into training materials and manuals for country use at community, first-level health facility and referral level.

Globally, for the first time in a number of years, estimates of maternal mortality showed a significant decline. The use of essential maternal health services also increased. These changes are documented in the 2010 Progress report on the reproductive health strategy for accelerating progress towards the attainment of international development goals and targets. The report highlights major public health changes at country level following adoption of the strategy by the World Health Assembly (resolution WHA57/12). It report provides information on the progress made by 57 member states in five key action areas: 1) Strengthening health systems capacity; 2) Improving information for priority setting; 3) Mobilizing political will; 4) Creating supportive legislative and regulatory frameworks; and 5) Strengthening monitoring, evaluation and accountability.

In the African and Eastern-Mediterranean Regions, WHO supported 14 centres through long-term institutional develop-

ment grants, and involved eight centres in research projects addressing regional and national reproductive health priorities.

In the Region of the Americas, three new research projects focusing on violence against women, medical abortion and the consequences of anaemia in pregnancy received funding.

In the South-East Asia and Western Pacific Regions, several capacity building activities were carried out, focusing on research methodology in sexual and reproductive health, research ethics and data analysis. Specific grants supported efforts to document improvements in the quality of care through integration of sexual and reproductive health in programmes at primary health-care level.

The Regional Office for South-East Asia also supported four collaborating centres in drawing up guidelines on the management of infertility at primary care level. In the European Region, WHO established a regional training centre for operations research, which carries out training in Russian and English for countries requesting assistance, and monitors the development of operations research project proposals. In the Western Pacific Region, Malaysia received support to conduct a knowledge, attitude and practice (KAP) study on abortion. Eight policy briefs, 42 technical publications, including new and updated guidelines, and more than 100 peer-reviewed scientific publications represent the cumulative output of the Secretariat at global level. Significant highlights include: the publication of the Kesho Bora study showing that antiretroviral treatment reduces the risk of infection in breastfed infants of mothers with HIV; guidelines on safe abortion care; prevention of violence against women; and treatment and management

of major causes of maternal mortality and morbidity, such as postpartum haemorrhage and preeclampsia. The delivery of a positive statement by a specially convened expert group on the safety of hormonal contraception in connection with the risk of HIV infection after observations reported in the scientific literature had generated serious and widespread concerns within the international community represented a valuable contribution. Research results were presented in regional and global congresses and conferences.

Collaboration between WHO programmes, such as the that with the health systems unit in the Regional Office for the Western Pacific, served to enhance support for the formulation of policies and strategies on universal access to reproductive health services. Similarly, collaboration between headquarters and the regions encouraged the introduction of new evidence and tools in regions and countries. In this area, collaboration with external partners was also important, including with international organizations such as UNFPA, UNICEF and the World Bank, and nongovernmental and professional organizations. Some challenges were met through the provision of technical support for relevant policy and strategy development, bearing in mind that such support is dependent on requests from countries and not all countries are ready to incorporate comprehensive sexual and reproductive health policies. The lower priority accorded to this area and its sensitive nature might also have prevented full implementation of the WHO Global Strategy in countries. A further challenge was a lack of data and information in countries owing to poor health information systems. Activities, including advocacy based on research evidence, as well as collaborative efforts and partnerships, have helped to overcome some obstacles.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
4.2.1 Number of research centres that have received an initial grant for comprehensive institutional development and support.	8	8	12
4.2.2 Number of completed studies on priority issues that have been supported by WHO.	16	28	60
4.2.3 Number of new or updated systematic reviews on best practices, policies and standards of care for improving maternal, newborn, child and adolescent health, promoting active and healthy ageing or improving sexual and reproductive health.	20	40	89

4.3

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

Fully Achieved

Overall, the estimated annual number of maternal deaths worldwide declined by 34% between 1990 and 2008. The annual rate of reduction of 2.3% in estimated maternal mortality ratios (MMRs) over the past two decades (1990–2008) remained well below the rate required to reach Millennium Development Goal 5. The average maternal mortality ratio in developing countries is 290 per 100 000 live births, while in developed countries it is 14 per 100 000 live births. In the European, South-East Asia and Western Pacific Regions, estimated maternal mortality ratios have fallen by 50% or more. The African Region continues to have the highest maternal mortality ratio (620 per 100 000 live births), which is more than 44 times the average maternal mortality ratio in more developed regions.

The United Nations Secretary-General's Global Strategy for Women's and Children's Health and the recommendations of the Commission on Information and Accountability have served to strengthen advocacy, resource mobilization, accountability and partnerships, in addition to existing activities that support health systems strengthening to improve maternal health, at regional and national level. The number of Member States implementing strategies for increasing coverage with skilled care for childbirth has increased from 25 in 2010 to 66 at the end of the biennium. Globally, the proportion of births attended by a skilled health practitioner increased from 58% to 68% between 1990 and 2008. Ongoing armed conflicts in some countries continue to challenge efforts to reduce maternal mortality and morbidity.

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

Country-specific support was provided to improve ma-

ternal health, including the introduction of the "Beyond the Numbers" methodology on analysis of maternal mortality and morbidity, the development and updates of national guidelines based on the WHO Integrated Management of Pregnancy and Childbirth guidelines, training courses, maternal mortality reviews estimating resource requirements, and programme reviews. The Campaign on Accelerated Reduction of Maternal Mortality was launched in 34 African countries. Updated guidelines were disseminated widely through WHO offices and partners. The focus has increasingly been on improving the quality of care and on maternal death surveillance and response. Global, regional and inter-country workshops were held to review progress and update strategies and plans.

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

High quality WHO tools continue to attract the interest of ministries of health. There is also a willingness among partners to support the development, updating, dissemination and implementation of such tools. The United Nations Secretary-General's Global Strategy for Women's and Children's Health and follow-up activities have led to renewed efforts to improve maternal health. The collaboration between the international organizations known as the H4 + has also helped mobilize resources and support implementation. However, there are insufficient human and financial resources at all levels of the Organization to meet all the requests from Member States for technical support. In order to address this, WHO has improved the prioritization of activities and enhanced the harmonization of tools and approaches among partners.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
4.3.1 Number of Member States implementing strategies for increasing coverage with skilled care for childbirth.	25	50	66

4.4

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

Fully Achieved

Neonatal mortality rates are declining in all regions and fewer newborn infants are dying worldwide than ever before, but there are major regional variations. The largest reduction in neonatal mortality rates was in low- and middle-income countries in the Region of the Americas and the European and Western Pacific Regions. While there was a noticeable decline among low- and middle-income countries in the South-East Asia Region, overall rates remained high. The smallest decline in neonatal mortality was in low- and middle-income countries in the African and Eastern Mediterranean Regions. The proportion of child deaths during the neonatal period increased in all regions, with the largest relative increase in the European, South-East Asia and Western Pacific Regions. In all regions, except the African Region, newborn deaths represented more than 40% of all early childhood deaths. In response to this epidemiological shift, national governments, international agencies and civil society have focused attention on newborn health. Given the close links between neonatal mortality and morbidity and the health of the mother and the care provided to her at the time of birth, progress towards increasing coverage of skilled care at birth should be taken into account. In many countries and regions this has drawn attention to the need to address inequities within regions and countries in access to care for maternal and perinatal health, as well as to the quality of the care provided.

The Secretariat provided technical support to countries for policies, planning and programme development for newborn health. The main focus was on four areas: (1) an integrated approach to strengthen the neonatal health component within maternal and child health programmes; (2) implementation of essential newborn care as part of the Integrated Management of Pregnancy and Childbirth guidelines; (3) promotion of Integrated Management of Childhood Illness and its newborn component; and (4) promotion of caring for the newborn at home.

Demonstrating a change in policy, newborn health was explicitly addressed in most Road Maps for accelerating the attainment of the Millennium Development Goals related to Maternal and Newborn health in the African Region, where 35 countries, in addition to a further 10 in the Western Pacific Region, have adapted their national Integrated Management of Childhood Illness (IMCI) strategies to include the first week of life.

In the Region of the Americas, technical cooperation was directed towards enhancing country capacity to develop and

implement national action plans on neonatal health as part of the continuum of care, while in the European Region the focus was on building the capacity of national health-system functions in order to improve maternal and perinatal health. The Regional Office for South-East Asia established a pool of country-based experts and a network of institutions to provide technical support across countries.

A key intervention package for newborn health as part of the continuum of care through pre-pregnancy, pregnancy, childbirth, postpartum, newborn care and care of the child was described in a guidance document for WHO's work in this area. WHO developed and introduced two training packages for newborn health: the Essential Newborn Care course (ENCC); and a training course for community health workers on Caring for the Newborn at Home (CNHC). Both generic versions are available in English and French. The Secretariat paid increased attention to assessing the state of neonatal health at global and regional levels. The Regional Office for the Western Pacific conducted a desk review of newborn care guidelines and began implementation in priority countries in the Region. Neonatal mortality estimates, including causes of death, are now being produced annually. In addition, WHO regularly collects information on country policies relevant to newborn health.

Country adaptations of, and capacity building activities on, the essential newborn care course received support in countries in the African and South-East Asia Regions. In the European Region, the effective perinatal health course was used to enhance essential newborn care practices; the development of national essential clinical newborn care protocols also received support. The assessment of quality of newborn care in facilities received support in the two Regions.

With WHO support, the number of Member States implementing strategies for increasing coverage of interventions for neonatal survival and health increased from 40 in 2010 to 56 at the end of the biennium. A total of 22 countries in the African Region, three countries in the South-East Asia Region and two countries in the Western Pacific Region have adapted materials on care of the newborn at home, and started implementing the new strategy of home visits for newborn care.

Work with WHO collaborating centres, involving experts with different backgrounds, including midwives, neonatolo-

gists and obstetricians, partner agencies in co-funded activities for improving newborn health, was particularly successful. The presence of three inter-country support teams in the African Region allowed timely support to be provided to countries and facilitated the organization of inter-country activities. However, insufficient human resources were available to meet countries' demands connected with newborn health. Other challenges included delays in making guidelines and tools available in languages other than English, which led to deferred country implementation, particularly in lusophone countries in the African Region, as well as in the adoption of supportive policies in some countries.

WHO headquarters and regional offices increased advocacy in order to direct greater attention towards, and investment in, newborn health, intensified collaboration with partner organizations, and established pools of consultants to increase the Organization's capacity for responding to country requests for technical assistance in newborn health. The Regional Office for the Western Pacific began country-specific situation analyses on newborn health.

INDICATOR	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
4.4.1 Number of Member States implementing strategies for increasing coverage with interventions for neonatal survival and health.	40	50	56

4.5

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

Fully Achieved

Child mortality reached an historic low of 7.6 million during the biennium. The African Region doubled its average annual rate of reduction in under-five mortality from 1.2% per year between 1990 and 2000 to 2.4% per year between 2000 and 2010. Support was provided to countries in all regions for developing or revising national strategies in order to improve the skills of health-care providers in newborn care (using WHO's essential newborn care course), and care of the newborn at home. In many countries and regions, including the African, Eastern Mediterranean, South-East Asia and Western Pacific Regions, Integrated Management of Childhood Illness (IMCI) became Integrated Management of Childhood and Newborn Illness (IMNCI) to reflect its adaptation to include the first week of life. In some regions it also includes the healthy child. IMCI remains the principal strategy for newborn and child health in all regions and has been widely adopted by partners.

WHO provided support to regions and countries for the development of policies, strategies and plans, for training, and programme reviews. Regional activities include scaling-up the IMCI computerized adaptation and training tool (ICATT) in the African Region, the Region of the Americas, and the European, South-East Asia and Western Pacific Regions. The implementation and evaluation of basic training in IMCI for doctors and nurses is being spearheaded by the Regional Office for the Eastern Mediterranean. A total of 14 countries in the European

Region embarked on systematic improvements in hospital paediatric care. Additionally, WHO provided support for improving and monitoring the quality of care given to sick children at first-level health facilities and in hospitals.

An initiative to re-prioritize the prevention and control of pneumonia and diarrhoea was supported by the Regional Offices for Africa and South-East Asia; state-of-the-art guidelines and materials to train lay community health workers in the treatment of pneumonia, diarrhoea and malaria were finalized, adapted and implemented in the African, Eastern Mediterranean, South-East Asia and Western Pacific Regions. The Regional Office for the Eastern Mediterranean developed, and began implementing a region-specific package. The Regional Office for the Americas created a course that incorporates a life-cycle approach. Based on a situation assessment, the Regional Office for South-East Asia began developing a regional framework on preventing birth defects and building the capacity of Member States. Infant and young child feeding has received increasing attention, particularly in the context of HIV infection.

Advocacy and partnership with key stakeholders was particularly successful, as was leveraging of renewed commitments by Member States to attaining Millennium Development Goal 4.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
4.5.1 Number of Member States implementing strategies for increasing coverage with child health and development interventions.	40	40	79
4.5.2 Number of Member States that have expanded coverage of the integrated management of childhood illness to more than 75% of target districts.	30	45	54

4.6

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

Partly Achieved

WHO supported Member States to carry out national situation analyses and programme reviews and to draw up strategic plans. As a result, the number of Member States with a functioning adolescent health and development programme increased from 40 at the beginning of the biennium to 74 as at the end of 2011. Within the context of multisectoral programmes the place of health service provision for adolescents was defined and strengthened; national quality standards for adolescent friendly health services were developed; training and monitoring tools were adapted; competency based training was carried out; activities aimed at achieving national quality standards were implemented; and in Ukraine an accreditation system was introduced.

A systematic review on the prevention of early pregnancy was completed and guidelines on the subject, as well as on poor reproductive outcomes among adolescents in developing countries, were produced. The Regional Office for the Americas placed particular emphasis on this age group at regional and country level.

Within the school setting, health promoting schools were set up or strengthened, the global school health survey was conducted, and situation analyses of school health service provision were carried out, accompanied by the development of road maps for implementation.

Support at country level covered, among others, the following areas: advocacy for attention to adolescents, and for the application of evidence-based approaches; dissemination of information on evidence for effective programmes; individual and institutional capacity building in both technical and programme management; policy formulation or reformulation; development of strategies, plans, norms and standards; adaptation of tools; and programme measurement.

At global and regional level, activities carried out covered: dissemination of global documents; publication and dissemination of documents outlining regional visions or strategic directions; regional mapping of the status of adolescent health and of adolescent health programmes; regional meetings on advocacy, information sharing, capacity building, reviewing progress and planning; establishment of regional networks; strengthening of regional collaboration; capacity building for human resources within integrated adolescent health and development; situation analyses in countries; and guidance on core adolescent health indicators.

During the biennium, sustained advocacy resulted in increased support for programmes, and efforts to build partnerships led to better coordination and joint activities. The use of conceptual and operational frameworks to guide the work (for example, the social determinants approach) was also helpful. However, at the country level, poor linkages between adolescent health programmes and reproductive health and HIV programmes and a lack of earmarked funding at sub-national level hampered implementation. At regional level, the absence of a regional framework to provide direction and strengthen coordination and collaboration, as well as the absence of human resources (in some regions), slowed down implementation. To address these challenges, WHO built capacity in various ways and prepared regional guidance documents. Additionally, efforts were intensified to strengthen collaboration, establish links with regional partners, including faith-based organizations, and address the shortage of resources.

Organization-wide expected result 4.6 was reported as being partly achieved by the African, Eastern Mediterranean and South Eastern Regions and headquarters mainly because of insufficient financial and human resources for providing systematic technical support to countries, especially for strategic planning and adolescent-friendly health services.

INDICATOR	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
4.6.1 Number of Member States with a functioning adolescent health and development programme.	40	50	74

4.7

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

Fully Achieved

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

Good progress was made in some countries in improving the coverage of family planning. Certain countries also incorporated norms in other areas of sexual and reproductive health, including: cervical cancer prevention; addressing unsafe abortion; management of sexually transmitted infections; eliminating vertical transmission of congenital syphilis and HIV through strengthened antenatal care services; and enhanced monitoring systems, such as perinatal information systems and monitoring fetal growth. In the African Region, numerous countries updated their family planning guidelines and the repositioning of family planning was supported through national advocacy actions. The European Region focused mainly on access to quality services at primary health-care level, and on analysis of social determinants of health.

The Secretariat supported countries to incorporate new evidence in policy and programmes and to implement evidence-based interventions. Updated norms and guidelines covered various aspects of sexual and reproductive health, including family planning (four cornerstones of family planning), maternal and perinatal health (haemorrhage and eclampsia guidelines), cervical cancer prevention, and prevention of unsafe abortion. Regional meetings discussed ways of enhancing the incorporation of effective interventions into practice through implementation research and other models, for example, WHO/ExpandNet guidance.

The indicator targets were achieved even exceeded despite limited funding. For example, the number of Member States implementing the WHO reproductive health strategy to accelerate progress towards the attainment of international development goals and targets increased from 30 at the beginning of the biennium to 60 by the end of 2011. It was noted that some target indicator definitions were not uniform across regions, especially for 4.7.1. The standard definition should include implementation of recommended actions in at least four of the five topics in WHO reproductive health strategy. Future measurements will highlight this common definition.

Collaboration among WHO programmes, external partners and between headquarters and regional offices was enhanced. The WHO reproductive health strategy and its implementation framework provided a blueprint for effective policies and practices. Close monitoring of the global strategy and the sharing of the questionnaire survey used for this purpose helped attract attention to issues and gaps. A renewed thrust in family planning and the repositioning of family planning within overall reproductive health increased its visibility.

The uncertainty and limitations of funding, leading to the abolition of staff positions in some regions, posed a challenge; the politically and culturally sensitive nature of some of the topics, such as unsafe abortion, adolescent sexual and reproductive health and sexual health, further hampered full implementation of the broad sexual and reproductive health actions. Advocacy activities based on evidence and enhancing partnerships were carried out in all regions in order to overcome obstacles. Continuous advocacy for universal access to integrated sexual and reproductive health services and for sustainable funding is needed.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
4.7.1 Number of Member States implementing the WHO reproductive health strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health agreed at the 1994 International Conference on Population and Development (ICPD), its five-year review (ICPD+5), the Millennium Summit and the United Nations General Assembly in 2007.	30	40	60
4.7.2 Number of targeted Member States having reviewed their existing national laws, regulations or policies relating to sexual and reproductive health.	8	12	20

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 throughout the life course and for the training of health-care providers in approaches that ensure healthy ageing.

Partly Achieved

Healthy ageing is slowly being recognized as a major global challenge, as evidenced by the steadily increasing number of countries with functioning programmes. In the African Region, healthy ageing is now an emergent area of work, which previously had not been addressed or defined as a health priority. National programmes and laws on healthy ageing were implemented in Algeria, Guinea and Togo and were being developed in Angola, Congo and Zambia. Significant progress was also noted in the Eastern Mediterranean, European and South-East Asia Regions. The Regional Office for the Western Pacific appointed a regional focal point and will scale up interventions during the next biennium.

The impact of the Organization's normative work, including guidelines and assessment frameworks, is greatest where bottom-up initiatives exist, for example, the age-friendly cities network, where healthy ageing is promoted through improving the capacity of the health workforce. Training courses on ageing and health were conducted in several regions, aiming to address the current knowledge gap at national level. The age-friendly cities network was active at community level. Support was provided for networking activities among cities, and governance of the sub-network of the healthy cities programme was set on a solid footing in many countries.

A university consortium in public health and ageing was established in order to build the capacity of the health workforce.

Regional Offices contributed evidence for policy in the field of ageing with a number of publications, such as "Facts and figures on health ageing" and "Healthy ageing: the solid facts". Cooperation with the European Commission was strengthened in preparation for the European Year for Active Ageing and Solidarity between Generations 2012; the 2012 World Health Day will be on Ageing. The momentum generated can be used to increase the visibility of programmes on ageing and advocate for public investment.

With the exception of the European Region, the number of Member States with healthy ageing components in their national policy frameworks was low. Implementation varied greatly between regions, with large geographical differences persisting. Availability of good quality services for older people with functional limitations is still fragmented and limited in many countries and this needs to be addressed during the biennium 2012–2013. The steady progress notwithstanding, the area of ageing was assessed as partly achieved in the African and South-East Asian Regions where financial and technical resources are inadequate.

In spite of staff shortages in the area, WHO was able to attract significant attention to some aspects of ageing, and to provide technical support for regions and countries. Given the limited resources available, cooperation with other stakeholders is critical.

INDICATOR	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
4.8.1 Number of Member States with a functioning active healthy ageing programme consistent with WHA58/16 "Strengthening active and healthy ageing".	15	20	33

SUMMARY OF FINANCIAL IMPLEMENTATION

The approved budget for strategic objective 4 was US\$ 332 million, of which US\$ 292 million are for Base programmes and US\$ 40 million for Special programmes and collaborative arrangements.

Available funding by end of 2011 was US\$ 222 million, of which US\$ 172 million was distributed to Base programmes and US\$ 50 million to Special programmes and collaborative arrangements.

Implementation as at 31 December 2010 was US\$ 190 million, which corresponds to 57% of the approved budget and 86% of the available resources.

Looking at implementation rates across major offices, it is noted that all offices with the exception of the Regional Office for the Eastern Mediterranean have an implementation of more than 80% against funds available. The low implementation in

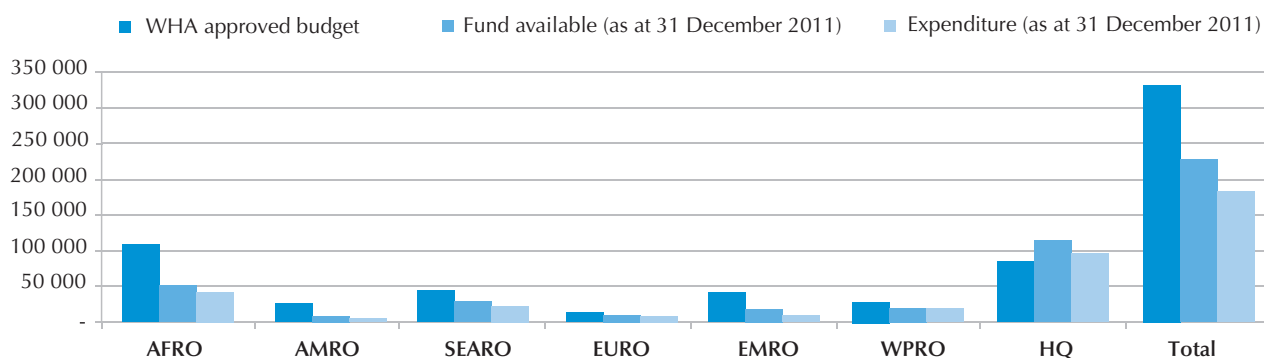
the Eastern Mediterranean Region of 55% can be explained by the late receipt of funds at the end of the biennium.

Despite the current high level of political awareness and commitment to accelerating action to meet Millennium Development Goals 4 and 5, funding has not met expectations to cover the approved Programme budget. As a result, funds available in comparison to the approved budget were less than 70% in all regional offices. A notable increase in overall funding is required in order to maintain priority activities and accelerate implementation at country level in 2012–2013.

The high availability of resources in headquarters (133%) 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.

All Segments

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	107 735	25 362	44 702	12 937	36 114	23 329	82 519		332 698
Funds Available									
AC	15 562	6 420	7 665	2 592	2 975	4 256	10 355		49 824
VC	35 691	2 659	8 515	5 330	11 020	9 709	99 481	-	172 406
Total	51 253	9 079	16 180	7 922	13 995	13 965	109 836	-	222 230
Funds Available as % of approved budget	48%	36%	36%	61%	39%	60%	133%		67%
Expenditure	44 404	8 926	13 148	7 426	7 679	12 836	95 965		190 384
Expenditure as % of approved budget	41%	35%	29%	57%	21%	55%	116%		57%
Expenditure as % of funds available	87%	98%	81%	94%	55%	92%	87%		86%



DETAILS OF INDICATOR ACHIEVEMENT

4.1.1 Region of the Americas: Bolivia (Plurinational State of), Honduras, Nicaragua. **European Region:** Armenia, Georgia, Hungary, Ireland, Kazakhstan, Romania, Slovakia, Tajikistan, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, Indonesia, Myanmar, Sri Lanka, Thailand. **Western Pacific Region:** Cambodia, Lao People's Democratic Republic, Philippines, Solomon Islands.

4.1.2 Region of the Americas: Argentina, Belize, Bolivia (Plurinational State of), Canada, Chile, Costa Rica, Cuba, Ecuador, El Salvador, Guyana, Honduras, Peru, Uruguay. **European Region:** Azerbaijan, Kyrgyzstan, Republic of Moldova, Romania, Spain, Tajikistan, Turkmenistan, Uzbekistan. **South-East Asia Region:** Bhutan, India, Indonesia, Maldives, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, Lao People's Democratic Republic, Philippines, Solomon Islands.

4.2.1 Eastern Mediterranean Region: Afghanistan, Lebanon, Tunisia. **European Region:** Lithuania.

4.2.2 The list of completed studies are available upon request.

4.3.1 Region of the Americas: Argentina, Belize, Brazil, Canada, Chile, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Peru, Trinidad and Tobago, United States of America, Uruguay, Venezuela (Bolivarian Republic of). **European Region:** Albania, Armenia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, China (People's Republic of), Mongolia, Papua New Guinea, Viet Nam.

4.4.1 Region of the Americas: Argentina, Bolivia (Plurinational State of), Brazil, Dominican Republic, Ecuador, Guatemala, Guyana, Honduras, Nicaragua, Panama, Paraguay, Peru. **European Region:** Albania, Armenia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Democratic People's Republic of Korea, India, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, Lao People's Democratic Republic, Mongolia, Philippines, Viet Nam.

4.5.1 African Region: Angola, Benin, Botswana, Burundi, Eritrea, Ethiopia, Namibia, Swaziland, Uganda, Zambia, Zimbabwe. **Region of the Americas:** Bolivia (Plurinational State of), Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Nicaragua, Paraguay, Peru. **European Region:** Albania, Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Tajikistan, Turkey, Turkmenistan, Ukraine, Uzbekistan. **South-East Asia Region:** Bangladesh, Democratic People's Republic of Korea, Indonesia, Maldives, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, Fiji, Lao People's Democratic Republic, Mongolia, Philippines, Viet Nam.

4.5.2 African Region: Benin, Botswana, Burkina Faso, Central African Republic, Equatorial Guinea, Eritrea, Gambia, Ghana, Guinea Bissau, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Niger, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia. **Region of the Americas:** Belize, Bolivia (Plurinational State of), Colombia, Dominican Republic, Ecuador, El Salvador, Guyana, Honduras, Nicaragua, Paraguay, Peru. **European Region:** Armenia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Turkmenistan, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, Myanmar, Nepal, Timor-Leste. **Western Pacific Region:** Cambodia, Fiji, Mongolia, Philippines.

4.6.1 African Region: Botswana, Cameroon, Cap Verde, Central African Republic, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Togo, United Republic of Tanzania, Zambia, Zimbabwe. **Region of**

the Americas: Argentina, Belize, Bolivia (Plurinational State of), Brazil, Canada, Costa Rica, Cuba, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Mexico, Nicaragua, Peru, Venezuela (Bolivarian Republic of). **South-East Asia Region:** Bangladesh, Bhutan, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand. **Western Pacific Region:** Malaysia, Mongolia, Papua New Guinea, Philippines, Solomon Islands, Viet Nam.

4.8.1 African Region: Guinea, Togo. **Eastern Mediterranean Region:** Bahrain, Egypt, Jordan, Libya, Syrian Arab Republic. **European Region:** Albania, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bulgaria, Croatia, Cyprus, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kyrgyzstan, Latvia, Lithuania, Luxembourg. **South-East Asia Region:** Bangladesh, Democratic People's Republic of Korea, Indonesia, Myanmar, Sri Lanka, Thailand.

SO5

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



ASSESSMENT OF THE ORGANIZATION-WIDE EXPECTED RESULTS

Of the seven Organization-wide expected results for this strategic-objective, three were «fully achieved» and four «partly achieved».

Overview

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

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

During the biennium, three of the Organization-wide expected results for strategic objective 5 were considered to have been fully achieved and four partly achieved. The overall ratings were based on the level of achievement of the indicator targets as measured and reported by major offices, using methods consistent with previous biennial performance reports. However, a

qualitative analysis of WHO's work in emergency preparedness, response and recovery suggests that a more robust set of Organization-wide performance standards is required to accurately measure achievements. Without such criteria, most of these Organization-wide expected results should be rated as only partly achieved, particularly in the light of the challenges that exist in this area of work, including lack of an Organization-wide approach and performance standards for emergency work, and of institutional capacities and procedures.

To address the challenges faced by WHO and Member States in emergency risk management and humanitarian response, and to align with developments emanating from the WHO reform process and the Inter-Agency Standing Committee 2011 Transformative Agenda process, WHO undertook an extensive consultative process with internal and external stakeholders during the second half of the biennium to refine and restructure its work in emergencies. The results were as follows: (1) the development of a new, Organization-wide emergency response framework that includes measurable performance standards; (2) the restructuring, reorienting and 50% downsizing of the headquarters emergency department; (3) the streamlining of the expected results for strategic objective 5 from seven to two (for preparedness and response); and (4) a more realistic 2012–2013 Programme budget for the strategic objective, with emphasis placed on strengthening regional- and country-level capacity. Moving into 2012, the Executive Board and Health Assemblies will discuss WHO's role in emergencies and its proposed emergency response framework, and providing further direction to the Organization's work in this area.

5.1

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

Partly Achieved

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

WHO participated in the establishment of a Global Platform for Disaster Risk Reduction with the goal of improving implementation of disaster risk reduction measures through better communication and coordination among stakeholders. It also participated in a multi-agency statement calling for community level action to reduce risk in the health sector. Regional offices developed guidelines for disaster risk reduction, as well as toolkits for evaluating health-system capacity for crisis management.

The Regional Office for Africa embarked on the development of a regional strategy for disaster risk reduction and emergency preparedness. In the Region of the Americas, PAHO's plan of action for safe hospitals 2010–2015 was approved by the Fiftieth Directing Council. In the Eastern Mediterranean Region, a disaster risk reduction strategy was developed and promoted. The Regional Office for Europe devised a toolkit for evaluating health-system capacity for crisis management, a complementary user handbook, and an e-atlas of disaster risk. The Regional Office for South-East Asia completed a tool for assessing country preparedness. In the Western Pacific Region, tools and training materials were developed, including a safe hospital assessment tool, an emergency exercise guide and advocacy materials. Headquarters provided technical support to all six regional offices for developing and implementing country-level emergency risk management programmes and for implementing resolution WHA64.10 on strengthening national health emergency and disaster management capacities and resilience of health systems. As a result, the percentage of Member States implementing safe hospitals programmes rose from 23% to 46% during the biennium and the percentage of Member States with national emergency preparedness plans from 60% to 72%.

In the African Region, 30 Member States (65%) have national emergency preparedness plans that cover multiple hazards, however, owing to a lack of resources, the safe hospitals programme has not yet been established in countries. In the Region of the Americas, 32 countries have now developed and

evaluated disaster preparedness plans for the health sector. During the reporting period, seven additional countries began implementing programmes for reducing the vulnerability of health infrastructures, making a total of 25 countries. In the Eastern Mediterranean Region, nine countries developed or reviewed their national policies, strategies and plans; and a model for an institutional approach to emergency risk management was developed in Oman. In the European Region, country capacity assessments were conducted in Croatia, Greece, Italy, Kazakhstan, Malta, Poland, Turkey, Ukraine and United Kingdom. In the South-East Asia Region, preparedness was assessed in Bangladesh, Indonesia, Myanmar and Nepal, and advocacy for safe hospitals was conducted across 11 countries following their commitment to the Kathmandu Declaration of Health Ministers in Protecting Health Facilities from Disasters. The national disaster management authority in India prioritized its safe health facilities programme. In the Western Pacific Region, many countries developed and updated their national preparedness and response plans; and safe hospital activities were implemented in four priority countries, including Cambodia, Lao People's Democratic Republic, Philippines and Viet Nam.

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

Member States have been tailoring their implementation of interventions for emergency risk management to suit local needs, hence, the structure and components of national plans vary from country to country. WHO requires a framework, guidance and checklist so that countries can better plan and manage their programmes. Some regional offices have developed strategies and guidance over many years, but a global and regional corporate plan is required for standardization and tracking of Member States' achievements in this area. Other major challenges include: (1) engaging key partners beyond health, such as national and intergovernmental disaster management authorities; (2) competing priorities in health; and (3)

a shortage of expertise in this area of work, including within WHO itself, especially at country level. In 2012–2013, WHO will engage in an Organization-wide process to finalize the development of the WHO framework for emergency risk management, building on the core commitments and performance

standards set out in the emergency response framework, and a checklist for tracking the achievements of Member States in this area.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
5.1.1 Proportion of Member States with national emergency preparedness plans that cover multiple hazards.	60%	65%	72%
5.1.2 Number of Member States implementing programmes for reducing the vulnerability of health facilities to the effects of natural disasters.	46	50	91

5.2

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

Fully Achieved

With the support of WHO, Member States continued to build their national capacity for emergency response in the health sector during the biennium. WHO led the collaborative work of the Global Health Cluster, which comprises more than 30 international humanitarian health bodies, in building response and recovery capacity. It also conducted 44 training courses on strengthening the response and recovery capacity of national counterparts, WHO staff, together with international partners, introduced 75 Heads of WHO Country Offices to their cluster leadership responsibilities at WHO's annual induction courses, reviewed WHO's role as cluster lead agency with all Heads of WHO Country Offices during their bi-annual meeting in 2011, reinforced its operational platforms for rapid deployment of experts, funds and supplies at regional and headquarters levels, developed key tools related to child health, mental health and post disaster needs assessments, and influenced policy making in the global humanitarian arena through active involvement in the work of the Inter-Agency Standing Committee.

The Regional Office for Africa conducted four training programmes on public health emergency operations, including a course on public health in complex emergencies and a pre-deployment course. The Regional Office for the Americas conducted training activities on the cluster approach and on cholera preparedness and response, and prepared and published a report entitled *Earthquake in Haiti – January 2010: Lessons to be learned for the next massive sudden-onset disaster*. In addition, a new emergency operations centre (EOC) is being set up. The Regional Office for the Eastern Mediterranean conducted readiness capacity development in high-risk countries and two training courses for Health Cluster Coordinators. The Regional Office for Europe organized a public health and emergency management capacity-building programme in priority countries and an emergency operations centre. The Regional Office for South-East Asia enhanced its response capacity by establishing a regional operational platform that includes the South-East Asia Regional Health Emergency Fund in order to be able to provide funding support within 24 hours for immediate needs prior to the arrival of resources from larger humanitarian funding mechanisms. In the Western Pacific Region, technical support was provided to strengthen health response capacity through various training courses and the development of response procedures.

To improve the quality of health-care services during emergencies, WHO developed and promoted a job aid for child health care and two key normative products related to mental health in emergencies: a psychological first aid guide and the Humanitarian Emergency Settings Perceived Needs Scale (HESPER) assessment tool. To ensure the availability of quality medical supplies during emergencies, headquarters established and managed a system for rapidly procuring and delivering these vital supplies, which were stockpiled in five WHO hubs that comply with International Public Sector Accounting Standards (IPSAS) and are located in existing United Nations Humanitarian Response depots. Supplies from these hubs were sent to acute and chronic emergencies, including in Haiti, the Horn of Africa, Libya and Sudan. WHO continued to promote the Interagency Emergency Health Kit (IEHK) and the publication, *Guidelines for Drug Donations*. To improve the speed and efficiency of WHO's emergency response, the emergency standard operating procedures were regularly updated and readily available online.

Although this Organization-wide expected result was assessed as fully achieved, more work needs to be done to develop minimal institutional readiness standards and Organization-wide response systems and procedures. A cohesive and continuous capacity-building programme is required, including simulations for national counterparts and WHO staff. Response capacity development goes beyond training; there is also a need to strengthen management and coordination structures and procedures. When Member States and country offices are overwhelmed by emergencies, the rapid deployment of emergency experts from across the Organization and beyond is essential for a timely and effective response. Existing mechanisms were not up to meeting surge demand. This was particularly evident in 2011 when the Organization and partners did not have the human resources surge capacity to meet the demand from Member during major humanitarian emergencies. By November 2011, WHO had established a system of on-call surge teams ready for rapid deployment to acute-onset emergencies, which will be enhanced and strengthened during the next biennium. For overall institutional readiness, the emergency response framework provides the basis for making advances in 2012–2013.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
5.2.1 Operational platforms for surge capacity in place in regions and headquarters ready to be activated in acute-onset emergencies.	80%	100%	100%
5.2.2 Number of global and regional training programmes on public health operations in emergency response.	22	35	44

5.3

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

Partly Achieved

Many Member States facing protracted emergencies made progress on positioning health in the humanitarian action plan. All 39 countries with a humanitarian coordinator developed a health component in their humanitarian action plans. A total of 33 countries drew up health-sector recovery strategies during the biennium. In the African Region, the 13 countries with humanitarian coordinators included a health component in their humanitarian action plans, and seven countries developed health-sector recovery strategies. In the Region of the Americas, all countries with humanitarian action plans had a health component in them. In Haiti, WHO, the World Bank and the Government used the Post Disaster Needs Assessment process to develop its recovery plan. The Regional Office for the Eastern Mediterranean conducted three 10-day national training programmes for 120 professionals involved in recovery planning. In the European Region, three countries implemented health-sector recovery projects, of which three were completed and phased out. In the Western Pacific Region, Cambodia, China, Fiji, Japan, New Zealand, Philippines and Viet Nam made efforts to strengthen health service and system recovery following crises. Following the earthquake in Japan in March 2011, an informal consultation on disaster recovery for the health sector was conducted in May 2011 to discuss guidance and recommendations for early recovery activities and to strengthen the role of health partners in recovery.

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

While the indicator targets for this Organization-wide expected result have been achieved, the African and Eastern Mediterranean Regions, as well as headquarters, reported partial achievement, mainly because of the lack of a consistent Organizational approach and guidance to countries affected, as well as inadequate post-crisis donor support. Resources are needed to strengthen health systems in post conflict environments through integrated capacity building efforts. At WHO, several country-level positions had to be discontinued owing to a lack of sustainable resources and termination of recovery projects. As seen in Haiti and elsewhere, funding fades dramatically during the recovery phase, especially for disaster preparedness. In the aftermath of a conflict, there is often limited government capacity for recovery planning and humanitarian concerns tend to take priority. There is also often a lack of health data on which to base recovery programmes, as well as of relevant guidance. The development of such guidelines should be a priority in the next biennium.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
5.3.1 Number of humanitarian action plans with a health component formulated for on-going emergencies.	26	In all countries with humanitarian coordinators (39)	In all countries with humanitarian coordinators (39)
5.3.2 Number of countries in transition that have formulated a recovery strategy for health.	12	18	33

5.4

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

Fully Achieved

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

A communicable diseases working group on emergencies was established to provide technical support to Member States, regional and country offices and partners for communicable disease control in humanitarian emergencies. Six public health risk assessment documents were produced following the earthquake in Haiti, crises in Kyrgyzstan and Uzbekistan, floods in Pakistan, unrest in Libya, famine in the Horn of Africa and the earthquake in Turkey. Another six communicable disease epidemiological profiles were developed for Afghanistan, Chad, Central African Republic, Côte d'Ivoire, Sri Lanka and Zimbabwe.

All acute natural disasters or conflicts where communicable disease-control interventions have been implemented were successfully addressed, including activation of early-warning systems and disease-surveillance for emergencies. The Regional Office for Africa coordinated technical support for communicable disease control, including early warning and surveillance in all conflicts and natural disasters. The Regional Office for the Americas led the massive coordination effort in response to the cholera outbreak in Haiti and Dominican Republic, enhanc-

ing collaboration between disaster management and epidemic alert and response areas of work; it also responded to dengue in Bolivia, Peru and Paraguay and measles in Ecuador, among others. The Regional Office for the Eastern Mediterranean conducted relevant training courses in Egypt, Jordan and Lebanon. In the European Region, capacity building efforts related to the International Health Regulations (2005) have been effectively integrated into all hazard emergency preparedness activities at regional and country level. The Regional Office for South-East Asia established early warning surveillance and reporting systems for diseases with epidemic potential in all emergencies except in Bhutan. In the Western Pacific Region, post-disaster communicable disease risk assessments and surveillance were priority areas of work, with technical support provided to Cambodia, Japan, Philippines and Viet Nam.

WHO will strengthen its efforts to ensure that contingency plans include crisis management of epidemics and stronger collaboration with national communicable disease surveillance programmes, laboratories and pharmacies within and outside the health sector. Health needs and risks assessments in disasters and conflicts should take account of communicable disease risk and make better use of International Health Regulations (2005) assessment capabilities.

INDICATOR	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
5.4.1 Proportion of acute natural disasters or conflicts where communicable disease-control interventions have been implemented, including activation of early-warning systems and disease-surveillance for emergencies.	100%	100%	100%

5.5

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

Partly Achieved

Environmental health was a key component in many crises faced by Member States during the biennium, from the earthquake in Haiti to the flooding in Pakistan and mass lead poisoning in Nigeria. Collaboration between WHO departments during humanitarian emergencies increased the effectiveness of the response.

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

Training materials were developed to strengthen national preparedness and for establishing alert and response mechanisms for chemical, radiological and other environmental health emergencies. Headquarters provided technical support to national and subregional workshops on chemical incidents and radiological events. The Regional Office for the Eastern Mediterranean translated key tools into Arabic. The Regional Office for the Americas trained health and non-health national counterparts in Dominican Republic and Jamaica and provided technical support for the elaboration of their national response plans to chemical emergencies. In the Euro-

pean Region, a handbook on public health interventions for flood events was jointly developed with the United Kingdom Health Protection Agency. Technical support was provided to strengthen health system preparedness for extreme weather events in Albania, Kazakhstan and Macedonia. In the Western Pacific Region, environmental health support was provided in response to disease outbreaks related to food and water-borne diseases, such as cholera in Papua New Guinea. In the area of food safety, three guides were developed to strengthen Member States' capabilities in managing food safety events more efficiently: (1) the FAO/WHO guide for application of risk analysis principles and procedures during food safety emergencies, (2) the FAO/WHO framework for developing national food safety emergency response plan, and (3) the FAO/WHO guide for developing and improving national food recall systems. A new user-friendly community website was developed to allow members of the International Food Safety Authorities Network (INFOSAN) from 177 Member States to better interact, discuss and share information on emergency food safety events and their management.

While the indicator targets for this Organization-wide expected result have been achieved, the African, Eastern Mediterranean, South-East Asia and Western Pacific Regions reported partial achievement, mainly because of concern over the lack of experts in this area. The contribution of WHO collaborating centres in this regard has proved to be crucial.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
5.5.1 Proportion of Member States with national plans for preparedness, and alert and response activities in respect of chemical, radiological and environmental health emergencies.	60%	65%	70%
5.5.2 Number of Member States with focal points for the International Food Safety Authorities Network and for the environmental health emergencies network.	173	all	177

5.6

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

Partly Achieved

Building on global and country level partnerships, WHO served as lead agency of the Health Cluster in all countries implementing the cluster approach. In all these countries, WHO supported Member States by coordinating the work of the humanitarian health community in accordance with the health-sector plan. However, in some countries, partners and stakeholders expressed concern that cluster leadership functions were not fully delivered. The absence of standard criteria for measuring performance in this area has led to these indicators, and therefore the expected result, being rated as partly achieved. The lack of the following: a harmonized Organization-wide approach; skills in coordination, information collection and management and strategic planning; a strategy for coordinating numerous partners in mega-crises, such as in Haiti; and of funding for cluster leadership functions made it difficult to achieve the expected result.

WHO's ability to lead and coordinate is linked to its national and sub-national presence and capacity. However, a lack of sustainable funding resulted in staff reductions throughout the biennium. As experienced in Haiti and elsewhere, overwhelming numbers of health partners at country level during mega-crises makes effective coordination very difficult and can ultimately have a negative impact on the health response. WHO needs to develop a mechanism for more effective partner participation, such as a core group that analyses available information and determines the sector-wide strategy for the larger group. Inter-cluster coordination needs to be strengthened, particularly with the Water, Sanitation and Hygiene (WASH) and Nutrition Clusters. Simulations are needed to test WHO's capacity to perform cluster leadership functions. WHO needs to improve its emergency event monitoring, assessment and information management systems.

The work of strategic objective 5 is complex, and, therefore, partnerships are not confined to national health author-

ities alone. Joint work was required with other agencies in government, those dealing with disaster management as well as development, in addition to civil society, United Nations and non-United Nations agencies, existing and new donors, the media, the Inter-Agency Standing Committee, global and country health cluster partners, the private sector, and scientific and technical institutions.

WHO continued to strengthen its global partnership for emergency work through active engagement in the United Nations International Strategy for Disaster Reduction and the Global Platform, through its leadership of the Global Health Cluster and through its influential role in the development of the Inter-Agency Standing Committee Transformative Agenda, 2011. The Regional Office for Africa incorporated the health component of the United Nations International Strategy for Disaster Reduction health component in its African strategy and programme of action on disaster risk reduction 2010–2015. The Regional Office for the Americas supported the Organization of American States and subregional disaster related agencies in the Andean Region, Caribbean, Central America and the Southern Cone, and worked with the World Bank to ensure the integration of safe hospitals in the latter's internal guidelines. In the Western Pacific Region, the first regional Health Cluster Forum was conducted in August 2011 to develop an operational framework for health cluster response at country level.

To increase the visibility of WHO and health in emergencies, WHO's communications team worked closely with Member States and other stakeholders at country level, as well as media outlets, represented WHO at bi-weekly media briefings in Geneva, and developed media products such as photo essays, films and podcasts on key issues and crises throughout the biennium.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
5.6.1 Proportion of Member States affected by acute-onset emergencies and those with on-going emergencies and a humanitarian coordinator in which the Inter-Agency Standing Committee Humanitarian Health Cluster is operational in line with IASC cluster standards.	60%	80%	>80%
5.6.2 Proportion of Member States with on-going emergencies and a humanitarian coordinator having a sustainable WHO technical presence covering emergency preparedness, response and recovery.	60%	75%	>75%

5.7

Acute, on-going and recovery operations implemented in a timely and effective manner.

Fully Achieved

Together, Member States, WHO and partners responded to health needs in acute and protracted emergencies throughout the biennium. Acute emergencies included: earthquakes in Chile, Haiti and Turkey; flooding in Pakistan and Philippines; the earthquake and resulting radiological event in Japan; mass lead poisoning in Nigeria; civil unrest in Egypt, Libya, Syrian Arab Republic and Yemen, as well as in Côte d'Ivoire; and the famine and its health consequences in the Horn of Africa. In the African Region, 10 countries faced protracted emergencies: Chad, Central African Republic, Democratic Republic of the Congo, Ethiopia, Guinea, Kenya, Madagascar, Niger, Uganda and Zimbabwe. The Region of the Americas experienced several acute crises, including the earthquakes in Chile and Haiti, the aftermath of hurricanes in the Bahamas, Saint Vincent and the Grenadines and Saint Lucia, and floods in Bolivia, Colombia, El Salvador, Guatemala, Honduras and Nicaragua. The Regional Office for Europe dealt with crises in Kyrgyzstan, Tajikistan, Turkey and Uzbekistan, while in the South-East Asia Region there were fires in Bangladesh, torrential rain and floods in the Democratic People's Republic of Korea, a tsunami and volcanic eruption in Indonesia, a cyclone in Myanmar, floods in Thailand, and the protracted response in Sri Lanka. In the Western Pacific Region there were earthquakes in China, Japan and New Zealand, floods in Cambodia, China, Lao People's Democratic Republic, Philippines and Viet Nam, and drought in some Pacific island countries. In most of these emergencies, WHO coordinated the response with partners and implemented activities in accordance with the health component of humanitarian action plans.

Support for emergency management and cluster leadership was provided by all regional offices and headquarters. Support for communicable disease surveillance and control was provided in Haiti, Liberia, Pakistan, the Republic of Congo and South Africa, and to South Sudan and Tajikistan for surveillance evaluations. Technical support for comprehensive clinical care for new-borns, children and adolescents was provided to Chile, Haiti, Japan, Pakistan and Somalia. Technical support for mental health, in particular, was provided to Haiti and Japan. Technical expertise relating to water and sanitation was made available during numerous environmental emergencies, as well as chemical and radiological emergencies. Logistics support was provided to Libya, the Horn of Africa and South Sudan. There

was effective media coverage, including the timely production and dissemination of press releases and other advocacy products, such as photo essays, films and podcasts on the crises in Côte d'Ivoire, Haiti, Libya, Pakistan, Somalia and Yemen. In the African Region, improvements were made in grant management that resulted in a reduction in funds returned to donors from 40% in 2006–2007, to 2% in 2008–2009 and 2010–2011. In the Region of the Americas, financial, operational and technical support was provided; in Haiti WHO ran the central pharmaceutical warehouse. The Regional Office for the Eastern Mediterranean supported Egypt, Libya, Pakistan, Somalia, Tunisia and Yemen by developing concept of operations documents. Pakistan also received support for contingency planning that was used effectively in the subsequent flooding. The Regional Office for the Eastern Mediterranean strengthened its surge capacity and mechanisms for rapid deployment of experts. The Regional Offices for South-East Asia and the Western Pacific provided countries with financial support, emergency supplies and technical and operational support.

Health sector/cluster coordination is vital for an effective health response. The "Arab Spring" highlighted the importance of contingency planning and business continuity planning in WHO country offices. WHO has difficulty in recruiting expertise when required and needs to establish new systems for recruitment and deployment, particularly in order to ensure adequate leadership at the onset of crises. One of the main obstacles to rapid response is the amount of time spent in uploading to, and awaiting approval from, the Global Management System. The system needs to be improved and simplified. Staff in country offices require training in handling emergency recruitment and procurement, conducting health needs assessments, and in coordination and resource mobilization in close collaboration with health authorities and health partners.

While the Organization-wide expected result was fully achieved in terms of the indicators having been met, the lack of the following: an overall response framework, including measurable performance standards, response capacity, a reliable surge mechanism, procedures and a robust system for monitoring and evaluation continue to pose a challenge.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
5.7.1 Proportion of acute-onset emergencies for which WHO mobilizes coordinated national and international action.	80%	90%	90%
5.7.2 Proportion of interventions for chronic emergencies implemented in accordance with humanitarian action plans' health components.	100%	100%	100%

SUMMARY OF FINANCIAL IMPLEMENTATION

The total approved budget for strategic objective 5 was US\$ 364 million, of which US\$ 109 million (30%) was for Base programmes and US\$ 250 million for Outbreak and crisis response to fund specific country-level appeals in response to crises.

As at 31 December 2011, available resources for the strategic objective amounted to US\$ 392 million, representing 108% of the approved budget. Of this total amount, US\$ 47 million were for Base programmes (59% of the approved budget for Base programmes). Funding in Base programmes has been particularly low with less than 65% in all major offices. The high availability of funds in the Eastern Mediterranean Region of 263% can be explained by the number of large emergencies being funded through Outbreak and crisis response during the biennium, including in Afghanistan, Libya and Pakistan.

US\$ 326 million were for Outbreak and crisis response, which corresponds to 131% of the approved budget for this budget segment. Significant increases in financing were for activities related to the civil unrest of the “Arab Spring” in Egypt, Libya, Syrian Arab Republic and Yemen, as well as to flooding in Pakistan (213% of the available funding for the Eastern Mediterranean Region). In the Region of the Americas, increases in Outbreak and crisis response funding under strategic objective 5 stemmed primarily from WHO’s response to the earthquake in Haiti (470% of available resources compared to the approved

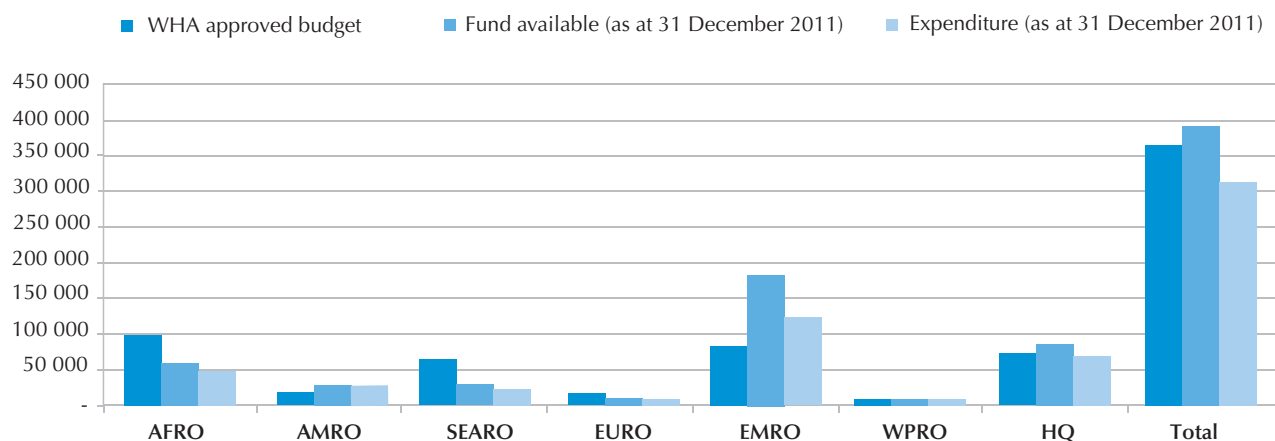
budget for the Outbreak and crisis response segment), and to flooding in the Philippines in the Western Pacific Region (177% of funds available compared to the approved budget).

The implementation rate (expenditures) against available funds as at 31 December 2011 for all segments was 86% and against the approved budget 80%. This high implementation against the approved budget can be explained by the high implementation in the Outbreak and crisis response segment. With regard to the Base programmes segment it is obvious that lack of funding of the approved budget has led to low implementation in all major offices (with the exception of the Eastern Mediterranean Region) while implementation against funds actually available has been more than 80% in five of the seven major offices.

The low levels of base funding demonstrate that Member States are more interested in funding response than core emergency risk management activities, such as country preparedness and risk reduction, as well as WHO’s institutional readiness. Very low rates of predictable core funding undermine the long-term goal of prepared and resilient Member States. To perform effectively, WHO requires sustainable funding for human resources in priority countries and regional offices. It also needs to manage strategic objective 5 funding appropriately, so that funding is not diverted to cover costs outside the strategic objective.

All Segments

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	98 782	20 118	63 202	17 960	84 277	7 581	72 103		364 023
Funds Available									
AC	4 105	1 517	4 262	1 545	838	1 469	2 180		15 916
VC	58 407	27 064	18 376	9 221	182 378	6 046	75 486		376 978
Total	62 512	28 581	22 638	10 766	183 215	7 515	77 666		392 894
Funds Available as % of approved budget	63%	142%	36%	60%	217%	99%	108%		108%
Expenditure	53 280	27 983	18 758	8 871	127 208	7 283	69 060		312 444
Expenditure as % of approved budget	54%	139%	30%	49%	151%	96%	96%		86%
Expenditure as % of funds available	85%	98%	83%	82%	69%	97%	89%		80%



Base programmes

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	31 532	14 518	14 002	10 860	8 077	5 031	25 003		109 023
Funds Available									
AC	4 105	1 517	3 111	1 545	838	1 469	2 180		14 765
VC	6 947	755	3 443	5 255	20 370	1 526	11 699	-	49 996
Total	11 052	2 272	6 554	6 801	21 208	2 995	13 879	-	64 761
Funds Available as % of approved budget	35%	16%	47%	63%	263%	60%	56%		59%
Expenditure	10 054	2 157	4 665	6 025	8 382	2 765	12 805		46 854
Expenditure as % of approved budget	32%	15%	33%	55%	104%	55%	51%		43%
Expenditure as % of funds available	91%	95%	71%	89%	40%	92%	92%		72%

Special programmes and collaborative arrangements

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	-	-	-	-	-	-	5 000		5 000
Funds Available									
AC	-	-	-	-	-	-	-		-
VC	-	-	-	-	-	-	1 528	-	1 528
Total	-	-	-	-	-	-	1 528	-	1 528
Funds Available as % of approved budget	-	-	-	-	-	-	31%		31%
Expenditure	26	-	-	-	-	-	2 264		2 291
Expenditure as % of approved budget	-	-	-	-	-	-	45%		46%
Expenditure as % of funds available	-	-	-	-	-	-	148%		150%

Outbreak and crisis response

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	67 250	5 600	49 200	7 100	76 200	2 550	42 100		250 000
Funds Available									
AC	-	-	1 151	-	-	-	-		1 151
VC	51 460	26 309	14 933	3 965	162 007	4 520	62 259		325 454
Total	51 460	26 309	16 084	3 965	162 007	4 520	62 259		326 605
Funds Available as % of approved budget	77%	470%	33%	56%	213%	177%	148%		131%
Expenditure	43 199	25 825	14 093	2 846	118 826	4 519	53 991		263 299
Expenditure as % of approved budget	64%	461%	29%	40%	156%	177%	128%		105%
Expenditure as % of funds available	84%	98%	88%	72%	73%	100%	87%		81%

DETAILS OF INDICATOR ACHIEVEMENT

5.1.1 African Region: Algeria, Benin, Burkina Faso, Burundi, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Namibia, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States of America, Uruguay. **Eastern Mediterranean Region:** Afghanistan, Bahrain, Iran (Islamic Republic of), Lebanon, Oman, Pakistan, Qatar, Sudan. **European Region:** Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** China (People's Republic of), Kiribati, Lao People's Democratic Republic, Papua New Guinea, Philippines, Tonga, Vanuatu, Viet Nam.

5.1.2 Region of the Americas: Argentina, Barbados, Belize, Bolivia (Plurinational State of), Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Lucia, Trinidad and Tobago, United States of America. **Eastern Mediterranean Region:** Djibouti, Iran (Islamic Republic of), Jordan, Lebanon, Morocco, Oman, Pakistan, Saudi Arabia, Somalia, Syrian Arab Republic, Yemen. **European Region:** Albania, Andorra, Armenia, Austria, Belarus, Bulgaria, Croatia, Cyprus, Denmark, Finland, France, Georgia, Germany, Greece, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Ukraine, United Kingdom of Great Britain and Northern Ireland. **South-East Asia Region:** Bangladesh, Indonesia, Myanmar, Nepal, Sri Lanka. **Western Pacific Region:** Cambodia, Kiribati, Lao People's Democratic Republic, Mongolia, Philippines, Tonga, Vanuatu, Viet Nam.

5.3.1 African Region: Burundi, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Guinea, Kenya, Liberia, Niger, Uganda, Zimbabwe. **Region of the Americas:** Colombia, Dominican Republic, El Salvador, Haiti, Nicaragua. **Eastern Mediterranean Region:** Afghanistan, Djibouti, Iraq, Libya, Pakistan, Somalia, Sudan, Syrian Arab Republic, Tunisia, Yemen. **European Region:** Albania, Belarus, Georgia, Kyrgyzstan, Tajikistan. **South-East Asia Region:** Indonesia, Myanmar, Nepal, Sri Lanka, Thailand. **Western Pacific Region:** Philippines.

5.3.2 African Region: Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Kenya, Liberia, Uganda, Zimbabwe. **Region of the Americas:** Haiti. **Eastern Mediterranean Region:** Afghanistan, Djibouti. **European Region:** Albania, Armenia, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Georgia, Lithuania, Romania, Russian Federation, Serbia, Slovakia, Slovenia, Turkey. **South-East Asia Region:** Bangladesh, Myanmar, Sri Lanka, Thailand. **Western Pacific Region:** Cambodia, Japan, New Zealand, Philippines, Viet Nam.

5.5.1 African Region: Algeria, Angola, Côte d'Ivoire, Ethiopia, Gambia, Guinea Bissau, Liberia, Mauritania, Mozambique, Swaziland, Zambia. **Region of the Americas:** Argentina, Barbados, Bolivia (Plurinational State of), Brazil, Canada, Chile, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Trinidad and Tobago, United States of America, Uruguay. **Eastern Mediterranean Region:** Bahrain, Egypt, Iran (Islamic Republic of), Jordan, Lebanon, Oman, Saudi Arabia, Syrian Arab Republic, Tunisia. **European Region:** Albania, Andorra, Austria, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic,

Denmark, Estonia, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kyrgyzstan, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Norway, Poland, Portugal, Republic of Moldova, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, The former Yugoslav Republic of Macedonia, Turkey, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Brunei Darussalam, Cambodia, China (People's Republic of), Cook Islands, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, New Zealand, Niue, Palau (Republic of), Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

5.5.2 African Region: Angola, Benin, Burkina Faso, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gabon, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Mali, Mauritania, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States of America, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Bahrain, Egypt, Iran (Islamic Republic of), Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen. **European Region:** Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Brunei Darussalam, Cambodia, China (People's Republic of), Cook Islands, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, New Zealand, Niue, Palau (Republic of), Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

5.6.1 African Region: Burundi, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Guinea, Kenya, Liberia, Niger, Uganda, Zimbabwe. **Region of the Americas:** Dominican Republic, El Salvador, Haiti, Nicaragua. **Eastern Mediterranean Region:** Djibouti, Iraq, Somalia, Syrian Arab Republic, Tunisia, Yemen. **European Region:** Albania, Belarus, Georgia, Kyrgyzstan, Tajikistan. **South-East Asia Region:** Democratic People's Republic of Korea, Indonesia, Myanmar, Sri Lanka, Thailand. **Western Pacific Region:** Philippines.

5.6.2 African Region: Central African Republic, Chad, Democratic Republic of the Congo, Ethiopia, Guinea, Kenya, Liberia, Niger, Uganda, Zimbabwe. **Region of the Americas:** Haiti. **Eastern Mediterranean Region:** Djibouti, Iraq, Saudi Arabia, Somalia, Syrian Arab Republic. **European Region:** Georgia, Kyrgyzstan, Tajikistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Nepal, Sri Lanka, Timor-Leste. **Western Pacific Region:** Philippines.

5.7.1 African Region: Benin, Botswana, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Mauritania, Mozambique, Namibia, Niger, Nigeria, Senegal, Togo, Uganda, Zambia, Zimbabwe. **Region of the Americas:** Bahamas, Bolivia (Plurinational State of), Chile, Colombia, El Salvador, Guatemala, Haiti, Honduras, Nicaragua, Saint Lucia, Saint Vincent and the Grenadines. **Eastern Mediterranean Region:** Afghanistan, Egypt, Iraq, Jordan, Lebanon, Libya, Pakistan, Saudi Arabia, Somalia, Sudan. **European Region:** Georgia, Kyrgyzstan, Tajikistan. **South-East Asia**

Region: Bhutan, Democratic People's Republic of Korea, Indonesia, Myanmar, Nepal, Sri Lanka. **Western Pacific Region:** Cambodia, China (People's Republic of), Fiji, Japan, Lao People's Democratic Republic, Philippines, Viet Nam.

5.7.2 African Region: Central African Republic, Chad, Côte d'Ivoire, Ethiopia, Kenya, Madagascar, Niger, Uganda, Zimbabwe. **Region of the Americas:** Colombia, Haiti. **Eastern Mediterranean Region:** Afghanistan, Djibouti, Egypt, Jordan, Pakistan, Saudi Arabia, Somalia, Syrian Arab Republic, Yemen. **European Region:** Georgia, Kyrgyzstan, Tajikistan. **South-East Asia Region:** Bangladesh, Democratic People's Republic of Korea, Indonesia, Nepal, Sri Lanka, Timor-Leste. **Western Pacific Region:** Philippines.

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



ASSESSMENT OF THE ORGANIZATION-WIDE EXPECTED RESULTS

Of the six Organization-wide expected results for this strategic-objective, five were «fully achieved» and one «partly achieved».

Overview

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

A key to addressing behavioural risk factors is mustering the political, financial and technical commitment to address noncommunicable diseases as a health and development issue. Member States made an important step forward in tackling noncommunicable diseases, in particular, by addressing the key risk factors, in agreements reached through the Political Declaration of the High-level Meeting of the United Nations General Assembly on *the Prevention and Control of Noncommunicable Diseases* (resolution 66/2). This commitment is further evidenced in the continuing support for the WHO Framework Convention on Tobacco Control and resolutions, such as WHA53/17 on the Prevention and control of noncommunicable diseases: implementation of the global strategy, WHA63/14 on Marketing of food and non-alcoholic beverages to children, and WHA57/12 on Reproductive health: draft strategy to accelerate progress towards the attainment of international development goals and targets. Multisectoral action for health is key in all of these strategies.

6.1

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

Fully Achieved

By the end of 2011, 120 Member States had evaluated and reported on at least one of the action areas and commitments of the Global Conferences on Health Promotion. The Urban Health Equity and Response Tool (Urban HEART) was applied in 34 cities in 23 countries in order to reduce health inequalities. Training in Urban HEART application was provided to officials, including mayors from 47 countries. Key outcomes of the application of Urban HEART included, improved water and sanitation in Nakuru, Kenya, and better access to health and other public services for the urban poor in Jakarta, Indonesia. Institutionalization of Urban HEART has also been reported in some cities through local ordinances and a national policy in the case of Philippines. In addition, an ordinance on “smoke-free cities” was also developed in nine cities and used for training in eight countries in the Western Pacific Region. Building capacity to respond to earthquakes and tsunamis was also promoted.

The WHO Centre for Health Development in Kobe, Japan, organized the Global Forum on Urbanization and Health; the Kobe Call to Action which ensued was adopted by 81 Member States and led to the adoption of three resolutions by the

WHO Regional Committee for Western Pacific. The Centre also organized capacity building training in the use of Urban HEART in the African Region, the Region Office of the Americas, the Eastern Mediterranean, South-East Asia and Western Pacific Regions. It also supported the drawing up of a model ordinance for smoke-free cities based on a set of case studies on nine cities, and, in the aftermath of the earthquake and tsunami in East Japan, contributed to urban health emergency management procedures through field missions, dissemination of information and an agenda for transforming the lessons learnt into a broader framework for recovery and resilience.

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

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
6.1.1 Number of Member States that have evaluated and reported on at least one of the action areas and commitments of the Global Conferences on Health Promotion.	31	40	120
6.1.2 Number of cities that have implemented healthy urbanization programmes aimed at reducing health inequities.	17	22	34

6.2

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

Fully Achieved

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

During the biennium, WHO provided technical and logistical support for the development and implementation of the WHO STEPS adult risk factor surveys through country missions and two inter-country regional training workshops. A further eight inter-country regional workshops on survey implementation were also facilitated by WHO on the management and analysis of, and reporting on, the data for the benefit of Member States engaged in the Global school-based student health survey. In 2010–2011, WHO began work on reviewing and updating the questionnaires used in each of the global surveys to ensure that the most useful and appropriate questions and indicators were included. The updating of the questions on tobacco use, harmful use of alcohol and diet in the WHO STEPS survey guides will be finalized in 2012.

Member States continue to find the WHO methodology for both the STEPS and Global school-based student health sur-

veillance efforts useful tools for application at country level. Enhancements in technology to move from paper-based surveillance methods to electronic data collection have shortened the period between finalizing data collection and reporting survey results. This is important as Member States require timely and robust data on risk factor exposure in order to be able to prioritize policy and programme efforts.

During the biennium, WHO conducted a global assessment of country capacity to respond to noncommunicable diseases, including an assessment of country capacity to undertake risk factor surveillance. A detailed report on the outcomes of the survey was prepared and information drawn from the survey was reported in the noncommunicable diseases country profiles 2011, launched in September 2011.

There has also been an increase in the number of Member States conducting specific risk-factor surveys, such as the Global adult tobacco survey. During the biennium, WHO published the *Global status report on noncommunicable diseases*, which provides a comprehensive assessment of the current status of the key risk factors for this strategic objective, as well as a set of guidelines for addressing noncommunicable diseases through comprehensive intersectoral interventions.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
6.2.1 Number of Member States with a functioning national surveillance system for monitoring major risk factors to health among adults based on the WHO STEPwise approach to surveillance.	80	85	94
6.2.2 Number of Member States with a functioning national surveillance system for monitoring major risk factors to health among youth based on the Global school-based student health survey methodology.	52	58	72

6.3

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

Fully Achieved

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

WHO's plan is geared towards supporting the implementation of the WHO Framework Convention on Tobacco Control and has developed a single WHO approach at country level to that effect. The Secretariat has drawn up a specific side-by-side workplan with the Convention Secretariat, including for implementation of the two major grants from the Bill and Melinda Gates Foundation and the Bloomberg Philanthropies, in order to achieve this strategic objective. To enable policy changes at country level, WHO has worked with Member States in countering the tobacco industry in its efforts to undermine the adoption and implementation of effective tobacco control measures by governments in line with Article 5.3 of the WHO

Framework Convention on Tobacco Control and its guidelines. WHO has focused its tobacco control efforts in the African Region and has identified five target countries under the Bill and Melinda Gates Foundation funded African project. The Organization is providing technical assistance to the Member States in implementing effective tobacco control policies, including the creation of a centre for tobacco control in Africa, based in Kampala, Uganda, and hosted by Makerere University School of Public Health. WHO has become a unique repository of information on the response of Member States to the tobacco epidemic through its *Global report on the tobacco epidemic* and its contribution to the implementation of both the Global adult tobacco survey in 20 countries and the Global youth tobacco survey in 160 countries. For the first time, WHO has published a global report on mortality attributable to tobacco. In 2010, WHO successfully directed the world's attention to the issue of women, gender and tobacco, making it the theme of World No Tobacco Day and publishing a monograph on the subject. In 2011, World No Tobacco Day highlighted the importance of the WHO Framework Convention on Tobacco Control and its implementation in coordination with the Convention Secretariat.

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

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
6.3.1 Number of Member States having comparable adult tobacco prevalence data available from recent national representative surveys, such as the Global Adult Tobacco Survey (GATS) or STEPS.	56	78	78
6.3.2 Number of Member States with comprehensive bans on smoking in indoor public places and workplaces.	20	29	31
6.3.3 Number of Member States with bans on tobacco advertising, promotion and sponsorship.	26	20	20

6.4

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

Fully Achieved

Resolution WHA63.13 on the Global strategy to reduce the harmful use of alcohol was adopted by the Sixty-third World Health Assembly prompting a growing number of countries to develop or revise national alcohol policies and action plans in line with the global strategy. A total of 57 countries now have national policies on alcohol and another 10 have sub-national alcohol policies. WHO developed several technical tools to support implementation of effective alcohol control policy options, including the guide on legislation provision for alcohol control and identification and management of alcohol use disorders in health-care settings.

To ensure effective collaboration and coordination between Member States and the WHO Secretariat, the Global network of WHO national counterparts was established, as well as regional networks. The first meeting of the Global network of WHO national counterparts on implementation of the Global strategy to reduce the harmful use of alcohol was convened in February 2011 and collaborative implementation mechanisms and plans were discussed and agreed upon. Regional networks of WHO counterparts were established in all WHO regions. During 2010–2011, the Global Information System on Alcohol and Health (GISAH) was further strengthened and moved to the WHO Global Health Observatory platform. The Secretariat compiled all the data from Member States on alcohol consumption, alcohol-related harm and policy responses in the *Global status report on alcohol and health (2011)*, published in February 2011. A new set of data has been collected for use in 2012. Further work was carried out on refining the instruments for collecting data on alcohol consumption.

WHO supported an international study on alcohol marketing practices in the African Region, a study on alcohol and

injuries in the Region of the Americas, and initiated a global research initiative on alcohol, health and development, including components on fetal alcohol spectrum disorders and harm to others from drinking.

Adoption of the Global strategy to reduce the harmful use of alcohol and of regional strategies and action plans on alcohol and drugs in the African Region (2010), the Region of the Americas (2011), and the European Region (2011) has led to an increased 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.

In the area of illicit drugs, a number of countries in the Region of the Americas, and the European and South-East Asia Regions strengthened their drug treatment policies and programmes through implementation of the Joint WHO/UNODC Programme on drug dependence, treatment and care and with technical support from WHO. Screening and brief interventions for psychoactive substance use is being increasingly considered as a key part of the response of health services to illicit drug use, with the WHO Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) package being used as a reference document. The ASSIST package for screening and brief interventions for substance use in health care settings was developed and published in 2011 by WHO and has been translated into Spanish by PAHO. Several training workshops based on the ASSIST package were organized in WHO regions, including the Region of the Americas and the Eastern Mediterranean Region. An online version of the WHO ASSIST package is being prepared by the Secretariat.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
6.4.1 Number of Member States that have developed, with WHO support, strategies, plans and programmes for combating or preventing public health problems caused by alcohol, drugs and other psychoactive substance use.	38	50	57
6.4.2 Number of WHO strategies, guidelines, standards and technical tools developed in order to provide support to Member States in preventing and reducing public health problems caused by alcohol, drugs and other psychoactive substance use.	11	14	16

6.5

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

Fully Achieved

By the end of 2011, 79 Member States had adopted multi-sectoral strategies and plans for healthy diets or physical activity based on the Global strategy on diet, physical activity and health. During the biennium, WHO developed a guide to assist Member States in implementing the recommendations on the marketing of foods and non-alcoholic beverages as approved in resolution WHA63/14. WHO also published a set of Global recommendations on physical activity for health and has been working with Member States to implement them at national level.

At the regional level, in the Eastern Mediterranean Region, WHO's advocacy efforts focused on intersectoral collaboration between ministries of education and local municipalities to facilitate the creation of walking spaces and control of availability of unhealthy food and fizzy drinks. The Regional Office for the Americas convened a technical expert group on

population salt reduction, which has developed a number of tools to assist Member States in implementing strategies. The Regional Office for South-East Asia convened a technical meeting on identifying regional priorities in the area of population salt reduction.

At the global level, a set of tools to assist Member States in prioritizing areas for action in the field of population-based prevention of childhood obesity have been developed and field tested in four regions. Multisectoral capacity building was carried out in nine countries in the Region of the Americas (Antigua, Aruba, British Virgin Islands, Dominica, Grenada, Jamaica, St. Kitts and Nevis, St Vincent and the Grenadines and Trinidad and Tobago) and nine countries in the European region (Armenia, Azerbaijan, Belarus, Georgia, Kyrgyzstan, Moldova, Tajikistan, Turkmenistan and Uzbekistan).

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
6.5.1 Number of Member States that have adopted multisectoral strategies and plans for healthy diets or physical activity, based on the WHO Global Strategy on Diet, Physical Activity and Health.	61	65	79
6.5.2 Number of WHO technical tools that provide support to Member States in promoting healthy diets or physical activity.	16	20	22

6.6

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

Partly Achieved

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

WHO provided technical support to countries for the following: improving measurement of unsafe sex, developing sexual health strategies and curricula for comprehensive sexual health education, and producing documentation on country experiences and action plans to implement related regional and global frameworks. WHO also contributed to: the drawing up of the Asia-Pacific framework for the elimination of congenital

syphilis and paediatric HIV infection; the development of sexuality education standards; an analysis of sexual health and sexual behaviours of population sub-groups, including adolescents; and the development and testing of sexual health indicators. Analyses of global trends and levels of unsafe abortion, stillbirths and maternal mortality levels as major consequences of unsafe sex, were carried out and disseminated, following consultation with countries.

The Organization-wide expected result was assessed to have been “partly achieved” because of limited progress in some regions, particularly the African and Eastern Mediterranean Regions, as a result of limitations in funding and prioritization.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
6.6.1 Number of Member States generating evidence on the determinants and/or consequences of unsafe sex.	8	10	22
6.6.2 Number of Member States generating comparable data on unsafe sex indicators using WHO STEPS surveillance tools.	2	5	5

SUMMARY OF FINANCIAL IMPLEMENTATION

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.

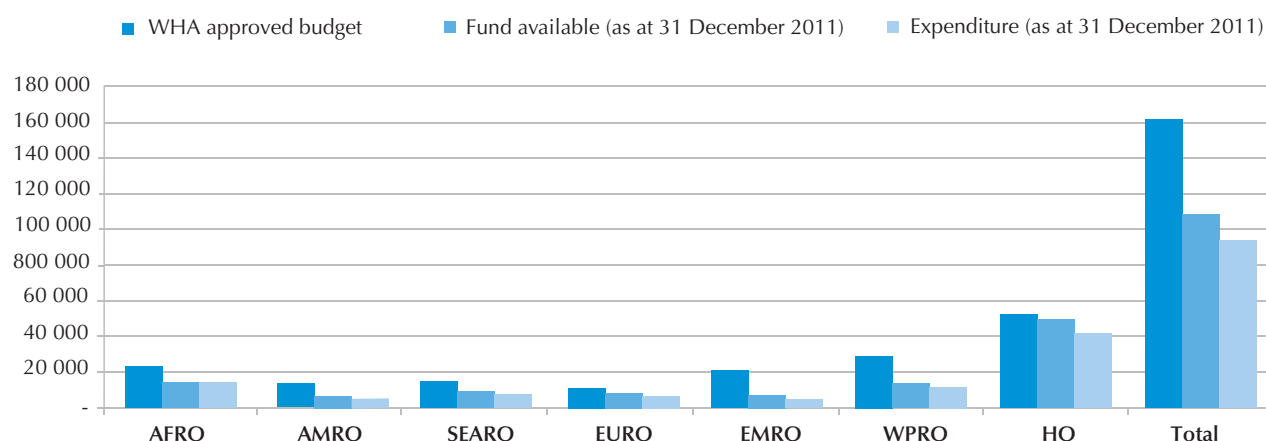
Available funding was US\$ 109 million (67% of the approved Programme budget), US\$ 94 million for Base programmes (63% of the approved Programme budget for Base programmes) and US\$ 15 million for Special programmes and collaborative arrangements (112% of the approved budget for Special programmes and collaborative arrangements). Available resources in Base programmes have been 70% and less in the Regional Offices for Africa, the Americas, South-East Asia and the Eastern Mediterranean Region.

Implementation as at 31 December 2011 was US\$ 94 million, which corresponds to 58% of the approved budget and 86% of the available resources. US\$ 81 million was the implementation for Base programmes, which corresponds to 54% of the approved budget for Base programmes and 86% of the available funds for this budget segment. Implementation against the approved budget was very low in all major offices with the exception of the Regional Office for Europe and headquarters.

Implementation in Special programmes and collaborative arrangements was US\$ 13 million (99% of the approved budget and 89% of the funds available).

All Segments

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	23 943	12 898	13 702	9 713	22 119	28 172	51 133		161 680
Funds Available									
AC	8 349	2 920	3 627	1 055	4 185	3 382	7 548		31 066
VC	4 609	2 894	5 992	7 505	4 287	9 413	42 941	38	77 680
Total	12 958	5 813	9 620	8 560	8 472	12 795	50 489	38	108 746
Funds Available as % of approved budget	54%	45%	70%	88%	38%	45%	99%		67%
Expenditure	12 218	5 328	8 322	7 823	6 763	11 702	41 871		94 028
Expenditure as % of approved budget	51%	41%	61%	81%	31%	42%	82%		58%
Expenditure as % of funds available	94%	92%	87%	91%	80%	91%	83%		86%



DETAILS OF INDICATOR ACHIEVEMENT

6.1.1 African Region: Angola, Benin, Botswana, Burundi, Côte d'Ivoire, Eritrea, Ethiopia, Ghana, Malawi, Mozambique, Nigeria, Seychelles, Togo, United Republic of Tanzania, Zimbabwe. **Region of the Americas:** Argentina, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guyana, Honduras, Jamaica, Mexico, Panama, Paraguay, Peru, Saint Vincent and the Grenadines, Trinidad and Tobago, United States of America, Uruguay. **Eastern Mediterranean Region:** Bahrain, Djibouti, Iran (Islamic Republic of), Jordan, Kuwait, Oman, Pakistan, Qatar, Saudi Arabia, Syrian Arab Republic, United Arab Emirates, Yemen. **European Region:** Albania, Andorra, Austria, Belarus, Belgium, Bosnia and Herzegovina, Croatia, Cyprus, Denmark, Finland, France, Georgia, Germany, Greece, Iceland, Ireland, Israel, Italy, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Romania, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, The former Yugoslav Republic of Macedonia, Turkey, Ukraine, United Kingdom of Great Britain and Northern Ireland. **South-East Asia Region:** Bangladesh, India, Indonesia, Maldives, Nepal, Sri Lanka, Thailand. **Western Pacific Region:** Cambodia, China (People's Republic of), Cook Islands, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Micronesia (Federated States of), Mongolia, Palau (Republic of), Philippines, Republic of Korea, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam, and in addition American Samoa.

6.2.1 African Region: Algeria, Benin, Botswana, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Sao Tome and Principe, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Bahamas, Barbados, Chile, Dominica, Grenada, Paraguay, Saint Kitts and Nevis, Trinidad and Tobago, Uruguay. **Eastern Mediterranean Region:** Bahrain, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libya, Oman, Pakistan, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia. **European Region:** Georgia. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand. **Western Pacific Region:** Cambodia, China (People's Republic of), Cook Islands, Fiji, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, Niue, Palau (Republic of), Papua New Guinea, Philippines, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, Viet Nam.

6.2.2 African Region: Algeria, Angola, Benin, Botswana, Ghana, Kenya, Malawi, Mauritania, Mauritius, Namibia, Senegal, Seychelles, Swaziland, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Antigua and Barbuda, Argentina, Belize, Chile, Colombia, Costa Rica, Dominica, Ecuador, Grenada, Guatemala, Guyana, Jamaica, Nicaragua, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Djibouti, Egypt, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen. **European Region:** Tajikistan, The former Yugoslav Republic of Macedonia. **South-East Asia Region:** India, Indonesia, Maldives, Myanmar, Sri Lanka, Thailand. **Western Pacific Region:** China (People's Republic of), Cook Islands, Fiji, Kiribati, Mongolia, Nauru, Niue, Philippines, Samoa, Solomon Islands, Tonga, Tuvalu.

6.3.1 African Region: Benin, Botswana, Cap Verde, Central African Republic, Chad, Comoros, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Liberia, Malawi, Mali, Mauritania, Niger, Sao Tome and Principe, Sierra Leone, South Africa, Swaziland, Togo, United Republic of Tanzania, Zambia. **Region of the Americas:** Argentina, Bahamas, Barbados, Brazil, Chile, Dominica, Grenada, Mexico, Paraguay, Saint Kitts and Nevis, Trinidad and Tobago, Uruguay. **Eastern Mediterranean Region:** Bahrain, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libya, Oman, Qatar. **European Region:** Georgia, Poland, Romania, Russian Federation, Turkey, Ukraine. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand. **Western Pacific Region:** Cambodia, China (People's Republic of), Fiji, Lao People's Democratic Republic, Malaysia, Micronesia (Federated States of), Mongolia, Niue, Palau (Republic of), Papua New Guinea, Philippines, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

6.3.2 African Region: Burkina Faso, Chad, Namibia, Seychelles. **Region of the Americas:** Barbados, Canada, Colombia, Guatemala, Honduras, Panama, Peru, Trinidad and Tobago, Uruguay. **Eastern Mediterranean Region:** Iran (Islamic Republic of), Libya, Pakistan. **European Region:** Albania, Greece, Ireland, Malta, Spain, Turkey, Turkmenistan, United Kingdom of Great Britain and Northern Ireland. **South-East Asia Region:** Bhutan, Maldives, Thailand. **Western Pacific Region:** Australia, Marshall Islands, Nauru, New Zealand.

6.3.3 African Region: Chad, Eritrea, Kenya, Madagascar, Niger. **Region of the Americas:** Colombia, Panama. **Eastern Mediterranean Region:** Djibouti, Iran (Islamic Republic of), Jordan, Kuwait, Qatar, Sudan, Syrian Arab Republic, United Arab Emirates. **European Region:** Montenegro, Norway, Turkey. **South-East Asia Region:** Myanmar, Thailand.

6.4.1 African Region: Botswana, Ghana, Liberia, Malawi, Namibia, South Africa. **Region of the Americas:** Argentina, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Chile, Costa Rica, Dominican Republic, El Salvador, Guatemala, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Iran (Islamic Republic of), Lebanon, Morocco, Oman, Pakistan, Somalia. **European Region:** Belarus, Croatia, Estonia, Georgia, Kazakhstan, Lithuania, Republic of Moldova, Romania, Serbia, Ukraine. **South-East Asia Region:** Bhutan, India, Maldives, Myanmar, Sri Lanka, Thailand. **Western Pacific Region:** Cambodia, China (People's Republic of), Fiji, Lao People's Democratic Republic, Malaysia, Mongolia, Philippines, Tonga, Vanuatu, Viet Nam.

6.5.1 African Region: Algeria, Benin, Cap Verde, Gabon, Madagascar, Mozambique, Nigeria, South Africa, United Republic of Tanzania, Zambia. **Region of the Americas:** Barbados, Bolivia (Plurinational State of), Brazil, Canada, Chile, Guatemala, Jamaica, Mexico, Paraguay, Saint Lucia, United States of America, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Bahrain, Egypt, Iraq, Lebanon, Oman, Saudi Arabia, Tunisia. **European Region:** Armenia, Belarus, Belgium, Czech Republic, Denmark, Estonia, Finland, Germany, Hungary, Iceland, Ireland, Italy, Kazakhstan, Latvia, Lithuania, Monaco, Montenegro, Poland, Russian Federation, San Marino, Slovakia, Slovenia, Tajikistan, The former Yugoslav Republic of Macedonia, United Kingdom of Great Britain and Northern Ireland. **South-East Asia Region:** Bangladesh, Democratic People's Republic of Korea, India, Indonesia, Maldives, Sri Lanka, Thailand. **Western Pacific Region:** Cambodia, Cook Islands, Fiji, Japan, Kiribati, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, Niue, Palau (Republic of), Papua New Guinea, Philippines, Republic of Korea, Singapore, Tonga, Vanuatu.

6.5.2 The list of tools can be made available upon request

6.6.1 African Region: South Africa, Uganda. **Region of the Americas:** Argentina, Chile, Guatemala, Jamaica, Nicaragua. **European Region:** Albania, Kazakhstan, Latvia, Republic of Moldova, Romania, Turkey, Ukraine. **South-East Asia Region:** Bangladesh, India, Indonesia, Maldives, Nepal, Thailand. **Western Pacific Region:** China (People's Republic of), Viet Nam.

6.6.2 South-East Asia Region: India, Maldives, Sri Lanka. **Western Pacific Region:** China (People's Republic of), Viet Nam.

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



ASSESSMENT OF THE ORGANIZATION-WIDE EXPECTED RESULTS

Of the five Organization-wide expected results for this strategic-objective, two were «fully achieved» and three «partly achieved».

Overview

Despite increasing global political attention, health inequities continue to grow within and between countries, aggravated by rapid urbanization, man-made and natural disasters, economic recession, and unemployment. Tackling inequities in health is a major public health priority. Member States increasingly seek innovative ways to foster intersectoral collaboration on the social and economic determinants of health and see the need to integrate equity-enhancing, pro-poor, gender-responsive and ethically sound approaches into their health sectors and social policies and programmes.

In order to advance implementation of resolution WHA62/14 to reduce health inequities through action on the social determinants of health, experiences from Member States were systematically analysed with regard to their regional specificities. This resulted in a global commitment during the World Conference on Social Determinants of Health, held in Rio de Janeiro, Brazil, in October 2011. The outcome of the Conference, the Rio Political Declaration on Social Determinants of Health, was endorsed in Resolution EB130.R11: Outcome of the World Conference on Social Determinants of Health. The Resolution recommends, inter alia, a better coordination of work between different stakeholders, such as ministries of health, education, housing and social services. Other major stakeholders include, civil society, the academic community, scientific and research groups, the private sector and bilateral donors. Better governance is called for at global, regional, national and local levels, and WHO is urged to ensure that work on social determinants of health carried out by different United Nations agencies is better aligned and harmonized. As a result, the demand from Member States for assistance from WHO has increased sharply: a total of 84 Member States requested technical assistance during the biennium. Improved harmonization and coordination has also been integrated into a number of disease-specific programmes across the Organization.

Globalization and trade have a major influence on health outcomes. WHO strives to support Member States in building capacity to assess the impact of trade and on health outcomes. A number of publications, including books, briefing documents and fact sheets, among others, *How to conduct patent searches for medicines: a step-by-step guide*, were produced during the biennium. As part of trilateral cooperation between WHO, WIPO and WTO, several joint activities were organized.

WHO has a specific mandate to ensure that ethical analysis is included in health policies and programmes. Close collaboration with national ethics committees, WHO Collaborating Centres for Bioethics and other international organizations active in the field, facilitates synergies between different global initiatives. In public health ethics, following the adoption in 2010 of resolution WHA63/22 on Human organ and tissue transplantation, a working group of representatives of national ethics committees was established to work on its implementation in countries. Ethical guidance on tuberculosis control was also developed and disseminated in countries. In research ethics, technical support was provided to Member States for strengthening ethics review systems, including clinical trial registration.

Worldwide, people are increasingly aware of their economic and social rights, including the right to health. They are demanding increased transparency and accountability for the realization of the right to health. As a result, the role of United Nations agencies is shifting towards supporting governments in building coherent and sustainable systems of governance that promote and protect human rights. At country level, the national health sector strategic plan serves as a roadmap for realization of the right to health. An important achievement was the support provided by WHO to countries for reviewing

their national health-sector strategic plans in order to ensure they are coherent with their health-related human rights obligations and commitments, such as the right to accessible and affordable health services, the right to participate in decision-making processes, and the right to redress through mechanisms of accountability.

A mid-term review was undertaken across the Organization to overview progress on implementing the WHO gender strategy. Among the key achievements was an increase in capacity building efforts. The Gender, Women and Health Network saw an increase in the number of gender focal points to 112 across all WHO regions.

7.1

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

Fully Achieved

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

The framework and findings of the Knowledge Networks of the Commission on Social Determinants of Health were used to support integration of social determinants of health and health equity into national health plans and public health strategies in nine countries. Six countries were supported to build the leadership capacity of health ministries to enable them to coordinate and manage interventions for reducing the equity gap by addressing social determinants of health.

Social determinants of health are being integrated into the work of all three levels of the Organization. The WHO country cooperation strategies guide specifically emphasizes the need to address social determinants of health and equity, and provides practical guidelines for countries. Currently, work on social determinants of health is highlighted in more than 80 country cooperation strategies. In 2010, the Secretariat prepared a report for the United Nations Secretary General on global health and foreign policy, which included governance mechanisms. The United Nations General Assembly, in resolution A/RES/65/95, noted with appreciation the report and its recommendations. Regional offices have focused on regional governance mechanisms. The Regional Committee for Africa endorsed its regional strategy to address key determinants of

health in the African Region in resolution AFR/RC60/R1. The Regional Office for Europe commissioned a regional review of the health divide and inequalities in health in order to provide information to underpin the new regional health policy. In its first phase, the review assessed levels of inequalities in health across the European Region, identifying barriers to, and opportunities for, reducing them, and published an interim report in December 2010. The resulting evidence informed the new European policy for health – Health 2020, which places emphasis on reducing health inequities in the 53 Member States of the Region.

While action on social determinants of health needs to be taken at all levels of government – local, sub-national and national – this often proves difficult owing to WHO's limited technical capacity to provide support at country level. Additional problems include political instability, complex emergencies, lack of social protection for the poor in least-developed countries and illiteracy among women in deprived areas.

To address such obstacles, WHO is currently engaged in building a case that highlights the economic benefits to be derived from addressing social determinants of health and reducing health inequities. Interventions include: scaling up of the Urban Health Equity Assessment and Response Tool (UrbanHEART) for work with local governments at the municipal corporation level; strengthening collaboration with networks, such as the Healthy Cities Network and other regional networks of civil society organizations; and stepping up capacity building efforts within WHO and at national level for public health programmes through workshops.

INDICATOR	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
7.1.1 Number of WHO regions with a regional strategy for addressing social and economic determinants of health as identified in the Report of the Commission on the Social Determinants of Health endorsed by the Director-General.	4	5	5

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.

Fully Achieved

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

Globalization and trade have a major influence on health outcomes. During the biennium, WHO continued to support Member States in building capacity to assess the impact of trade on health outcomes. Several publications, including books, briefing documents and fact-sheets were produced during the biennium, among others, *How to conduct patent*

searches for medicines: a step-by-step guide. Three countries in the Western Pacific Region and two in the South-East Asia Region were supported to enhance knowledge and awareness regarding linkages between trade and health and the implications of flexibilities in the Trade-related aspects of intellectual property rights (TRIPS) agreement. WHO established active tri-lateral cooperation with WIPO and WTO at global level and the three organizations are currently organizing a series of joint technical symposiums on issues covered by the Global strategy and plan of action on public health, innovation and intellectual property. The second symposium on “Access to medicines, Patent Information and Freedom to Operate” was held in February 2011. Jointly with UNDP and UNAIDS, WHO published a policy brief on the flexibilities in the TRIPS Agreement to improve access to HIV/AIDS treatment. The paper reviews how countries can and have used the flexibilities of the TRIPS Agreement to increase access to HIV treatment.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
7.2.1 Number of published country experiences on tackling social determinants for health equity.	10	14	28
7.2.2 Number of tools to support countries in analysing the implications of trade and trade agreements for health.	8	9	9

7.3

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

Partly Achieved

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

Overall, the capacity of Member States and technical programmes to collect data is still weak and more effort is needed to institutionalize the collection of disaggregated data and monitoring of health inequities. Experience shows that persuading countries to move beyond the indicators and develop a more comprehensive understanding of what lies behind them, and to make use of other sources of knowledge to build more comprehensive and specific situational analyses continue to pose a challenge.

Despite the obstacles, regions have made progress. The South-East Asia Region found that target populations can be identified through qualitative research that shows the context

of inequity and injustice in broader determinants of health, especially trade, human rights and public policies influencing health. For the African Region, it was helpful to identify key people in ministries of health or other constituencies in order to facilitate data analysis, reporting and dissemination and joint planning between the Secretariat and the ministry of health. An expert group was also established in the Region, to support countries in conducting health equity analysis; it found that utilizing the template for national health equity reports helped to streamline the work. Moreover, in the Eastern Mediterranean Region, although no country has yet reported on health indicators using disaggregated data, Egypt, Morocco, Pakistan, Sudan and Tunisia received training in assessing health equity in urban areas of five mega cities using Urban HEART.

While, overall, the target of country reports published during the biennium incorporating disaggregated data and analysis of health equity was met, this Organization-wide expected result was assessed as partly achieved. This was mainly due to the partial achievement of the result in the Eastern Mediterranean Region where many countries have not yet institutionalized the collection of disaggregated data, and in headquarters where the monitoring of health inequities and collection and use of disaggregated data was not sufficiently mainstreamed within WHO programmes or consolidated through the Global Health Observatory.

INDICATOR	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
7.3.1 Number of country reports published during the biennium incorporating disaggregated data and analysis of health equity.	35	40	46

7.4

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

Partly Achieved

WHO has a specific mandate to ensure that ethical analysis is included in health policies and programmes. Applying ethical standards is imperative for clinical trials and health research. Close collaboration between national ethics committees, WHO Collaborating Centres for Bioethics and other international organizations active in the field facilitated synergies between different global initiatives. Following the adoption of resolution WHA 63/22 on Human organ and tissue transplantation, a working group of representatives of national ethics committees was established to work on its implementation in countries. Guidance on ethical aspects of tuberculosis control was developed and disseminated in countries, and technical support was provided to Member States to enable them to strengthen their ethics review systems, including clinical trial registration. The number of clinical trials registered in the International Clinical Trial Registry Platform (ICTRP) database grew by 50 557 to a total of 153 092 by the end of 2011.¹ It is vital for all clinical trials to be registered in order to increase transparency for both researchers and users. WHO supported countries in reviewing national health-sector strategic plans in the light of their health-related human rights obligations and commitments, including the right to accessible and affordable health services, the right to participate in decision-making processes, and the right to redress through mechanisms of accountability.

To support Member States in the application of a human rights-based approach to health, WHO developed nine new tools in collaboration with other partners, including fact sheets on the right to water and on a human-rights based approach to health; a revised cartoon on HIV and human rights; and a tool on Human rights and gender equality in health sector strategies: how to assess policy coherence. The Regional Office for

South-East Asia prepared a study on the right to health in the constitutions of its 11 Member States, while the Regional Office for Africa produced a report on Health and human rights in the African Region: current situation and way forward for discussion by the Regional Committee for Africa at its Sixty-second session.

WHO serves as the permanent secretariat for the Global Summit of National Ethics Committees; in 2010, the eighth global summit was attended by representatives from 35 countries and four priority issues were identified: research ethics, bio banking, ethics of infectious diseases care and treatment, and ethics of transplantation. A global data base of national ethics committees is now available on the WHO web site with information on committees established in more than 90 countries; opinions published by these committees will soon be available. The Mexican National Ethics Committee hosted a regional meeting of national ethics committees in October 2011, establishing the basis for future regional networking activities. A similar regional event will take place in sub-Saharan Africa before the Ninth Global Summit of National Ethics Committee.

The Organization-wide expected result was partly achieved because the European and South-Eastern Asia Regions reported partial achievement of the expected results, primarily as a result of lack of capacity for identifying and addressing emerging priority issues and responding to urgent requests from countries. In addition, the reporting process was hampered by insufficient information on ethical activities implemented by countries in some regions.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
7.4.1 Number of tools produced for Member States or the Secretariat giving guidance on using a human rights-based approach to advance health.	28	37	37
7.4.2 Number of tools produced for Member States or the Secretariat giving guidance on use of ethical analysis to improve health policies.	12	16	16

7.5

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

Partly Achieved

In the area of gender and health, progress on mainstreaming gender within national policies and health interventions was observed, notably in the African Region and the Region of the Americas, where gender mainstreaming collaboration plans were developed in 10 countries. Following ongoing capacity development training in gender-based analysis in the Andean Region, high-level stakeholders selected key indicators on gender and health and agreed to include them in the list of social indicators of the Comunidad Andina de Naciones. Significant progress was also observed in the Western Pacific Region. In the Eastern Mediterranean Region, operational research on gender and health was supported in Afghanistan, Egypt, Jordan, Pakistan and Yemen. Technical support was provided to Afghanistan for preparation of a national health sector strategy on gender, and to Pakistan for the development of a national health sector protocol on gender-based violence.

WHO produced 98 guidance documents and tools, including publications on linkages between gender and gender-based violence and HIV, and implemented joint activities with different technical areas, including on Gender and primary care renewal, and in connection with a Gender and human rights tool. The Gender, Women and Health Network saw an increase in the number of gender focal points to 112 across all WHO regions.²

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

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
7.5.1 Number of WHO tools, documents (developed or updated) and joint activities with WHO technical units to promote gender responsive actions into the work of WHO.	63	85	98
7.5.2 Number of gender mainstreaming activities conducted in Member States supported by WHO.	142	170	189

SUMMARY OF FINANCIAL IMPLEMENTATION

The total approved budget for the biennium 2010–2011 for strategic objective 7 was US\$ 63 million for Base programmes. As at 31 December 2011, available resources were US\$ 42 million (67% of the approved budget). The implementation rate (expenditures) against available funds as at 31 December 2011 was 88%.

The relatively low level of available resources against the approved budget, especially in the Region of the Americas and the Eastern Mediterranean Region was due to lack of voluntary contributions.

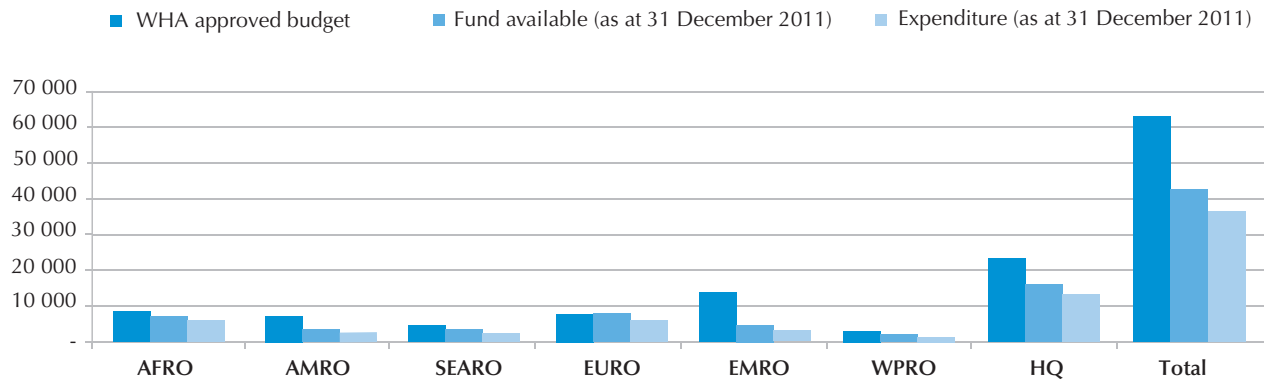
The low level of financing against the approved Programme budget is also one of the main reasons for the low overall implementation (expenditure) of 59%, while the overall implementation against funds available was 88%.

Much of the funding secured during the biennium 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. 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 in 2012-2013.

All Segments

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	8 495	6 422	4 501	6 944	11 835	2 011	22 439		62 647
Funds Available									
AC	5 203	1 319	1 089	851	2 462	180	4 796		15 900
VC	2 101	1 099	2 030	6 101	2 345	1 676	10 513	-	25 863
Total	7 304	2 418	3 118	6 951	4 806	1 856	15 309	-	41 763
Funds Available as % of approved budget	86%	38%	69%	100%	41%	92%	68%		67%
Expenditure	6 462	2 307	2 639	5 693	4 259	1 698	13 868		36 926
Expenditure as % of approved budget	76%	36%	59%	82%	36%	84%	62%		59%
Expenditure as % of funds available	88%	95%	85%	82%	89%	91%	91%		88%



REFERENCES

- 1 The average number of monthly hits on the ICTRP search portal (<http://www.who.int/trialsearch>) increased from 140 000 in 2009 to 2 100 000 in 2011. As a result, the ICTRP is number 3 on WHO's top ranking list, after classifications and the WHO media centre.
- 2 The focal point system, which has been the main strategy of the United Nations system-wide policy on gender equality and the empowerment of women recognized by the United Nations Chief Executives Board for Coordination, provides technical support for the integration of gender within WHO programmes at regional and country level and monitoring of implementation of the WHO Gender Strategy.

DETAILS OF INDICATOR ACHIEVEMENT

7.1.1 The African Region, the Region of the Americas, the European Region, the South-East Asia Region and the Western-Pacific Region.

7.2.1 The list of country experiences publications can be made available upon request.

7.3.1 African Region: Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Ethiopia, Gabon, Ghana, Guinea, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, South Africa, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **European Region:** Denmark, Finland, Lithuania, Norway, Poland, Slovenia, Spain, United Kingdom of Great Britain and Northern Ireland. **South-East Asia Region:** Bangladesh, India, Indonesia, Maldives, Nepal, Sri Lanka, Thailand. **Western Pacific Region:** Mongolia.

7.4.1 The list of tools produced during this reporting period can be made available upon request.

7.4.2 The list of tools produced during this reporting period can be made available upon request.

7.5.1 The list of tools produced during this reporting period can be made available upon request.



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



ASSESSMENT OF THE ORGANIZATION-WIDE EXPECTED RESULTS

Of the six Organization-wide expected results for this strategic-objective, four were «fully achieved» and two «partly achieved».

Overview

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

In its global leadership and convening role, WHO raised awareness of priority environmental and occupational health concerns in high-level forums and events, including in the context of international environmental agreements and related processes¹ and catalyzed high-level political commitment for country action to address those priority health concerns.²

WHO contributed to global monitoring and evaluation efforts associated with achievement of the Millennium Development Goals, in particular Target 7c, through the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation, and through the UN-Water Global Annual Assessment of Sanitation and Drinking Water (GLAAS).

Headquarters and regional offices, facilitated the development and implementation of global and regional strategies to align and harmonize country-level actions in order to address specific environmental and occupational risks (for example, health-care waste and safer use of radiation in health care settings), to strengthen engagement of the health sector in the Strategic Approach to International Chemicals Management (SAICM), to scale up action on particular occupational diseases (for example, asbestosis), to phase-out lead paint, to deliver integrated intervention packages in specific settings (for example, healthy workplaces, healthy cities and healthy hospitals), and to strengthen environmental and occupational health-risk management systems (for example, through the integration of essential occupational health interventions into primary health-care services, through strengthened poisons centres, greater use of water-safety plans, and enhanced health systems capacity to respond to increased demands posed by climate change). Through its country offices, WHO provided technical support for the implementation of primary prevention interventions, and for the articulation and implementation of national environment and health action plans.

Implementation of the activities under the strategic objective required substantial intersectoral engagement and collaboration. In addition to working with health development partners such as the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria, WHO also worked with United Nations agencies, multilateral financial institutions, bilateral and multilateral agencies, nongovernmental organizations and trade unions.

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).

Fully Achieved

Overall, knowledge on environmental risk factors to human health in countries across WHO regions increased. Often as a result of intersectoral political commitments, 67 countries reported conducting assessments of specific environmental threats using WHO tools and guidance on risk assessment as compared to 42 in the previous biennium. For example, in the African Region, within the ambit of the Libreville Declaration and follow-up process, 15 countries carried out national environment and health situation analyses and needs assessments, with financial and technical support from WHO. Similar momentum was created in the European Region by the Fifth Ministerial Conference on Environment and Health in March 2010; in the South-East Asia Region by the Second Ministerial Regional Forum on Environment and Health in July 2010; and in the Western Pacific Region by the Second East Asia Ministerial Conference on Sanitation and Hygiene in January 2010.

Global monitoring of progress towards achievement of Millennium Development Goals targets related to water and sanitation (Goal 7 target 10) and household solid fuel use (Goal 7 target 9) continued, for example, through the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation, and the UN-Water Global Annual Assessment of Sanitation and Drinking Water (GLAAS). In 2010, WHO and UNICEF launched the report, *Progress on sanitation and drinking-water – 2010 update*. The second UN-Water Global Annual Assessment of Sanitation and Drinking Water (GLAAS) report entitled *Targeting resources for better results* was published in 2010 at the first annual High-Level Meeting of Sanitation and Water for All. In 2011, GLAAS surveys were carried out in over 60 countries across all WHO regions.

Further improvements were also observed in the coverage of vector-control interventions and in the information on the distribution of insecticide resistance in malaria vectors. Some WHO regions also reported that drinking water quality standards and guidelines had been developed; that implementation of water safety plans had led to safer drinking water; that infection control measures in hospitals had improved as a result of appropriate management of health care waste; and that wastewater reuse practices in Jordan had been made safer.

At the country level, WHO disseminated guidelines on situation assessment and needs analysis in the African Region. At regional level, a malaria programme review, tools for monitoring access to drinking water and sanitation, and a protocol on monitoring insecticide resistance were also introduced across

the regions. Country support missions were undertaken to train national staff, including country task teams on chemical risk analysis, waste water reuse, environmental health impact assessment, and occupational health. In some cases, financial support for related activities was also supplied. Support was also provided to countries for developing their national environmental health strategies, and, in particular, for carrying out evaluations under the auspices of the Global Assessment and Analysis of Sanitation and drinking-water (GLAAS), a holistic assessment of the sector.

At global and regional level, a guide for assessing current health and environment priority intersectoral actions at country level was prepared and disseminated to 10 countries in order to document outcomes and/or impacts of health and environment intersectoral action in selected African countries. The standard procedures for vector surveillance were finalized, and a protocol on insecticide resistance monitoring and management was updated.

A series of tools for assessing the health risks posed by chemicals were produced and delivered in a toolkit tailored for use in low-resource settings. Several reports on key chemicals were published, including on DDT in indoor residual spraying, as well as a series addressing 10 Chemicals of Major Public Health Concern. Some 80 international chemical safety cards were produced, augmenting the collection of cards already available in 24 languages. The WHO Recommended Classification of Pesticides by Hazard, which is used by developing countries in particular to support risk management decisions, was updated.

Several countries across different WHO regions reported publication of the following: a policy brief on water and sanitation and a report on climate change vulnerability, and a regional report on management of solid wastes. A regional meeting on pesticides under the WHO Pesticide Evaluation Scheme was held in Guatemala. In collaboration with the GAVI Alliance, health-care waste management was addressed in some regions, and technical and financial support was provided to many countries for developing their national guidelines.

Global recommendations and health-based targets for evaluating household water treatment and related guiding principles for laboratory protocols were established through the International Network on Household Water Treatment and Safe Storage.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
8.1.1 Number of Member States that have conducted assessments of specific environmental threats to health or have quantified the environmental burden of disease with WHO technical support during the biennium.	42	44	67
8.1.2 Number of new or updated WHO norms, standards or guidelines on occupational or environmental health issues published during the biennium.	18	20	21

8.2

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

Partly Achieved

A total of 92 countries reported scaling up the use of primary prevention interventions to address environmental and occupational determinants of health in specific settings, as well as for specific population groups. Some countries, for instance in the African, South-East Asia and Western Pacific Regions, included the use of primary prevention interventions for occupational and environmental health in their national environmental health action plans, or, in the case of the African Region, in their joint national environment and health plans of action.

The following is a summary of how countries are using different settings-based approaches for the delivery of environmental and occupational health interventions:

Homes: Interventions delivered in the home primarily address one or all of the following: malaria (through integrated vector management), indoor air pollution (through the use of improved fuel or cookstoves), and water and sanitation.

With respect to malaria control, many countries in the African Region have made notable progress in integrated vector management, particularly through the use of long-lasting insecticide-treated nets and indoor residual spraying for malaria control. The primary beneficiaries of increased coverage of the proportion of households using long-lasting insecticide-treated nets and indoor residual spraying include children under five and pregnant women. The proportion of children under five sleeping under long-lasting insecticide-treated nets exceeded 40% in 14 countries, and the proportion of pregnant women sleeping under such nets exceeded 40% in 10 countries, reaching 60% in Rwanda and 71% in Niger and Madagascar. The number of countries using indoor residual spraying for malaria control increased from 24 in 2009 to 29 in 2011. Subsequently, population coverage of indoor residual spraying increased from about 50 million in 2009 to about 75 million during the last two years. In 12 countries, between 30% and 85% of the population at risk was estimated to be protected by indoor residual spraying.

Many countries in the African, South-East Asia and Western Pacific Regions reported an increase in the use of household water treatment and safe storage interventions as key measures for ensuring the provision of safe drinking water in the home. Use of WHO recommended interventions, such as water safety plans, also increased.

In the African Region, many countries (especially those receiving technical support through the Global Alliance for Clean Cookstoves, supported by WHO) are actively promoting the use of household interventions to address indoor air pollution, particularly in the light of the impact that indoor air pollution has on maternal and child morbidity and mortality. Some countries in the African Region are also promoting chemical safety in the home, for example, in connection with the use of kerosene fuel for cooking, heating and lighting. In September 2010, the Global Alliance for Clean Cookstoves, of which WHO is a founding member, was launched with the aim of saving the lives of the 1.9 million people who die prematurely from, inter alia, childhood pneumonia, cardiovascular disease, chronic obstructive pulmonary disease and low birth weight as a result of exposure to air pollution from solid fuel. Through the Global Alliance, 100 million homes in low- and middle-income countries will be provided with access to clean cookstoves. In September 2011, WHO launched the global database of outdoor air pollution comprising data from nearly 1100 cities across 91 countries.

Workplace: Several countries in the Eastern Mediterranean Region, for example the Gulf Cooperation Council countries, have formally adopted healthy workplace initiatives. In other regions, countries scaled up efforts to improve chemical safety in workplace settings, in line with the Strategic Approach for International Chemicals Management (SAICM). Many are reported to have conducted advocacy and awareness-raising campaigns, as well as having initiated monitoring of poisonings (among children and in association with the use of pesticides in agriculture).

Health-care settings: Country actions to address environmental and occupational risks to health in health-care settings, as reported for the African Region, Region of the Americas, South-East Asia and Western Pacific Regions, were focused primarily on protecting the health of health-care workers (for example, through national programmes for preventing needle stick injuries, vaccination against hepatitis B), and improving health-care waste-management capacity and practices.

Healthy cities: Many countries in the African, European, South-East Asia and Western Pacific Regions reported having implemented initiatives in support of urban health. Key issues addressed included, household and municipal waste man-

agement and the promotion of physical activity (for example, through active transport, such as cycling and walking).

WHO, through its major offices in regions and at headquarters, provided technical support to countries through the following: direct provision of technical assistance for implementation of specific types of intervention; support for planning policies; provision of guidance on best practice for management of specific environmental and occupational risks; and support for an evaluation of the effectiveness of specific interventions.

Technical support was provided to 23 countries in the African Region for developing integrated vector management policies and implementing programmes to provide long-lasting insecticide-treated nets and indoor residual spraying to at-risk populations. The Regional Office facilitated malaria programme reviews in 19 countries³ and specific reviews on indoor residual spraying in three countries.⁴ It also undertook an intestinal prevalence survey in the three largest administrative regions (Amhara, Oromia and SNNPR) in Ethiopia in order to determine the level of effectiveness of de-worming campaigns using the WHO global cut off 20% for soil transmitted helminths. The information was used to inform a de-worming campaign in schools.

Guidelines on public health pesticide management policy for the African Region were published and disseminated to all Member States. Several vector-control tools were developed, including standard operating procedures for vector surveillance, the prototype of the vector control decision support tool and standards for organizing and building vector control services in order to eliminate malaria and other vector-borne diseases in the African Region.

Technical support was provided to countries by the Regional Offices for South-East Asia and the Western Pacific for the design and implementation of national programmes on household water treatment and safe storage and water safety plans. Technical support and guidance was also provided to countries for developing health-care waste management improvement plans. For instance, the Regional Office for Africa, with support from headquarters and the GAVI Alliance, provided technical support to 27 countries for the implementation of national plans for health-care waste management.

Technical support was provided by the Regional Office for the Eastern Mediterranean for the drawing up of a regional plan of action to promote healthy workplaces (affirmed in the Cairo

Declaration), and for the initiation of institutionalization activities, starting in Egypt and Oman. A technical review of sanitation and water policy was provided to some countries. The concept of basic occupational health services was introduced and technical assistance provided by the Regional office for South-East Asia to Bhutan, Sri Lanka and Thailand for implementing basic occupational health services and integrating workers' health into primary health care.

The Regional Office for the Americas, with support from headquarters, provided technical support to countries for the development and implementation of policies and programmes to promote the occupational health of health-care workers. During 2010–2011, the Urban Health Equity Assessment and Response Tool (Urban HEART) was introduced in nine African countries in order to assist policy makers and programmers to assess and respond to health inequities in cities. The Regional Offices for the Eastern Mediterranean, South-East Asia and the Western Pacific were actively involved in developing a conceptual framework of healthy workplaces at global level through a review process, as well as consultations and global workshops. The Regional Office for South-East Asia also hosted an international meeting on healthy workplaces, which enabled development of guidance on how to set up healthy workplaces.

A global framework for occupational health for health-care workers was drawn up by headquarters, in close collaboration with ILO and colleagues from the Regional Office for the Americas. Guidance on water and sanitation and the safe use of radiation in health-care settings was developed.

The obstacles faced in primary prevention have always been related to intersectoral working and the difficulty of establishing common objectives. Reducing environmental risks requires cooperation on the part of sectors that do not necessarily see health as their most important concern. Such obstacles are slowly being overcome by raising awareness of the links between health and the work of other sectors.

While the indicator targets were achieved, the Organization-wide expected result was assessed as having been partly achieved mainly because some work on risk communication, for example, in connection with radiation protection in health-care settings and radon in the home, had to be deferred to the next biennium because of resource constraints and the need for staff to respond to the Fukushima nuclear emergency. Similar human resource constraints affecting activities planned under the strategic objective were experienced in the Eastern Mediterranean Region.

INDICATOR	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
8.2.1 Number of Member States implementing primary prevention interventions for reducing environmental risks to health, with WHO technical support, in at least one of the following settings: workplaces, homes or urban settings.	48	52	92

8.3

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

Fully Achieved

National policy frameworks, strategies and action plans to support the management of environmental and occupational risks were put in place in 88 Member States, for example, in the African Region as part of the Libreville Declaration and follow-up process. By the end of 2011, an additional 13 countries⁵ had finalized their national situation assessment and needs analysis reports. Five more countries⁶ initiated the process, while Comoros, Gambia, Guinea and South Africa requested technical and financial support for the purpose. Situation assessment and needs analysis reports are used to inform the development of joint national action plans on environment and health, which then provide a framework for intersectoral action to address environmental and occupational determinants of health. Sixteen countries⁷ in the African Region developed national plans and programmes dealing specifically with the health of workers.

In the Eastern Mediterranean Region, the Gulf Cooperation Council countries formally adopted the Healthy Workplace initiative in Cairo in January 2010. WHO provided technical support for a regional plan of action to promote healthy workplaces and institutionalize related activities, starting in Egypt and Oman. Similar progress was reported in the South-East Asia Region, where nine out of 11 countries implemented national activities aimed at achieving the objectives of the Global plan of action on workers' health 2008–2017. A growing awareness of the need to foster stronger linkages between occupational health and primary health-care services became apparent during the process surrounding the global conference on the theme of Connecting Health and Labour: What Role for Occupational Health in Primary Health Care? co-organized by WHO in 2011. Country-level activities to promote and protect the health of health-care workers were also scaled up, for example, following the release, in 2010, of Health WISE, a WHO/ILO tool to improve working conditions in the health sector, which was piloted in the African Region and the Region of the Americas.

Countries also reported on their activities through regional consultations, held in July 2010, to update the occupational health strategy. As a result, new strategies for implementing the Global plan of action on workers' health 2008–2017 were identified, among which, the one most likely to be effective was the proposed integration of basic occupational health services in health systems. Sri Lanka and Thailand made significant progress in this area, particularly in setting up healthy workplace initiatives and engaging with the enterprise community.

In preventing exposure of workers to risks, including chemical risks, funds obtained through the Strategic Approach to International Chemicals Management (SAICM) enabled successful implementation of chemical safety programmes in Indonesia, Sri Lanka and Thailand, resulting in the voicing of intentions to phase in the banning of asbestos in Sri Lanka and Thailand.

The Regional Office for Africa provided technical assistance to Namibia, Nigeria and Tanzania (Zanzibar) for implementing national campaigns to immunize health-care workers against hepatitis B. In 2010, a mass yellow fever campaign in Guinea provided an opportunity to invest in strengthening health-care waste treatment technologies. As a result, four new high temperature incinerators were installed in the country and another was refurbished.

The Regional Office for South-East Asia facilitated participation by Member States' representatives in training activities and international forums. By highlighting the links between exposure risks and health outcomes and communicating the evidence, Member States were assisted in focusing their programmes on priority areas. With Member States having limited resources for implementation of occupational health programmes, resource mobilization support by the Regional Office enabled three countries (Bhutan, Maldives and Nepal) to raise funds for occupational and environmental health work. Specific progress made during the biennium included development of the National Occupational Health Profile, health and safety standards and manuals prepared by the health authorities in Bhutan, with technical support provided by the Regional Office and through collaborative work between the country's health and labour sectors. Policies and strategies conducive to workers' health were advocated through country-level reviews. Key to the process were stakeholder meetings and the integration of workers' health into primary health care, as well as a review of existing national legislation and integration of occupational health into primary health care.

With the WHO collaborating centre in Chennai, training modules for workers' health were developed and used in a training course held in Maldives, which marked the first step in the elaboration of a training of trainers course for programme managers. National programmes for addressing priority occupational risks and diseases were developed and implemented in Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Sri Lanka and Thailand. In Sri Lanka, eight training programmes

for national- and district-level medical and public health inspectors were implemented by the department responsible for delivery of occupational health services.

Technical support was provided to countries by the Regional Office for the Western Pacific to develop and strengthen national and local environmental health action plans and for occupational health and safety improvement programmes, especially in relation to asbestos, and protection of the health of informal workers. Technical support was also provided to some countries, for example, China, for harmonizing environmental and occupational health monitoring and for employing assessment tools, including health impact assessments and burden of disease methodologies.

In the African Region, in the context of the health and environment strategic alliance, WHO collaborated with UNEP in drawing up a draft framework for an African action plan to reduce risks posed by chemicals to human health and ecosystems. WHO prepared an assessment tool to enable countries to evaluate the extent to which joint actions are effectively implemented. The tool (guide for assessment of health and environment intersectoral action) is currently being used to document best practices in selected countries, including Cameroon, Ethiopia, Gabon, Kenya, Mali and Sierra Leone. The Regional Office for the Eastern Mediterranean actively engaged in developing a regional model for integrated management of workers' health. It also continued its support for occupational health programmes and plans at regional and national level based on the strategic regional framework for implementing the Global plan of action on workers' health. In the European Region, the main achievement was an update of the environment and health and occupational health indicators as part of the preparation of background documentation for the Ministerial Conference on Environment and Health, held in Parma, in

March 2010. This included follow-up workshops conducted in November 2010 to define the set of indicators that Member States would use to report on their progress in achieving the Parma commitments, and to measure inequalities in environment and health.

At global level, a review and analysis of national policies and profiles on workers' health in 50 countries was carried out as planned. Technical assistance was provided to Member States for implementing policy commitments under the WHO Global plan of action on workers' health and for national efforts to prevent diseases related to asbestos and silica, and other airborne diseases, in close collaboration with regional offices. New linkages were established in headquarters between the Departments of Protection of the Human Environment and Health Systems and Services to support work on integrating or linking basic occupational health services with primary care services. In respect of the management of chemical risks, significant progress was made in strengthening poisons centre networks, particularly in the African, South-East Asia and Western Pacific Regions. Key achievements included: capacity development conducted for expansion of the global network of poisons centres (14 centres now use the WHO INTOX Data Management System); and updating of the WHO global directory of poisons centres and its transfer to the Global Health Observatory. In the South-East Asia Region, efforts to develop guidelines for establishing healthy workplaces resulted in the production of a tool for action. The Regional Office contributed to the global occupational health efforts by hosting an international conference on healthy workplaces, during which it became apparent that over 70% of workers in the informal sector were not covered by the guidelines, therefore, further work has been carried out on developing a framework for action in the informal sector.

INDICATOR	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
8.3.1 Number of Member States that have implemented national action plans/policies for the management of occupational health risks, such as in relation to the Global Plan of Action on Workers' Health (2008–2017), with support from WHO.	67	72	88

8.4

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

Partly Achieved

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

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

WHO co-sponsored the 1st International Conference on UV and Skin Cancer, held in Copenhagen, in May 2011, bringing together stakeholders from around the world. Work on a booklet compiling policy interventions for sunbeds and a complementary sunbed policy database were initiated.

During 2010–2011, WHO, the Ministry of Health of Ghana, and the Ghana Health Service piloted the use of a new WHO strategic health impact assessment framework in the country's rapidly emerging oil and gas sectors. A range of health impacts associated with cumulative and multiple investments in other sectors is being assessed, including issues connected with rapid population migration to certain geographical areas, such as ports, and servicing of the oil operations, as well as potential health impacts associated with related infrastructure developments, such as pipelines, refineries and other petrochemicals facilities. The impact of occupational and public health risks on health systems is also being assessed in order to identify the capacities needed to respond to the impacts identified. Technical support was provided to six countries in the African Region for strengthening management of pesticides so as to reduce risks posed by pesticides to public health.⁸

In the European Region, advances were made in implementation of two new projects, supported by the Directorate-General for Health and Consumers of the European Commission, on capacity building in environment and health (subregional workshops organized in Estonia and Hungary), and physical activity promotion (work in progress on all work packages). The European Network for the promotion of health-enhancing physical activity (HEPA) introduced new activities and held steering committee meetings, as well as its annual meeting in November 2010; other work on occupational health progressed as planned.

In the South-East Asia Region, advocacy documents on water and sanitation were prepared and disseminated to all Member States as part of World Water Day. In the Western Pacific Region, technical support was provided to the health sectors of Member States for influencing policies in other government sectors, including: (1) the transport sector (environmentally sustainable transport and environmentally sustainable and healthy urban transport). Technical assistance was provided to Cambodia, China, Lao People's Democratic Republic, Malaysia, Mongolia and the Philippines. Six cities have implemented and documented progress on implementing environmentally sustainable and healthy urban transport (Cambodia, China, Japan, Philippines and Republic of Korea); (2) the agriculture sector (pesticides management) with technical assistance provided to Cambodia for activities associated with the WHO pesticide evaluation scheme; and (3) the industrial sector: China began harmonizing the monitoring of occupational and environmental health in the brick, chemical manufacturing and power generation industries.

The Regional Office for Africa coordinated the work of the WHO-UNEP Joint Task Team in support of the Health and Environment Strategic Alliance (HESA). A road map was disseminated to key partners including, WHO, UNEP, the African Development Bank and selected countries. A number of initiatives and consultations took place in collaboration with other sectors in the Region of the Americas, such as training in health and tourism (development of a manual/guide for training of trainers), and preparation of a manual on the vulnerabilities of water and sanitation systems, with the involvement in businesses, municipalities and nongovernmental organizations. In headquarters, significant progress was made in developing and

implementing environmental safeguards for WHO, including tools and modifications to internal capacity and monitoring and reporting. Health and development partners, including other United Nations agencies and the GAVI Alliance expressed interest in learning from WHO pilot experiences.

A systematic review of the health co-benefits of climate change mitigation policies in five sectors was completed (housing, transport, agriculture, health and household energy) and launched at major environment and health events globally, for example, the World Conference on Social Determinants of Health and United Nations Climate Change Conferences, held in Cancun in 2010 and Durban in 2011.

April 2011 marked the twenty-fifth anniversary of the nuclear accident at Chernobyl. WHO's Chernobyl risk communication strategy was updated in close collaboration with the Department of Communications, the Regional Office for Europe and IARC. Through the International Chernobyl Research and Information Network, seven workshops were held in 2011

for Chernobyl-affected population groups in Belarus, Russian Federation and Ukraine. Fact sheets on the current knowledge regarding mobile phones and health were developed, coinciding with the release of the IARC INTERPHONE study (May 2010) and the IARC classification on cancer hazards from radio frequency fields (June 2011).

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

INDICATOR	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
8.4.1 Number of Member States that are implementing WHO-supported initiatives to identify and address the health impacts of activities in one or more of the following sectors: agriculture, energy and transportation.	67	72	Not available

8.5

Health-sector leadership enhanced for creating a healthier environment and changing policies in all sectors so as to tackle the root causes of environmental threats to health, through means such as responding to emerging and re-emerging consequences of development on environmental health and altered patterns of consumption and production and to the damaging effect of evolving technologies.

Fully Achieved

Overall, awareness of the health risks associated with chemicals increased as a result of WHO's normative and risk assessment activities, including publication of reports on key chemicals, such as, on DDT in indoor residual spraying, and a series addressing the 10 Chemicals of Major Public Health Concern. Some 80 international chemical safety cards were produced, augmenting the collection of cards already available in 24 languages. The WHO recommended classification of pesticides by hazard was also updated.

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

In the African Region, the leadership of ministries of health was strengthened through the adoption of the Luanda Commitment on Implementation of the Libreville Declaration on Health and Environment in Africa. In the Region of the Americas, *Determinantes Ambientales y Sociales de Salud* was published and preparatory work for the United Nations Conference on Sustainable Development, to be held in Rio de Janeiro, Brazil in June 2012, was initiated. This included country implementation of a toolkit to measure sustainable development. In the Eastern Mediterranean Region, evidence-based decision making and planning capacity were enhanced through better access to reliable and relevant environmental health information. In the European Region, the Fifth European Ministerial Conference on Environment and Health, held in March 2010, resulted in the adoption of the Parma Declaration on Environment and Health and in a new institutional framework to advance implementation of the Parma commitments. A ministerial board for environment and health was also established.

A Second Ministerial Regional Forum on Environment and Health in South-East and East Asian countries took place in Jeju, Republic of Korea, in July 2010. 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.

Specifically within the South-East Asian Region, the main achievement was establishing health sector leadership in an urbanization and health campaign. All the countries of the Region engaged in the process bringing together many other sectors for an ongoing programme of activities over 2010. Greater awareness was created in all Member States of the relationship between urbanization and health. Particular progress was noted in Bangladesh, Indonesia, Maldives and Nepal. Maldives updated its national environmental health action plan to include collaborative actions. Myanmar was updating its national environmental health action plan; Sri Lanka has prioritized capacity building in occupational and environmental health. Health-related policies and guidelines for other sectors, for instance on a programme to eliminate asbestos-related diseases, were advocated.

In the Western Pacific Region, Member States, through regional meetings and forums on aspects of environmental and occupational health, enhanced health-sector leadership for creating a healthier environment. Major achievements included, the Second East Asia Ministerial Conference on Sanitation and Hygiene, an occupational health and safety initiative for small and medium-sized enterprises in Association of South-east Asian Nations (ASEAN) countries; and the Third Asia Asbestos Initiative Seminar, held back-to-back with a meeting on a regional framework for occupational health.

At global level, 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. Health and development partners, including other United Nations agencies and the GAVI Alliance expressed interest in learning from WHO pilot experiences using environmental safeguards for its public health activities. In 2010, countries began utilizing technical support from WHO in managing the health benefits and risks from extractive industry projects. Demand from countries for support in this area is growing steadily. WHO continued to encourage development banks to promote the adoption and implementation of criteria

for measuring and monitoring the impact on public health of the performance of their investments in developing countries in accordance with WHO guidance.

The Regional Office for Africa coordinated the preparation of the *First synthesis report on environmental determinants and management systems for human health and ecosystem integrity in Africa*. WHO coordinated the organization of the Second Inter-Ministerial Conference on Health and Environment in Africa, held in Luanda in November 2010. The Conference adopted three key elements: the Luanda Commitment on the Implementation of the Libreville Declaration; arrangements for a health and environment strategic alliance; and an African Ministers of Health and Environment Joint Statement on Climate Change and Health.

In the Region of the Americas, a final draft of *Health in the Americas* was completed. In addition, the following meetings received support: a high-level regional meeting for Rio+ 20 organized by the United Nations Economic Commission for Latin America and the Caribbean; a regional preparatory meeting for Ministers of Health for Rio + 20; and the 16th Conference of the Parties to the United Nations Framework Convention on Climate Change, hosted jointly with the Government of Mexico.

In the Eastern Mediterranean Region, WHO began implementation of a regional strategy on climate change and health. The Regional Centre for Environmental Health Activities, in co-operation with the UNEP, completed a joint capacity-building project in early 2011. More than 135 health and environmental health experts from Iraq, Jordan, Morocco, Syria, Tunisia and Yemen were trained as trainers in the use of Online Access to Research in the Environment (OARE) and Health Internet-network Access to Research Initiative (HINARI), which together

improve access to more than 8000 online refereed journals and several online databases for all institutions with an interest in health and the environment.

The Regional Centre for Environmental Health Activities established partnerships with the Hamdan Ben Mohammed e-University and the Center for Environment and Development for the Arab Region and Europe (CEDARE) to address the lack of certified training courses and workshops in different fields of environmental health. Efforts continued to start the first online training programme on environmental health risk assessment, management and communication.

In the Western Pacific Region, technical assistance and support were provided to Member States through regional meetings and forums on various aspects of environmental and occupational health in order to enhance health-sector leadership for creating a healthier environment. Technical guidelines were published on household water treatment and safe storage, and on sanitation and hygiene in East Asia (published jointly by WHO, the United Nations Secretary-General's Advisory Board and USAID Asia). In addition, support was given to Member States for data collection and management of the United Nations Global Annual Assessment of Sanitation and Drinking-Water; for the launch of the Asia-Pacific Water Safety Plan Network; and for the production of a regional framework for action for occupational health, 2011–2015.

At global level, an analysis of health in the green economy was completed for the transport, housing, health care and household energy sectors, 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.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
8.5.1 Number of studies or reports on new and re-emerging occupational and environmental health issues published or co-published by WHO.	15	17	21
8.5.2 Number of reports published or jointly published by WHO on progress made in achieving water and sanitation objectives of major international development frameworks, such as the Millennium Development Goals.	8	10	10
8.5.3 Number of high-level regional forums on environment and health issues organized or technically supported by WHO biennially.	9	10	11

8.6

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

Fully Achieved

A total of 30 countries across all WHO regions reported carrying out assessments of health vulnerability and adaptation to climate change; the findings are being used in 18 major pilot projects across 14 countries. A systematic review of health co-benefits of climate change mitigation policies was carried out in five sectors (housing, transport, agriculture, health and household energy). The results, together with a report prepared by the Regional Office for the Americas (on environmental and social determinants of health) were released at the World Conference on Social Determinants of Health in October 2011 and at the Sixteenth and Seventeenth Sessions of the Conference of the Parties to the United Nations Framework Convention on Climate Change in 2010 and 2011, respectively.

In the African Region, four countries prepared national plans on public health adaptation to climate change. Kenya was supported to implement measures for health adaptation to climate change with a focus on malaria in the Highlands region. A study on the impact of climate change on water-borne diseases was conducted in Mali. In the Region of the Americas, Brazil and Ecuador completed assessments on health vulnerability and adaptation to climate change, and Colombia, Costa Rica and Peru began to implement adaptation plans. In the Eastern Mediterranean Region, Jordan embarked on the adaptation of a strategy and plan of action to protect health from the impact of climate change, which was scheduled for completion by February 2012. In the South-East Asia Region, most Member States established climate change units in the health sector, developed national adaptation plans and programmes, and obtained funds to assess vulnerability and adaptation. Some Member States began implementing the plans. Myanmar is upgrading the course curriculum in its medical universities to include topics on climate change and health.

Achievements in the Western Pacific Region, included: (1) an assessment of health vulnerability resulting from climate change, and development of adaptation plans by Cambodia, China, Federated States of Micronesia, Kiribati, Lao People's Democratic Republic, Palau, Papua New Guinea, Philippines, Solomon Islands, Vanuatu and Vietnam; and (2) development of adaptation plans by Mongolia and Samoa. Additional studies were carried out in China on mortality and use of environmental and meteorological data for early warning models for heat waves and mitigating their health consequences.

In the European Region, a new UNEP Global Environment Facility project on climate change was negotiated in Uzbekistan and other projects on climate change nearing completion, included, a climate, environment and health action plan and information system and research on the impact of climate change on the Mediterranean environment. Progress was made in all seven countries from South Eastern Europe and the Newly Independent States participating in a project on protecting health from climate change. WHO supported these activities through a capacity-building programme that included training materials, a database on national expertise, guidance on access to funding sources, a toolkit for programme managers on public health adaptation, and a clearing house of existing public health system adaptation projects.

WHO's contributions to country offices included: technical support missions to support climate change and health planning in three countries in the African Region; technical support, capacity building and guidance provided to Member States in the Eastern Mediterranean Region to establish national frameworks for action, strategies and programmes for mitigating the effects of climate change on health in compliance with resolution EM/RC55/R.8, and participation, with other United Nations agencies, in the development and launch of Jordan's climate-change adaptation strategy; organization and funding of meetings of high-level officials, including parliamentarians and ministers of health and environment (for example, in Thimphu, Bhutan, in October 2010, and in Dhaka, in October 2010) in the South-East Asia Region; and providing technical support and advice to Member States on health-vulnerability studies and health adaptation plans for climate change in the Western Pacific Region. All the above served to address a serious gap in funding for health in relation to climate change, an area which is generally under funded in Member States.

WHO continued its advocacy and leadership activities to encourage regional and global processes on environment, climate change and sustainable development to take greater account of health.

The Regional Office for Africa carried out an assessment of health in national adaptation programmes and published a report. WHO subsequently prepared a framework for public health adaptation to climate change. The document was sub-

mitted to the 61st session of the WHO Regional Committee for Africa and was endorsed by ministers of health in resolution AFR/RC61/R2. In the Region of the Americas, resolution CD51. R15 on a Strategy and plan of action on climate change was approved by the 51st Directing Council of PAHO. Training activities and implementation of the plan of action are being initiated in countries in the Region. In the European Region, the main achievement was an update of environment and health and occupational health indicators as part of the preparation of background documentation for the Ministerial Conference on Environment and Health, held in Parma in March 2010. The Regional Office for Europe also produced a guidance package on health responses to heat waves.⁹ In the South-East Asia Region, Member States were assisted to develop tools for assessing the vulnerability of people and health systems to the impact of climate change and in preparing strategies to strengthen their capacity to manage the health impacts of climate change. The Regional Office for the Western Pacific Region convened workshops and meetings for the preparation of a workplan and implementation of projects on climate change and vector-borne diseases in Cambodia, Mongolia and Papua New Guinea. The WHO South Pacific Office also facilitated implementation of a project on Piloting climate change adaptation to protect human health in Fiji, funded by the Global Environment Facility. Fiji and China are among the seven countries in the Region taking part in the project.

At global level, the Secretariat worked with Member States to emphasize the importance of health in climate change policy, and the linkages between climate change and other environmental and social determinants of health through events at the Sixty-third World Health Assembly, the World Conference on Social Determinants of Health, and 12 events held during the 17th Conference of the Parties to the United Nations Framework Convention on Climate Change. WHO coordinated a contact group of delegates from Member State Parties to the Framework Convention in order to encourage the inclusion of health in the negotiations. It also established a consultation group of health professional associations and nongovernmental organizations in order to generate and disseminate information on health advocacy.

WHO contributed the health perspective to the response of different United Nations' bodies to climate change, including the United Nations System Chief Executives Board for Coordination, the United Nations High-Level Committee on Programmes, the Conference of the Parties to the United Nations Framework Convention on Climate Change and its associated policy and technical meetings; and the High-Level Committee on Programmes Task Team on the Social Dimensions of Climate Change, which WHO co-organizes. As a result, health is now recognized as one of the core sectors in global adaptation efforts.

Secretariat staff have contributed as authors to the Intergovernmental Panel on Climate Change (IPCC) Special Report on extreme events, and to the Panel's forthcoming fifth assessment report. WHO continue to identify the likely health benefits of strategies to reduce greenhouse gas emissions from key sectors assessed by the Panel, and has published reports on the housing and transport sectors.

WHO worked with WMO and other partners to design the health component of a new global framework for climate services, which is designed to ensure that meteorological information is used effectively to support health decisions. It also produced new technical reports and guidance on subjects that include vulnerability and adaptation assessment, and gender, climate change and health.^{10 11}

To overcome weak health-sector representation in climate change, WHO engaged more fully in the United Nations Framework Convention on Climate Change mechanisms, including creating a contact group with interested Member States, facilitating a network of health nongovernmental organizations, and routinely submitting policies and leading events within the Framework Convention process.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
8.6.1 Number of studies or reports on the public health effects of climate change published or co- published by WHO.	Not available	30	35
8.6.2 Number of countries that have implemented plans to enable the health sector to adapt to the health effects of climate change.	Not available	30	48

SUMMARY OF FINANCIAL IMPLEMENTATION

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

Available funding by the end of the biennium was US\$ 94 million and implementation as at 31 December 2011 was US\$ 83 million, that is, 88% against the funds available and 73% against the approved Programme budget.

Despite substantial funding gaps in relation to funds available against the approved budget, all major offices implemented well over 80% against available funds. For example, as at 31 December 2011, the Regional Office for Africa indicated having 59% of funds available against approved Programme budget allocation with an implementation rate of 90% against funds available. While funds available to the Regional Office of the Americas was only 59% against the Programme budget and in the Eastern Mediterranean Region only 51%, implementation against available funds was 97% and 83%, respectively.

Most of the resources for strategic objective 8 continued to be highly-specified voluntary funds raised directly by the technical programmes. This limits flexibility within the strategic objective, as well as within technical activity areas and between 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.

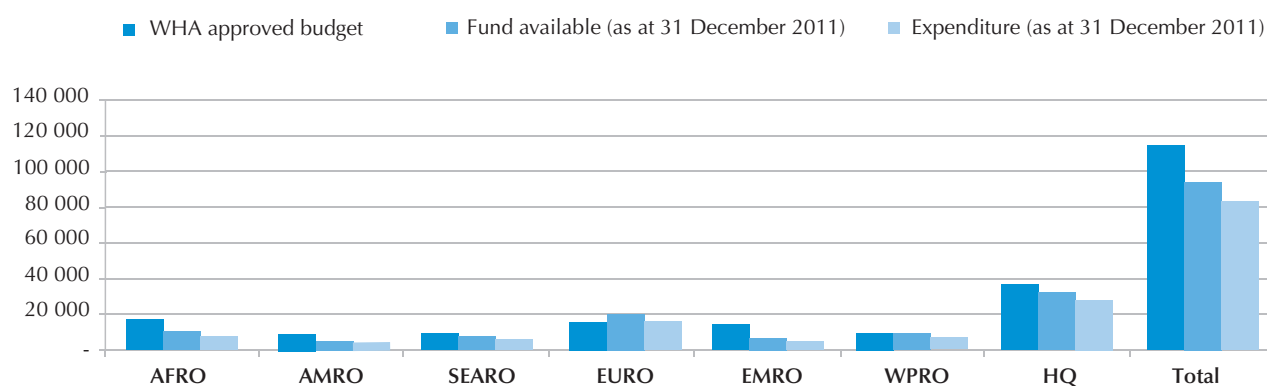
Shortfalls in funding for the Regional Offices for Africa and the Eastern Mediterranean, in particular, led to difficulties and delays in recruiting the necessary human resources to implement environmental health-related activities, including those related to settings and workplaces, homes and urban settings,

children's environmental health and operational research. At headquarters, there is a significant funding gap for covering activities and staff costs for carrying out activities pertaining, in particular, to indoor air pollution and healthy housing. Despite closure of the Rome office during the biennium, and the political and financial fall-out, the Regional Office for Europe managed to successfully raise the necessary funds and achieve a very commendable implementation rate. Generally, fears have been expressed by headquarters and the regional offices regarding their ability to raise the necessary financial resources to fully cover all existing staff positions under the strategic objective for the biennium 2012–2013 in order to carry out necessary environment-related activities. For the Regional Office for South-East Asia, financial issues featured slightly less than political concerns. Obstacles to the application of the healthy settings approach and primary prevention were considered to be closely related to the difficulties of intersectoral working, which requires the sharing of common objectives. The Regional Office for South-East Asia has noted that work on reducing environmental risks requires working with other sectors that do not necessarily see health as their most important concern. The Regional Office for the Western Pacific also suffered reductions in human resources because of funding cuts. Given the limited availability of human resources, the Regional Office for the Western Pacific will focus primarily on prioritized activity areas as defined in the regional technical strategic framework for strategic objective 8.

Renewed global interest in sustainable development, particularly surrounding the UN Conference on Sustainable Development to take place in June 2012, will open up significant opportunities to promote and protect health through increased action on environmental and occupational determinants of health. For example, investments in climate change mitigation policies and clean energy would not only protect the integrity of the environment (through improved air quality), but would also bring about an associated reduction in respiratory and cardiovascular disease, among others. Therefore, a key priority for strategic objective 8 for 2012–13 is to leverage WHO's existing tools, evidence and expertise to help Member States harness opportunities for health and development (and primary prevention of disease) associated with this global renewed interest and investment in sustainable development.

All Segments

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	16 335	10 437	11 002	17 220	14 053	10 702	34 615		114 364
Funds Available									
AC	4 901	5 016	5 419	2 062	3 153	2 740	7 677		30 969
VC	4 675	1 107	3 702	16 576	4 026	8 016	25 275	-	63 376
Total	9 576	6 123	9 121	18 638	7 180	10 756	32 952	-	94 345
Funds Available as % of approved budget	59%	59%	83%	108%	51%	101%	95%		82%
Expenditure	8 575	5 937	7 811	15 778	5 947	9 634	29 784		83 467
Expenditure as % of approved budget	52%	57%	71%	92%	42%	90%	86%		73%
Expenditure as % of funds available	90%	97%	86%	85%	83%	90%	90%		88%



REFERENCES

- 1 In particular the Rotterdam, Stockholm and Basel Conventions, the Globally Harmonized System of Classification and Labelling of Chemicals, the Strategic Approach to International Chemicals Management, and the current UNEP-convened negotiations for a legally-binding international instrument on mercury.
- 2 Examples include the Luanda Declaration on environment and health in the African Region (November 2011); the Parma Declaration on Environment and Health in the European Region (March 2010); the Asturias Declaration on environmental and occupational determinants of cancer (March 2011).
- 3 Benin, Botswana, Burundi, Comoros, Ethiopia, Malawi, Madagascar, Mozambique, Namibia, Niger, Rwanda, Sao Tome & Principe, Senegal, South Africa, United Republic of Tanzania, Togo, Uganda, Zambia and Zimbabwe.
- 4 Botswana, Nigeria and Gambia.
- 5 Angola, Cameroon, Democratic Republic of Congo, Eritrea, Ethiopia, Ghana, Lesotho, Madagascar, Mali, Mozambique, Republic of Congo, Sierra Leone and United Republic of Tanzania.
- 6 Benin, Botswana, Burundi, Nigeria and Seychelles.
- 7 Benin, Burkina Faso, Chad, Ethiopia, Ghana, Guinea, Kenya, Mozambique, Mauritania, Namibia, Niger, Senegal, Sierra Leone, South Africa, Swaziland and Togo.
- 8 Cameroon, Kenya, Gambia, Madagascar, Mozambique, and United Republic of Tanzania.
- 9 Public health advice on preventing health effects of heat. Copenhagen, WHO Regional Office for Europe, 2011 (available online at http://www.euro.who.int/_data/assets/pdf_file/0007/147265/Heat_information_sheet.pdf, accessed 14 October 2011).
- 10 Protecting health from climate change. Vulnerability and adaptation assessment. Draft for discussion. World Health Organization, Pan American Health Organization, 2010 (available online at http://www.who.int/globalchange/VA_Guidance_Discussion.pdf, accessed 13 October 2011).
- 11 Gender, climate change and health. World Health Organization (available online at <http://www.who.int/globalchange/GenderClimateChangeHealthfinal.pdf>, accessed 13 October 2011).

8.2.1 African Region: Angola, Benin, Botswana, Burkina Faso, Burundi, Comoros, Congo, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Kenya, Madagascar, Malawi, Mali, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Belize, Colombia, Ecuador, Guatemala. **Eastern Mediterranean Region:** Jordan, Lebanon. **European Region:** Andorra, Austria, Belarus, Belgium, Bosnia and Herzegovina, Croatia, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Latvia, Luxembourg, Malta, Monaco, Netherlands, Norway, Portugal, Romania, San Marino, Spain, Sweden, Switzerland, The former Yugoslav Republic of Macedonia, Ukraine, United Kingdom of Great Britain and Northern Ireland. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, Cook Islands, Kiribati, Lao People's Democratic Republic, Mongolia, Nauru, Papua New Guinea, Philippines, Samoa, Solomon Islands, Tonga, Viet Nam.

8.3.1 African Region: Benin, Burkina Faso, Chad, Ethiopia, Ghana, Guinea, Kenya, Mauritania, Mozambique, Namibia, Niger, Senegal, Sierra Leone, South Africa, Swaziland, Togo. **Region of the Americas:** Argentina, Belize, Bolivia (Plurinational State of), Guatemala, Guyana, Nicaragua, Panama, Paraguay, Peru. **European Region:** Albania, Andorra, Austria, Belgium, Bosnia and Herzegovina, Croatia, Cyprus, Denmark, Finland, France, Georgia, Germany, Greece, Iceland, Ireland, Israel, Italy, Kazakhstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Romania, San Marino, Serbia, Spain, Sweden, Switzerland, The former Yugoslav Republic of Macedonia, Turkey, Ukraine, United Kingdom of Great Britain and Northern Ireland. **South-East Asia Region:** Bangladesh, Bhutan, India, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, China (People's Republic of), Lao People's Democratic Republic, Malaysia, Mongolia, Philippines, Solomon Islands, Viet Nam.

8.5.1 The details are available upon request.

8.5.2 The details are available upon request.

8.5.3 The details are available upon request.

8.6.2 African Region: Kenya. **Region of the Americas:** Colombia, Costa Rica, Peru. **Eastern Mediterranean Region:** Jordan. **European Region:** Albania, Andorra, Austria, Belarus, Belgium, Croatia, Cyprus, Czech Republic, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Portugal, Republic of Moldova, Russian Federation, Spain, Sweden, Switzerland, The former Yugoslav Republic of Macedonia, United Kingdom of Great Britain and Northern Ireland. **South-East Asia Region:** Bangladesh, India, Indonesia, Maldives, Nepal, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, China (People's Republic of), Mongolia, Papua New Guinea, Philippines, Samoa.

DETAILS OF INDICATOR ACHIEVEMENT

8.1.1 African Region: Algeria, Cameroon, Congo, Democratic Republic of the Congo, Eritrea, Ethiopia, Ghana, Lesotho, Madagascar, Mali, Mozambique, Sierra Leone, United Republic of Tanzania. **Region of the Americas:** Colombia, Guyana, Trinidad and Tobago. **Eastern Mediterranean Region:** Somalia. **European Region:** Andorra, Austria, Belarus, Belgium, Bosnia and Herzegovina, Croatia, Cyprus, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Iceland, Ireland, Israel, Italy, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Portugal, San Marino, Serbia, Spain, Sweden, Switzerland, The former Yugoslav Republic of Macedonia, Turkey, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, India, Myanmar, Nepal, Sri Lanka, Timor-Leste. **Western Pacific Region:** Cambodia, China (People's Republic of), Lao People's Democratic Republic, Mongolia, Philippines, Viet Nam.

8.1.2 The list of new or updated WHO norms, standards or guidelines produced during the reporting period can be made available upon request.

SO9

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



ASSESSMENT OF THE ORGANIZATION-WIDE EXPECTED RESULTS

Of the six Organization-wide expected results for this strategic-objective, three were «fully achieved» and three «partly achieved».

Overview

Undernutrition, poor vitamin and mineral status and obesity affect large sections of the global population and are often interconnected and present simultaneously. In addition, food-borne disease outbreaks are a major challenge in a globalized world, and unsafe food is a threat to global health security.

In women, both low body mass index and short stature are highly prevalent in low-income countries, leading to poor fetal development, increased risk of complications in pregnancy, and the need for assisted delivery. Every year an estimated 20 million children are born with low birth weight. Iron-deficiency anaemia affects one third of women of reproductive age and almost half of preschool-age children.

Childhood malnutrition is the underlying cause of death in an estimated 35% of all deaths among children under five years and diet, including unsafe food intake, is a major risk factor for diabetes, cardiovascular disease and cancer. In 2010, about 104 million children under five years worldwide were underweight, 55 million had low weight for their height, 171 million had stunted growth and 43 million were overweight. In 2008, 205 million men and 297 million women over the age of 20 were obese.

Diarrhoeal diseases caused by a variety of pathogens in food and water interact with undernutrition in a vicious cycle negatively affecting development.

Several policy developments took place during the biennium. The Sixty-third World Health Assembly adopted resolutions WHA63.23 on Infant and young child nutrition and WHA63.3 on Advancing food safety initiatives. A comprehensive implementation plan on maternal, infant and young child nutrition was developed, following regional consultations that involved different government sectors from 92 Member States,

United Nations system agencies, development banks, donors and civil society. Regional nutrition strategies were developed in the Eastern Mediterranean Region (Regional strategy on nutrition 2010–2019, adopted by the Fifty-seventh session of the Regional Committee), in the Region of the Americas (Strategy and Plan of Action for the Reduction of Chronic Malnutrition, adopted by the 50th Directing Council of PAHO), and in the South-East Asia Region (Regional nutrition strategy, adopted by the Sixty-fourth session of the Regional Committee). The Pacific Islands Forum Secretariat endorsed a Framework for Action on Food Security in the Pacific. Global initiatives, such as the Scaling Up Nutrition initiative and the 1000 days campaign have considerably advanced the global nutrition agenda and WHO has played an active role in their development.

National and regional networks were reinforced and food safety systems strengthened. Intersectoral collaboration between the health, agriculture and veterinary sectors was established for the integrated surveillance of foodborne and zoonotic diseases (including antimicrobial resistance in the food chain), in order to improve surveillance of food contamination and food hygiene education and build laboratory capacity.

Progress was made in monitoring nutritional status, food-borne diseases and implementation of food and nutrition policies. A total of 115 countries adopted the WHO growth standards. A childhood obesity surveillance system and a database on implementation of food and nutrition policies were established in the European Region. A global nutrition policy review was conducted and responses were received from 119 Member States and four territories. Assessment of food safety programmes was carried out in 28 countries. The Global Food-borne Infections Network (GFN) has members in 181 Member States. The International Food Safety Authorities Network (INFOSAN) now links 177 Member States in information ex-

changes and response to outbreaks of food-borne illnesses. The International Food Safety Authorities Network is interlinked with and complements the work under the International Health Regulations (2005).

The establishment of the Nutrition Guidance Expert Advisory Group marks a major step forward in the provision of scientific advice on nutrition. Fourteen nutrition guidelines were developed or updated, using the WHO guideline development process. Guidelines are translated into the six WHO official languages and disseminated through the e-Library of Evidence on Nutrition Actions. This now complements the already established scientific advisory bodies in food safety, the Joint FAO/WHO Expert Committee on Food Additives (JECFA), the Joint FAO/WHO Meetings on Pesticide Residues (JMPR) and the Joint FAO/WHO Meetings on Microbiological Risk Assessment (JEMRA). By scaling up their efforts, these food-related expert bodies have significantly improved and increased the number of scientific advice outputs provided as evidence to the Codex Alimentarius Commission, which has led to a significant increase in the number of international food safety standards. These include international standards to limit melamine contamination in powdered infant formula, other foods and animal feed, which were rapidly developed in response to a global

food safety incident. Improvements in risk assessment methodologies were through the publication of comprehensive guidance documents, for example, on methods and principles for carrying out risk assessments of chemicals in food. The focus of health issues in the Secretariat of the Codex Alimentarius and in country level implementation of Codex standards has been strengthened. The effective participation of developing countries and countries with economies in transition in the Codex process has been further enhanced, as illustrated by the number of countries who are graduating from the Codex Trust Fund but continuing to participate in Codex.

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

9.1

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

Partly Achieved

Increased awareness by policy makers of the importance of food safety and nutrition, improved collaboration between the health, agriculture and veterinary sectors and better coordination between stakeholders was noted in most countries. This is evidenced by the increase in the number of Member States, from 89 in 2010 to 128 at the end of the biennium, that have functional, institutionalized coordination mechanisms to promote intersectoral approaches and actions in the area of food safety, food security and nutrition. Several Member States established coordination mechanisms to promote intersectoral approaches and actions in the area of food safety and nutrition, but in some regions national food safety programmes remained compartmentalized with limited collaboration and cooperation between the different sectors.

WHO was engaged in the United Nations REACH (Ending Child Hunger and Undernutrition) Partnership at country level and in the United Nations Standing Committee on Nutrition at the global level, and has contributed to the development of the Scaling Up Nutrition initiative by leading the Task Force on monitoring and surveillance and by developing a comprehensive implementation plan on maternal, infant and young child nutrition.

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

In addition, WHO enhanced its collaboration with international players focusing on food security issues in order to

foster intersectoral collaboration and ensure that food safety is included in the international discussions on the food crisis. WHO strengthened its partnership with the International Livestock Research Institute (ILRI) and the International Food Policy Research Institute (IFPRI) in connection with the research programme on agriculture for improved nutrition and health, and supported the development of the report submitted to the United Nations Human Rights Council by the Special Rapporteur on the right to food.

A greater impact was observed when direct technical input and assistance were delivered at country level, when issues were discussed at global, regional and national levels and when guidelines, manuals and tools were available to support WHO recommendations. Working with partner agencies and major stakeholders has shown that even with limited funds, results could still be produced and programmes implemented as planned. Obstacles to achieving results include, the low level of attention paid to nutrition and food safety programmes at national level, competing priorities introduced by partner agencies, and limited technical capacity of relevant staff. Communication with national counterparts and sharing of information with partner agencies reduced repetition of activities and engendered a better utilization of resources. The need for supra-coordination structures is increasingly being recognized, including ministries of the environment, housing, education, agriculture, commerce, finance, labour and development, as well as health.

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

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
9.1.1 Number of Member States that have functional institutionalized coordination mechanisms to promote intersectoral approaches and actions in the area of food safety, food security or nutrition.	89	125	128
9.1.2 Number of Member States that have included nutrition, food-safety and food-security activities and a mechanism for their financing in their sector-wide approaches or Poverty Reduction Strategy Papers.	28	35	117

9.2

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

Fully Achieved

A major step forward was the establishment of a mechanism for providing scientific advice on nutrition, following the WHO guideline process, that is leading to improved management of malnutrition and micronutrient deficiencies. Similarly, in the area of food safety, the main achievement was an increased understanding of the importance of science-based food safety standards, namely, Codex standards, and their implementation for exported foods and for the local food supply.

The Nutrition Guidance Expert Advisory Group (NUGAG) was established to provide scientific advice on nutrition, including micronutrients, nutrition and Tb, nutrition and HIV and the revision of dietary goals for fat, sugar and salt. Fourteen nutrition guidelines were developed or updated, using the WHO guideline development process. Guidelines are translated in the six official languages and disseminated through the e-Library of Evidence for Nutrition Actions. A country adaptation process has been tested in Peru and Madagascar. WHO scientific advice is feeding into the Codex Committee on Food Labelling (CCFL) and into the Codex Committee on Nutrition and Foods for Special Dietary Uses (CCFNSDU).

In the area of food safety, the scientific advisory bodies (Joint FAO/WHO Expert Committee on Food Additives (JECFA), Joint FAO/WHO Meetings on Pesticide Residues (JMPR) and Joint FAO/WHO Meetings on Microbiological Risk Assessment (JEMRA) and *ad hoc* working groups) expended considerable effort in substantially improving and increasing the number of scientific advice outputs. That, in conjunction with improved efficiency in the Codex standard-setting process, led to the

adoption of a significantly greater number of international food safety standards, including on limiting melamine contamination in powdered infant formula, other foods and animal feed. Global understanding of the importance of science-based food safety standards (Codex standards) has increased, as demonstrated by the growing number of requests from Member States for scientific advice and more extensive implementation of Codex standards, which have subsequently been incorporated in national legislation.

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

Risk assessment methodologies were published in comprehensive guidance documents, such as the Principles and methods for the risk assessment of chemicals in food. The effective participation of developing countries and countries with economies in transition in the Codex process was further enhanced as illustrated by the number of countries who are graduating from the Codex Trust Fund but continuing to participate in Codex.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
9.2.1 Number of new nutrition and food-safety standards, guidelines or training manuals produced and disseminated to Member States and the international community.	23	43 and 200 Codex standards	88 and 557 Codex standards
9.2.2 Number of new norms, standards, guidelines, tools and training materials for prevention and management of zoonotic and non-zoonotic foodborne diseases.	14	19	20

9.3

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

Fully Achieved

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

A childhood obesity surveillance programme was established in the European Region and a global nutrition policy review that covered 119 Member States and four territories was implemented.

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

In the European Region, an information system was established that provides updates on nutrition policies for the prevention of obesity. Support to 17 Member States was provided for implementation of the European childhood obesity surveillance initiative. In the African Region, nutrition indicators were integrated in International Disease Surveillance and Response and a training module elaborated. The WHO Child Growth Standards were incorporated in the National Child Road to Health booklets in eight countries and a workshop on nutrition surveillance was organized in Côte d'Ivoire for ten countries to initiate development of a new nutrition surveillance system for the African Region. In the Western Pacific Region, support was provided for reviewing and strengthening the nutrition surveillance system in Malaysia, and for the establishment of a common monitoring system for sodium and iodine intake. In the Eastern Mediterranean Region, WHO was engaged in strengthening the nutrition surveillance system by providing capacity building and technical support to Member States. A training manual was developed and a regional training course conducted. In the South-East Asia Region, technical assistance was provided for finalizing under-five growth charts in two Member States.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
9.3.1 Number of Member States that have adopted and implemented the WHO Child Growth Standards.	63	85	115
9.3.2 Number of Member States that have nationally representative surveillance data on major forms of malnutrition.	104	125	142

9.4

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

Partly Achieved

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

WHO provided support for carrying out a landscape analysis of country readiness to act in nutrition and for the development of scale-up plans. The nutrition friendly schools initiative was promoted. Regional consultations were held in the African Region, the Region of the Americas and the Eastern Mediterranean, South-East Asia and Western Pacific Regions to review the development of food and nutrition policies, identify implementation bottlenecks and comment on the draft comprehensive implementation plan on maternal, infant and young child nutrition.

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

Several activities were undertaken by the regional offices to support Member States. In the South-East Asia Region, a technical consultation with regional and global partners on sodium

intake, iodine deficiency disorders and cardiovascular problems in Asian populations was organized. A consensus protocol for managing severely malnourished children in hospital settings was developed and national training on managing severe childhood malnutrition was conducted. In the European Region, WHO convened nutrition counterpart meetings, as well as 12 meetings of the Member States Action Networks. The networks on reducing salt intake in the population and reducing marketing pressure on children have met every year since their launch and are linked with tangible policy developments in the Region. In the African Region, a training course on intersectoral policy and plan development was organized jointly with WHO and UNICEF for nutrition and food security focal points from ministries of health and agriculture. Activities to disseminate guidelines and develop country action plans on HIV, antiretroviral therapy and infant feeding were carried out. In The Western Pacific Region, technical support was provided for meetings on food fortification, reduction of salt consumption and prevention and control of obesity.

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

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

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
9.4.1 Number of Member States that have implemented at least three high-priority actions recommended in the Global Strategy for Infant and Young Child Feeding.	52	97	117
9.4.2 Number of Member States that have implemented strategies to prevent and control micronutrient malnutrition.	44	77	119
9.4.3 Number of Member States that have implemented strategies to promote healthy dietary practices for preventing diet-related chronic diseases.	at least 44	80	138
9.4.4 Number of Member States that have included nutrition in their responses to HIV/AIDS.	14	59	25
9.4.5 Number of Member States that have national preparedness and response plans for nutritional emergencies.	23	47	41

9.5

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

Partly Achieved

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

WHO provided support to countries for strengthening food safety institutions and foodborne disease surveillance, facilitated research projects on the aetiology of, and sources of contamination and risk factors for, foodborne diseases, offered expert guidance and analysis through the network of WHO Collaborating Centres, and initiated country pilot studies for assessing the burden of foodborne diseases. WHO developed two training modules on integrated surveillance of foodborne diseases and outbreak detection and response and two guidance documents on integrated surveillance of antimicrobial resistance in countries with limited resources. Emphasis was placed on strengthening national International Food Safety Authorities Network units, and on identifying food safety capacity as a core component of the International Health Regulations (2005). Information from food safety alerts was effectively shared with Member States.

Member States were assisted in carrying out total diet studies for food contaminant monitoring. WHO continued to raise interest and concern among policymakers and technical ex-

perts about the health hazard posed by unsafe food and increase awareness of the importance of strengthening laboratory capabilities for food analysis. With regard to the latter, WHO provided support for monitoring the analytical capacities of food control laboratories and strengthened laboratory capacity through training courses on foodborne disease surveillance, and promotion of intersectoral collaboration between food and public health laboratories and epidemiological services. In that regard, support was provided to countries in all WHO regions through training courses and workshops organized by the WHO Global Foodborne Infections Network, which has members in 181 Member States.

The main obstacles were: failure to include foodborne diseases in the surveillance systems of most countries; the complexity of coordination and collaboration of stakeholders, which impaired effective food safety monitoring and surveillance; limited resources in countries for implementing total diet studies; and lengthy development processes for foodborne disease burden protocols.

WHO's response will be: to encourage the inclusion of foodborne diseases in indicator-based disease surveillance systems; to advocate for safe foods and for the need for proper regulatory mechanisms; and to plan follow-up activities for the next biennium.

Despite the achievements during the biennium, the Organization-wide expected result was rated as partly achieved as the Regional Offices for the Eastern Mediterranean, South-East Asia and the Western Pacific reported their contributions as partly achieved.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
9.5.1 Number of Member States that have established or strengthened intersectoral collaboration for the prevention, control and surveillance of foodborne zoonotic diseases.	66	75	105
9.5.2 Number of Member States that have initiated a plan for the reduction in the incidence of at least one major foodborne zoonotic disease.	68	80	85

9.6

Capacity built and support provided to Member States, including their participation in international standard-setting in order to increase their ability to assess risk in the areas of zoonotic and non-zoonotic foodborne diseases and food safety, and to develop and implement national food-control systems, with links to international emergency systems.

Fully Achieved

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

In the South-East Asia Region, the number of participants from Member States attending various Codex and International Food Safety Authorities Network meetings increased. WHO and the Korean Food and Drug Administration provided technical support for strengthening International Food Safety Authorities Network activities in Member States, particularly capacity to respond to food safety emergencies. In the European Region, improved knowledge among officials and better intersectoral collaboration during food safety emergencies could be seen in many countries. In the Region of the Americas, 40 countries adopted the standards of Codex Alimentarius. In the Eastern Mediterranean Region, apart from countries experiencing complex emergencies, most others have laboratory ability to detect traditional chemical hazards in food. Countries contin-

ued to participate in the Codex Alimentarius Commission and its committee meetings, as well as in other international standard setting bodies. The FAO/WHO Coordinating Committee for Near East which assesses risks in food and prepares standards on traditional foods of the Region, met in Tunis in May 2011. So far, hazard analysis and critical control point generic models exist for 13 traditional foods. Countries continued to strengthen their microbiological and chemical laboratories to enable them to participate in the international food safety surveillance network. In conjunction with implementation of the International Health Regulations (2005), many countries have integrated foodborne disease surveillance in their national disease surveillance activities. However, availability of foodborne disease and monitoring data remains limited. In the Region of the Americas, several countries were supported either to formulate or finalize national food safety policies and evaluate their food control systems. The WHO Five Keys to Safer Food concept was integral in addressing food safety during the preparation and execution of the Fédération Internationale de Football Association (FIFA) World Cup 2010 in South Africa.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
9.6.1 Number of selected Member States receiving support to participate in international standard-setting activities related to food, such as those of the Codex Alimentarius Commission.	97	85	85
9.6.2 Number of selected Member States that have built national systems for food safety with international links to emergency systems.	59	70	177

SUMMARY OF FINANCIAL IMPLEMENTATION

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 end 2011 was US\$ 70 million (58% of the approved programme budget), and implementation as at 31 December 2011 was US\$ 62 million, which corresponds to 52% of the approved budget and 89% of the available resources.

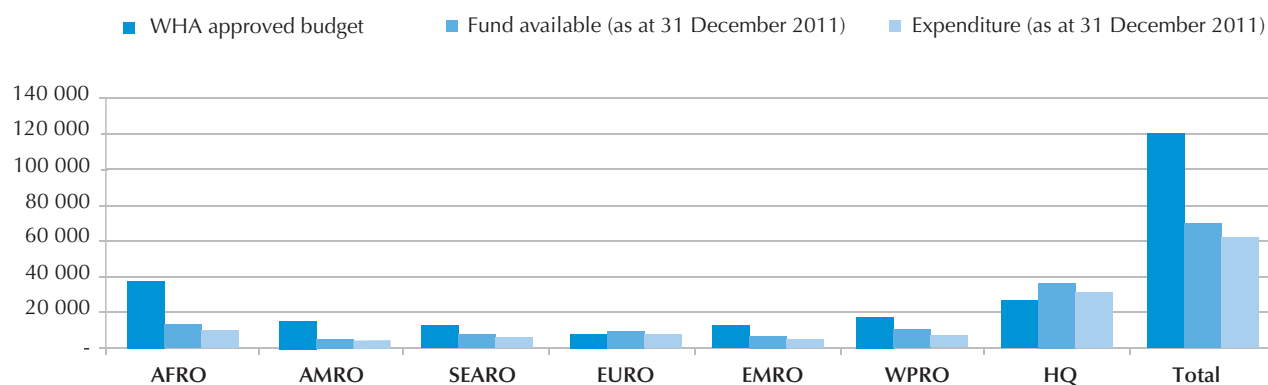
The proportion of funds coming from specified voluntary contributions has increased progressively. Strategic focus and intensive fundraising efforts have led to successful resource mobilization in headquarters and some regions and countries. However, the funds available for both staff and activities in some regional offices were insufficient. The level of available resources for all regional offices apart from the Regional Office for Europe is below 50%. Although greatly assisted by head-

quarters which has developed a resource mobilization strategy favouring multi year cross cutting grants on both technical and regional areas, resource mobilization should be intensified in all Regional offices. More large multi- country proposals need to be submitted. Donors appreciate WHO's role in guideline development and translation, surveillance and capacity building but greater efforts are required in some regions. Furthermore, the staffing levels in some Regions need to be adjusted to reach the critical mass to develop and manage larger scale projects. In some Regional offices implementation capacity was inadequate to achieve the given budget ceilings and this has led to discrepancies in the implementation against allocated programme budget.

Increases in the budget were requested by the Regional Office for Europe and headquarters in order to accommodate specified voluntary contributions. In addition, during the course of the year, headquarters was unable to implement some activities because of the sudden increase in staff costs, that took a large part of the already low budget.

All Segments

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	37 182	13 566	11 670	5 501	8 375	17 898	26 193		120 385
Funds Available									
AC	4 454	1 942	2 073	745	1 623	1 992	5 634		18 463
VC	6 552	1 204	2 526	5 178	2 223	5 684	27 709	-	51 075
Total	11 005	3 146	4 599	5 924	3 845	7 675	33 343	-	69 537
Funds Available as % of approved budget	30%	23%	39%	108%	46%	43%	127%		58%
Expenditure	9 728	3 097	4 249	5 044	3 436	6 607	29 863		62 025
Expenditure as % of approved budget	26%	23%	36%	92%	41%	37%	114%		52%
Expenditure as % of funds available	88%	98%	92%	85%	89%	86%	90%		89%



Base programmes

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	37 182	13 566	11 670	5 501	8 375	17 898	22 193		116 385
Funds Available									
AC	4 454	1 942	2 073	745	1 623	1 992	5 634		18 463
VC	6 552	1 169	2 526	5 178	2 223	5 684	22 187	-	45 518
Total	11 005	3 111	4 599	5 924	3 845	7 675	27 821	-	63 980
Funds Available as % of approved budget	30%	23%	39%	108%	46%	43%	125%		55%
Expenditure	9 728	3 062	4 240	5 044	3 436	6 607	25 464		57 581
Expenditure as % of approved budget	26%	23%	36%	92%	41%	37%	115%		49%
Expenditure as % of funds available	88%	98%	92%	85%	89%	86%	92%		90%

Special programmes and collaborative arrangements

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	-	-	-	-	-	-	4 000		4 000
Funds Available									
AC	-	-	-	-	-	-	-		-
VC	-	35	-	-	-	-	5 522	-	5 557
Total	-	35	-	-	-	-	5 522	-	5 557
Funds Available as % of approved budget	-	-	-	-	-	-	138%		139%
Expenditure	-	35	10	-	-	-	4 391		4 436
Expenditure as % of approved budget	-	-	-	-	-	-	110%		111%
Expenditure as % of funds available	-	100%	-	-	-	-	80%		80%

DETAILS OF INDICATOR ACHIEVEMENT

9.1.1 African Region: Benin, Burkina Faso, Burundi, Cameroon, Congo, Côte d'Ivoire, Ethiopia, Ghana, Guinea Bissau, Liberia, Madagascar, Mali, Mauritania, Mozambique, Namibia, Nigeria, Seychelles, Sierra Leone, South Africa, Togo, Uganda, United Republic of Tanzania, Zimbabwe. **Region of the Americas:** Antigua and Barbuda, Barbados, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Costa Rica, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Honduras, Mexico, Peru, Saint Vincent and the Grenadines, United States of America, Uruguay. **Eastern Mediterranean Region:** Afghanistan, Bahrain, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Morocco, Oman, Pakistan, Qatar, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen. **European Region:** Albania, Armenia, Austria, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, India, Maldives, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Brunei Darussalam, Cambodia, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Mongolia, Philippines, Republic of Korea, Singapore, Solomon Islands, Tuvalu, Vanuatu, Viet Nam.

9.1.2 African Region: Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Swaziland, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Belize, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Trinidad and Tobago, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen. **European Region:** Albania, Armenia, Austria, Azerbaijan, Bosnia and Herzegovina, Croatia, Georgia, Kazakhstan, Kyrgyzstan, Montenegro, Poland, Republic of Moldova, Romania, Serbia, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, Cook Islands, Fiji, Kiribati, Lao People's Democratic Republic, Micronesia (Federated States of), Mongolia, Philippines, Samoa, Solomon Islands, Tonga, Vanuatu, Viet Nam.

9.3.1 African Region: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Togo, Uganda, United Republic of Tanzania, Zambia. **Region of the Americas:** Antigua and Barbuda, Argentina, Barbados, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Honduras, Mexico, Peru, Saint Lucia, Saint Vincent and the Grenadines, Suriname, United States of America, Uruguay. **Eastern Mediterranean Region:** Afghanistan, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Jordan, Kuwait, Morocco, Oman, Qatar, Somalia, Sudan, Syrian Arab Republic, United Arab Emirates, Yemen. **European Region:** Albania, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Denmark, Estonia, Finland, France, Georgia, Hungary, Iceland, Israel, Kazakhstan, Kyrgyzstan, Montenegro, Norway, Poland, Portugal, Serbia, Slovakia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Timor-Leste. **Western Pacific Region:** Brunei Darussalam, Cambodia, Lao People's Democratic Republic, Malaysia, Mongolia, New Zealand, Philippines, Solomon Islands, Tuvalu, Viet Nam.

9.3.2 African Region: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Antigua and Barbuda, Argentina, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Paraguay, Peru, Suriname, United States of America, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, Yemen. **European Region:** Albania, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Czech Republic, Denmark, Finland, France, Georgia, Germany, Italy, Kazakhstan, Kyrgyzstan, Montenegro, Netherlands, Norway, Portugal, Republic of Moldova, Romania, Serbia, Slovakia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Cambodia, China (People's Republic of), Japan, Lao People's Democratic Republic, Malaysia, Mongolia, Nauru, New Zealand, Papua New Guinea, Philippines, Solomon Islands, Tuvalu, Vanuatu, Viet Nam.

9.4.1 African Region: Benin, Botswana, Burkina Faso, Burundi, Cameroon, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gabon, Ghana, Guinea, Kenya, Liberia, Madagascar, Mali, Mauritius, Mozambique, Niger, Nigeria, South Africa, Swaziland, Togo, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Vincent and the Grenadines, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Lebanon, Oman, Pakistan. **European Region:** Albania, Austria, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Ireland, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, Slovakia, Slovenia, Spain, Sweden, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, India, Indonesia, Maldives, Myanmar, Sri Lanka, Thailand. **Western Pacific Region:** Australia, Cambodia, China (People's Republic of), Fiji, Kiribati, Lao People's Democratic Republic, Malaysia, Mongolia, New Zealand, Papua New Guinea, Philippines, Solomon Islands, Vanuatu, Viet Nam.

9.4.2 African Region: Benin, Burundi, Cameroon, Congo, Côte d'Ivoire, Ethiopia, Ghana, Guinea Bissau, Liberia, Madagascar, Mali, Mauritania, Mauritius, Niger, Nigeria, Seychelles, Sierra Leone, South Africa, Togo, Uganda, Zambia, Zimbabwe. **Region of the Americas:** Antigua and Barbuda, Barbados, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Costa Rica, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Honduras, Mexico, Peru, Saint Lucia, Saint Vincent and the Grenadines, Suriname, United States of America, Uruguay. **Eastern Mediterranean Region:** Afghanistan, Bahrain, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen. **European Region:** Albania, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Denmark, Estonia, Finland, France, Georgia, Hungary, Iceland, Israel, Kazakhstan, Kyrgyzstan, Latvia, Malta, Montenegro, Netherlands, Poland, Republic of Moldova, Romania, Russian Federation, Serbia, Slovakia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Brunei Darussalam, Cambodia, Kiribati, Lao People's Democratic Republic, Malaysia, Mongolia, Papua New Guinea, Philippines, Republic of Korea, Singapore, Solomon Islands, Tuvalu.

9.4.3 African Region: Côte d'Ivoire, Eritrea, Ghana, Madagascar, Mauritania, Mauritius, Namibia, Niger, Nigeria, Seychelles, South Africa, Uganda, Zambia. **Region of the Americas:** Antigua and Barbuda, Argentina, Barbados, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Honduras, Mexico, Panama, Paraguay, Peru, Saint Lucia, Saint Vincent and the Grenadines, Suriname, United States of America, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Bahrain, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates. **European Region:** Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Latvia, Lithuania, Luxembourg, Malta, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Brunei Darussalam, China (People's Republic of), Cook Islands, Fiji, Japan, Kiribati, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, New Zealand, Palau (Republic of), Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

9.4.4 African Region: Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Côte d'Ivoire, Democratic Republic of the Congo, Lesotho, Madagascar, Malawi, Mali, Mozambique, Niger, Senegal, Swaziland, Zambia, Zimbabwe. **South-East Asia Region:** Bangladesh, Bhutan, India, Indonesia, Thailand. **Western Pacific Region:** Cambodia, Lao People's Democratic Republic, Viet Nam.

9.4.5 African Region: Algeria, Benin, Chad, Côte d'Ivoire, Eritrea, Ethiopia, Malawi, Mali, Mauritania, Niger, Nigeria, Rwanda, Senegal, Togo, United Republic of Tanzania, Zambia. **Region of the Americas:** Bahamas, Belize, Brazil, Colombia, Cuba, Ecuador, El Salvador. **Eastern Mediterranean Region:** Pakistan, Saudi Arabia, Somalia, Syrian Arab Republic. **European Region:** Albania, Belarus, Croatia, Georgia, Lithuania, The former Yugoslav Republic of Macedonia, Turkey. **South-East Asia Region:** Democratic People's Republic of Korea, Indonesia, Maldives, Myanmar, Nepal. **Western Pacific Region:** Mongolia, Viet Nam.

9.5.1 African Region: Algeria, Benin, Botswana, Cameroon, Cap Verde, Congo, Eritrea, Ethiopia, Gambia, Ghana, Kenya, Lesotho, Mauritania, Sao Tome and Principe, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda. **Region of the Americas:** Antigua and Barbuda, Barbados, Belize, Brazil, Colombia, Costa Rica, Dominica, Dominican Republic, Ecuador, Guyana, Honduras, Jamaica, Mexico, Saint Lucia, Trinidad and Tobago, United States of America. **Eastern Mediterranean Region:** Bahrain, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, United Arab Emirates. **European Region:** Andorra, Armenia, Austria, Azerbaijan, Belgium, Bosnia and Herzegovina, Croatia, Czech Republic, Denmark, Estonia, Finland, Georgia, Germany, Greece, Italy, Latvia, Lithuania, Luxembourg, Poland, Republic of Moldova, Romania, Russian Federation, San Marino, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey. **South-East Asia Region:** Bangladesh, India, Indonesia, Maldives, Myanmar, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Brunei Darussalam, Cambodia, China (People's Republic of), Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Mongolia, New Zealand, Palau (Republic of), Philippines, Republic of Korea, Singapore, Tonga, Viet Nam.

9.5.2 African Region: Angola, Benin, Botswana, Cameroon, Cap Verde, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Liberia, Madagascar, Mali, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Swaziland, Uganda. **Region of the Americas:** Argentina, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Guyana, Paraguay, Peru, Uruguay. **Eastern Mediterranean Region:** Iran (Islamic Republic of), Iraq, Jordan, Morocco, Saudi Arabia, Tunisia. **European Region:** Albania, Andorra, Armenia, Austria, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany,

Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Romania, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, The former Yugoslav Republic of Macedonia, Turkey, Ukraine, United Kingdom of Great Britain and Northern Ireland. **South-East Asia Region:** Indonesia, Sri Lanka, Thailand.

9.6.1 African Region: Angola, Benin, Burkina Faso, Burundi, Cap Verde, Central African Republic, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, Gambia, Guinea, Guinea Bissau, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Niger, Rwanda, Senegal, Seychelles, Sierra Leone, Togo, Uganda, United Republic of Tanzania, Zambia. **Region of the Americas:** Antigua and Barbuda, Belize, Cuba, Dominica, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname. **Eastern Mediterranean Region:** Afghanistan, Djibouti, Pakistan, Somalia, Sudan, Yemen. **European Region:** Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Georgia, Kazakhstan, Kyrgyzstan, Montenegro, Republic of Moldova, Romania, Tajikistan, The former Yugoslav Republic of Macedonia, Ukraine, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, Maldives, Myanmar, Nepal, Thailand. **Western Pacific Region:** Cambodia, Cook Islands, Fiji, Kiribati, Lao People's Democratic Republic, Papua New Guinea, Samoa, Solomon Islands, Tonga, Vanuatu.

9.6.2 African Region: Angola, Benin, Burkina Faso, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gabon, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Mali, Mauritania, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States of America, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Bahrain, Egypt, Iran (Islamic Republic of), Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen. **European Region:** Albania, Andorra, Armenia, Austria, Azerbaijan, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Brunei Darussalam, Cambodia, China (People's Republic of), Cook Islands, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, New Zealand, Niue, Palau (Republic of), Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

SO 10

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



ASSESSMENT OF THE ORGANIZATION-WIDE EXPECTED RESULTS

Of the thirteen Organization-wide expected results for this strategic-objective, seven were «fully achieved» and six «partly achieved».

Overview

The continuing financial crisis added an extra dimension to the challenges already facing countries seeking to develop their health systems, piling financial constraints on top of ongoing problems associated with achieving the health-related Millennium Development Goals: fragmented and low-quality service delivery compromising patient safety; lack of timely information and information systems (including vital registration), communication technologies and research capacity to generate it; shortages of health-care providers; and inequitable access to services and heavy reliance on direct out-of-pocket payments to finance health services

Under the guidance of the World Health Assembly, and in accordance with regional committee resolutions, WHO supported efforts to address these challenges by providing technical and policy support to countries, sharing best practices and experiences, and developing tools, guidelines, norms and standards. Many countries made progress in strengthening the different components of their health systems and in implementing and monitoring reforms to strengthen primary health care. Globally, 108 countries introduced comprehensive national planning processes, with stakeholder involvement in the national policy dialogue. Out of the 57 countries with a critical shortage of human resources for health, 35 have a multi-year strategic plan, and 20 have an investment plan for scaling up training and education of health workers. In order to improve the collection and analysis of health workforce data, 127 countries reported having two or more national data points on the available human resources for health. Since the publication of *The world health report 2010 – health system financing: the path to universal coverage*, more than 55 countries have approached WHO for technical support in various aspects of health financing, demonstrating a commitment to moving closer to universal coverage.

Countries have shown increased commitment to improving their civil registration and vital statistics systems through better use of information and communications technology. The presence of the Evidence-Informed Policy Network (EVIPNet) initiative in a growing number of countries has enhanced evidence-based policy making. There has been an expanded uptake of eHealth applications, especially mHealth, and development of virtual platforms for knowledge sharing, as well as a steady widening of access to scientific literature. In addition, most of the targets for WHO's country support, capacity building and development and dissemination of information products were achieved, including, publication of *The World Health Report 2010*, together with an action plan on sustainable health financing systems for universal coverage; annual updates of country health expenditures in the Global Health Expenditure database; adoption of resolution WHA64.8 on Strengthening national policy dialogue in order to build more robust health policies, strategies and plans; launch of the Global Learning Programme on National Health Policies, Strategies and Plans; adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel; and the Global Health Observatory portal and database. In addition, a national e-Health road map development toolkit was produced jointly with ITU. Virtual libraries and eLearning have become an integral part of the work of the Organization and its outreach to Member States. A number of countries have established patient safety programmes in hospitals and started monitoring and evaluation.

WHO collaborated with many external partners, including, the International Health Partnership (IHP⁺), the Providing for Health initiative (P4H), Harmonization for Health in Africa (HHA), a variety of bilateral, multinational and civil society organizations.

10.1

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

Fully Achieved

There is a growing interest at country level and within the Secretariat in promoting and developing service delivery based on integrated primary care. This is particularly the case in middle- and high-income countries. In some countries, primary care is starting to assume a more coordinating and gate keeping role. Enhanced and continued integration of noncommunicable diseases and their common risk factors introduces cross-cutting platforms, reduces the disadvantages associated with vertical approaches, and strengthens primary health care-based health systems.

During the biennium, the number of Member States that have regularly updated databases on numbers and distribution of health facilities and health interventions increased from 30 in 2010 to 73 at the end of 2011. Twenty-one countries made advances in implementing and monitoring reforms to strengthen primary health care. In the Region of the Americas, seven countries developed national policies and programmes to implement integrated health service delivery networks. The Region has also adopted a resolution on eHealth Strategy and Plan of Action. Additionally, there progress was made in integrating vertical programmes within health systems. In the European Region, 11 countries¹ continued to see positive developments in the reform of their public health services. In the Eastern Mediterranean Region, an initiative was launched in eight low- and middle-income countries to establish a model integrated district health system based on the family practice approach; and a selected number of countries implemented reforms in hospital management and autonomy with a focus on the Patient Safety Friendly Hospital Initiative. In the Western Pacific Region, major reforms of both primary care and hospital services continued in several countries.

In all regions, the support given to countries for the organization of health services in line with primary health-care principles was intensified. In the European Region, support was provided to eight countries to generate evidence for measuring the key characteristics of primary care, and for monitoring progress using the WHO primary care evaluation tool. Technical support was also provided to countries for reforming and strengthening their public health services. In the Eastern Mediterranean Region, four countries were supported in assessing progress in hospital management and autonomy; and a study in seven countries in the Region was conducted to assess hospital performance.

At global level, work progressed in formulating guidance on service delivery, in areas such as people-centred care, 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 developed the following: policy options and strategies for implementing the four primary health-care reforms that are outlined in *The World Health Report 2008*; an analytical framework and methodology for health system performance assessment through primary health-care “lenses”; communities of practice on primary health care; and a virtual course on primary health care in English through the Virtual Campus of Public Health, as well as five guidelines to support the implementation of integrated health service delivery networks. In the African Region, countries were supported in revisiting their essential health packages to take into account primary health-care reforms in service delivery and universal coverage. In the European Region, work on clarifying concepts of public health and health systems, and identifying essential public health services for Europe made advances. The European Region invested in facilitating international comparisons, experience sharing and knowledge transfer by generating data on primary care organization and provision in European countries. In the Western Pacific Region, the Regional Strategy for Health Systems, based on the values of primary health care, was adopted in October 2010 and is reflected in Member States’ reform efforts. In the Eastern Mediterranean Region, a consultation was convened to review the status of family medicine training and practice in the Region after almost three decades.

There still remains a disconnect between the importance of the hospital reform agenda for national health authorities and the attention this gets in the global health and aid environment. This hampers the development of coherent approaches to service delivery. Additionally, fragmentation and verticalization of services remain a major obstacle to the development of comprehensive, well-balanced and coherent services that meet the expectations of the population. Responsive people-centred care receives inadequate support from national authorities, particularly in low- and middle-income countries. To address these issues, WHO also helped further define the concept of people-centred care, its dimensions and policy options, and organized capacity building field visits (demonstration tours) on person-centred care for staff and delegations from developing countries.

INDICATOR	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
10.1.1 Number of Member states that have regularly updated databases on numbers and distribution of health facilities and health interventions offered.	30	35	73

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

Fully Achieved

Countries made advances in the formulation and implementation of their national health policies, strategies and plans. Globally, 108 countries have put in place comprehensive national planning processes with varying degrees of stakeholder involvement in the national policy dialogue. Sixty-nine Member States conducted participatory health sector reviews and progress evaluations based on agreed health system performance assessment criteria. Joint assessments of national strategies were successfully conducted in 10 countries.² In the Regional Office for the Americas, regulatory frameworks and legislation were revised and updated in 11 countries.³ In the European Region, six countries⁴ completed a health system performance assessment exercise. In the Eastern Mediterranean Region, 13 countries conducted assessment studies on regulation of the private sector. Road maps on information and accountability were developed for at least six countries by the Commission on Information and Accountability.

Direct support was provided by different levels of the Organization to more than 60 countries for health planning and policy dialogue reviews, in some cases through inter-country workshops, as well as by the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance, and, in line with IHP+ principles. Specific support was provided for donor harmonization of grants for health systems strengthening and the alignment of the grants with country fiduciary and monitoring and evaluation mechanisms, as well as for the development of new funding proposals for health systems strengthening. Direct funding was made available for national health policies, strategies and plans following joint assessment exercises. A new programme aimed at strengthening long-term support for country policy dialogues on national health policies, strategies and plans was launched in seven countries,⁵ with support from the European Union. The aim is to increase the number of countries under this programme during the next biennium. Technical support was also provided to countries in relation to regulatory frameworks; health-system performance assessment and essential public health functions.

A framework document on national health policies, strategies and plans was approved by the Regional Committees and the Sixty-fourth World Health Assembly – the latter also endorsing a resolution on supporting policy dialogue in countries (WHA64.8). The “joint assessment of national strategies”

approach with tools to support countries and partners in national planning processes were developed. Tools included the Country Planning Cycle Database, the WHO toolkit for building country health policies, strategies and plans and a glossary. The Global Learning Programme on national health policies, strategies and plans was launched in June 2010, in line with resolution WHA64/8. The aim of the Programme is to build the capacity of individuals, as well as of the Organization to engage in sectoral and intersectoral policy dialogues with national stakeholders and global partners on developing sound national health policies, strategies and plans within the context of primary health care and in line with the Paris Declaration on Aid Effectiveness. Generic capacity building materials and core messages were developed and adapted to meet the needs of each Region. Some 617 staff members from 75 WHO country offices completed the first phase of the Programme and have developed road maps for WHO support to national planning cycles in their countries.

The Regional Office for the Americas developed a framework and tools to support the analysis of health legislation, as well as the updating of regulatory frameworks. An operational tool for health system performance assessment was developed by the European Region and successfully tested in six countries. The aim is to expand its use in the future. In parallel, the European Observatory on Health Systems conducted a series of studies on health system performance assessment and produced publications for conducting international comparative analyses. In the Western Pacific Region, WHO tested a tool which would allow countries to assess the comprehensiveness of their public health legal and regulatory frameworks; some countries updated and streamlined their public health legislation.

Obstacles to achievement of the Organization-wide expected result included a lack of consistency and continuity in the support for national health policies, strategies and plans. Effective engagement in that area requires long-term consistent country support, skilled staff (often based in-country) and predictable funding. Through the Global Learning Programme on national health policies, strategies and plans staff are learning to engage different stakeholders in the development of balanced, coherent and comprehensive medium- to long-term national health policies, strategies and plans, with an agreed set of indicators for monitoring and evaluation, and joint op-

erational plans. Additionally, a good general overview of the situation in countries is lacking owing to the increased fragmentation of ministries of health and of technical support. The Secretariat convened and organized consensus building missions with national and international partners, including those

with no country presence, to facilitate national policy dialogue on harmonization and alignment.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
10.2.1 Number of Member States that have in the last five years developed comprehensive national health planning processes in consultation with stakeholders.	92	107	108
10.2.2 Number of Member States that conducted a regular or periodic evaluation of progress, including implementation of their national health plan, based on a commonly agreed performance assessment of their health system.	54	65	69

10.3

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

Partly Achieved

The aim of the International Health Partnership (IHP+) is to accelerate improvements in health outcomes through better alignment of partners with national health strategies; it has now become the generally accepted model for implementing the Paris/Accra agendas. WHO and the World Bank jointly serve as the Secretariat for IHP+. During the biennium, the number of signatories to the IHP+ Global Compact grew from 27 to 55, of which 30 are developing countries. Progress on the commitments of partners and countries is monitored and published annually by an independent consortium known as "IHP+ Results". During the biennium, 10 developing countries and 15 development agencies participated in the second round of "IHP+ Results".

National compacts were completed in five countries⁶ during the biennium. In addition, ministries of health developed and organized more comprehensive stakeholder/donor coordination mechanisms. The Secretariat continued to play a key role in supporting Member States in such coordination efforts. Progress was made in developing plans for a monitoring and evaluation platform – to date eight countries have monitoring and evaluation road maps. WHO facilitated the harmonization of the fiduciary and/or monitoring and evaluation mechanisms of the GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank and other relevant in-country partners, as well as their alignment with national systems in six countries.⁷ Beyond these results, which are directly related to IHP+, other countries increasingly adopted similar approaches.

Support was provided by the different levels of the Organization to ministries of health, in particular, for strengthening partner coordination mechanisms, and to governments for assessing national health policies, strategies and plans using the joint assessment of national strategies tool in 10 countries.⁸

During the biennium, the Regional Offices for Africa, the Americas, Europe, South-East Asia and the Western Pacific focused attention on the coordination of donors in the health sector and alignment of their funds and activities with national health priorities and plans. In the Eastern Mediterranean Region, an assessment on aid effectiveness and donor coordination was conducted in eight countries for use in developing a regional strategy.

WHO and the World Bank jointly service IHP+, oversee implementation of the workplan, and convene partners, for ex-

ample, in the third meeting of country teams in late 2010, which was attended by almost all signatories and was instrumental in reviewing achievements and setting future directions. The joint assessment of national strategies (JANS) approach has recently been revised by an IHP+ inter-agency working group. The IHP+ common monitoring framework is being used by the Commission on Information and Accountability. All levels of the Secretariat have been involved in implementing the IHP+ approach, especially, though not exclusively, in IHP+ countries.

WHO co-leads the OECD/DAC Task Team on Health as a Tracer Sector, which produced a report on the progress made in aid effectiveness in the health sector for the 4th High Level Forum on Aid Effectiveness in Busan, South Korea. WHO published the report *From Whom to Whom? Official Development Assistance for Health*, which describes the different elements of aid and provides information on official development assistance commitments to 122 Member States.

In general, governments demonstrated leadership and took ownership of their national planning processes, which was instrumental in achieving the progress made by development partners towards harmonization and alignment. In some countries, harmonization among a group of partners and the alignment of their work with country plans and processes has created confidence and even incentives to attract additional partners. The IHP+ approach is now widely supported by development partners; it has also given developing countries a greater say in their future. However, making progress in this area requires time and the adaptation of agencies and institutions, which is a difficult message to put across to policy makers and managers, who often want "quick wins" and disregard the importance of political results compared to quantified indicators. Without integration or mainstreaming of aid effectiveness principles in partner agencies' policies, the progress made cannot be sustained. Partner agencies often have to respond to competing interests among their constituencies. To address such issues, IHP+ has created platforms for inter-country exchanges of best practice. WHO invested in building the capacity of national authorities in order to improve their negotiating position when dealing with donors and has striven to keep the Paris and Accra agendas alive in discussions with the donor community at global level.

Despite the progress made, Organization-wide expected result 10.3 was "partly achieved" because the Regional Offices for the Americas and South-East Asia reported their con-

tributions as having been partly achieved. The main challenge faced was the length of time required for institutions to adapt

to harmonizing their policies with national policies and those of partner agencies.

INDICATOR	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
10.3.1 Number of Member states where the inputs of major stakeholders are harmonized with national policies, measured in line with the Paris Declaration on Aid Effectiveness.	25	30	52

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

Fully Achieved

Commitment to strengthening health information systems increased in many countries, as evidenced by the completion of the Health Metrics Network/WHO assessment, development of strategic plans, gradual enhancement of analytical capacity and better availability of data. Data is mainly collected through household surveys, but facility-based reporting systems are being improved. During the biennium, the proportion of low- and middle-income countries with adequate health statistics and mechanisms for monitoring the health-related Millennium Development Goals that meet agreed standards increased from 40% to 48%.

WHO contributed to the strengthening of countries' health information systems through the development and promotion of standards and tools, capacity building and provision of support to regional networks, such as the new Spanish language health information systems network (RELACIS) in the Region of the Americas and the Pacific Health Information Network (PHIN) in the Western Pacific Region. Tools to improve data collection included: the service availability and readiness assessment (SARA) facility and a platform for monitoring and evaluating country health strategies developed jointly by WHO and IHP+.

Countries' analytical capacity was enhanced through the joint development of tools and multi-country workshops (four were conducted during 2010–2011 in the African, Eastern Mediterranean, South-East Asia and Western Pacific Regions, covering more than 30 countries). Technical assistance focused on

strengthening the analytical component of health sector reviews, carried out within the IHP+ monitoring and evaluation framework. For example, in Sierra Leone, headquarters and the Regional Office for Africa, guided by the country office, provided technical assistance for the development of a plan to monitor and evaluate the country's health strategy, data quality, service availability, and health-sector performance. The first country interactions on implementing the accountability framework, as recommended by the Commission on Information and Accountability for Women's and Children's Health, were also initiated through a multi-country workshop in West Africa.

In the scaling up of efforts to attain the Millennium Development Goals more emphasis has been placed on health information systems and accountability, which, in turn has directed international and national attention towards the need to strengthen health information systems in countries through a more integrated approach. The IHP+ monitoring platform and similar regional approaches form a good basis for WHO support to country-led monitoring and evaluation systems for improved information and accountability for health. The introduction of information and communications technologies is beginning to bear fruit in some areas of health information, but much more needs to be done to bring this up to the level required for good and timely public health statistics for use in decision making. Institutional capacity in most low- and middle-income countries is still limited meaning that health information systems can only be improved gradually.

INDICATOR	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
10.4.1 Proportion of low- and middle-income countries with adequate health statistics and monitoring of health-related Millennium Development Goals that meet agreed standards.	40%	45%	48%

10.5

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

Partly Achieved

There has been gradual progress in the availability of and reporting on quality health data by countries. Statistical profiles for countries are improving, but major gaps, such as causes of death, remain in many countries with virtually no improvement occurring during the last decade. An increasing number of countries in the African Region are planning or establishing health observatories, for example, as part of the African Health Observatory.

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

WHO published cross-cutting analytical reports at the global level (*World Health Statistics*), regional analyses (the Regional Office for the Americas), statistical summaries (all regions) and journals (for example, the *African Health Monitor*). The WHO Family of International Classifications held annual meetings and made considerable progress in the revision of the international classification of diseases, of which the Alpha version was launched in 2010.

WHO continued to engage with countries through surveys on adult health and ageing, strengthening of vital statistics systems and comprehensive analyses to inform health sector reforms and reviews. As a result, the number of countries in which WHO plays a key role in supporting the generation and use of information and knowledge, including primary data collection through surveys, civil registration or improvement or

analysis and synthesis of health facility data for policies and planning has increased from 30 in 2010 to 36 at the end of the biennium.

Headquarters and regional offices continued to incorporate the social determinants of health and health equity approaches in programme strategies. WHO also engaged in supporting country data collection and analysis on neglected topics, such as health and ageing (through a longitudinal multi-country study on Ageing and Health (SAGE) in six countries) and household surveys on mortality (for example, in Afghanistan).

The proportion of countries that are able to provide quality health statistics has grown in response to demands for health monitoring and situation and trend analyses, including evaluation of health systems performance. However, serious data gaps remain, although, in virtually all cases, they are filled by use of modelled estimates. It should be possible to solve the problem through stronger country health information systems.

WHO's statistical and normative work will continue to build on partnerships with academic institutions, United Nations agencies and countries. While scientific progress may be spearheaded by academic institutions, WHO must provide a platform for all stakeholders to work together to generate good quality information for health decision making. WHO's role as an authoritative source of data depends on the effectiveness of its relationship with countries and the support of international academic institutions in all regions. Working together across the Organization will be key in generating and communicating country, regional and global health statistics. The work on health observatories constitutes a major step in that direction.

Although good progress was made in achieving the strategic objective, the African and South-East Asia Regions reported their contribution as "partly achieved" owing to different levels of capacity in collecting evidence for health decision-making and coordination. Building capacity for ethical conduct of research still poses a major challenge.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
10.5.1 Proportion of countries for which high quality profiles with core health statistics are available from its open-access databases.	85%	90%	98%
10.5.2 Number of countries in which WHO plays a key role in supporting the generation and use of information and knowledge, including primary data collection through surveys, civil registration or improvement or analysis and synthesis of health facility data for policies and planning.	30	35	36
10.5.3 Effective research for health coordination and leadership mechanisms established and maintained at global and regional levels.	In progress, at different stages at global and regional levels	Mechanisms operating at global and all regional levels	Global research for health strategy established at WHO headquarters. Regional strategies established in 4 Regional Offices ⁹

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

Partly Achieved

The WHO strategy on research for health, approved by the Sixty-third World Health Assembly, provided a common framework for the organization of WHO support to Member States. The strengthening of research for development activities within countries was reported by five regional offices.

In the African Region, WHO prepared a set of guidelines informed by the framework for implementation of the Algiers Declaration. A policy on health research was approved by the 61st session of the Regional Committee of the Americas. The Regional Office for the Eastern Mediterranean prepared a strategy for scaling up research for health, which was endorsed by the 58th session of the Regional Committee. The Regional Office for South-East Asia devised a regional strategy on research for health. The Regional Office for the Western Pacific focused on governance of research, strengthening research ethics reviews and the sharing of data to improve public health. It held a consultation of experts from the Region in August 2011 for the purpose of making recommendations in those areas. The presence of the Evidence-Informed Policy Networks (EVIPNet) initiative in a growing number of countries enhanced evidence-based policy making. The European Region has recently prioritized research and evidence for policy. As a result, the European Advisory Committee on Health Research was reconstituted and began work on developing a regional research for health strategy and the establishment of a regional EVIPNet (Evidence Informed Policy Network).

Implementation of the headquarters research strategy was harmonized with the global strategy and plan of action on Public Health, Innovation and Intellectual Property. The main publications include "Overview of research activities associated with the World Health Organization: results of a survey covering 2006/07",¹⁰ "Defining research to improve health systems"¹¹ and "A checklist for health research priority setting: nine common themes of good practice".¹²

The research for health strategy has been used to guide the development of the research agenda in a number of technical areas, including: influenza, food-borne diseases, radiation risks, vaccines and social determinants of health, and has also been used in the report on women and health to develop a six-point agenda for a gender-based approach to research. The strategy framework has provided input into the *World Health Report 2012*, which has research for health as its focus. The Secretariat coordinated the production of Standards and operational guidance for ethics review of health-related research with human participants.¹³

One of the main obstacles to achieving Strategic objective 10 was the difficulty in obtaining reliable high-level data on research and development resource flows and mapping without global standards on the classification and reporting of research and development data. Indicator 10.6.2 is not a precise measure of country support for research and development. While countries can report their own achievements, WHO is unable, with its current resources, to verify the figures. Therefore the indicator will be discontinued in 2012–2013. An automated approach to the mapping of reported research and development data is being explored as a potential tool for improving the situation. *The World Health Report 2012* will focus on research highlighting the value of research to public health and the need for greater efforts in mapping, standards and harmonization in line with priority public needs.

Overall, the Organization-wide expected result was partly achieved because the Regional Offices for Africa, Europe, South-East Asia and the Western Pacific, as well as headquarters, reported their contributions as having been partly achieved. Obtaining reliable high-level data on research and development resource flows and mapping remains very difficult without global standards on the classification and reporting of this data.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
10.6.1 Proportion of low- and middle-income countries in which national health-research systems meet internationally agreed minimum standards.	10%	15%	40%
10.6.2 Number of Member states complying with the recommendation to dedicate at least 2% of their health budget to research (Commission on Health Research for Development, 1990).	15%	8% increase from 2009 target	Not available ¹⁴

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

Partly Achieved

There was an expanded uptake of eHealth applications, especially mHealth,¹⁵ and development of virtual platforms for knowledge sharing, as well as a steady increase in access to scientific literature. Enhanced support for eHealth was evidenced by resolutions in the African Region and the Region of the Americas. In the European Region, WHO advised on e-strategies and development, including at European Union ministerial conferences. The South East-Asia and Western Pacific Regions have active regional eHealth networks, with countries actively building strategies and regulatory frameworks.

The Global Observatory for eHealth reports covered mHealth, legal issues, online safety, patient information systems and telemedicine. A total of 114 countries contributed to the Global Observatory for eHealth survey and all countries have access to the results of the survey through published reports. The number of countries with eHealth policies increased from 53 at the beginning of the biennium to 75 as at the end of 2011.

Use of the HINARI Access to Research in Health Programme continued to grow rapidly in registered institutions in all regions, with increasing input from publisher partners. A new discovery tool partner is working to better expose the wealth of resources available to the institutions. National capacity-building was supported in Reasrch4Life programmes (HINARI, OARE and AGORA). Governing bodies collections (2004–2011) in the six official languages were added to the institutional repository. Work is in progress to develop and harmonize WHO knowledge sharing platforms. Countries have developed and joined e-journals consortia. Global Information Full Text (GIFT) is facing difficulties because the package for next biennium cannot be completely renewed owing to the necessary funding not having been identified or secured. Use of collaborative space increased among knowledge management teams as they build virtual platforms, portals and facilities in countries. Conducting and setting up in-depth searching for systematic reviews has increased in support of evidence-based guidelines. Training courses on in-depth searching for systematic reviews are fully booked and in high demand.

Expertise in searching for developing country health literature improved with an increase in the capacity to search both Russian and Chinese databases. Over 700 WHO staff in headquarters and the regions were trained in library and search skills. The second Global survey on eHealth was completed and the results published electronically and in "Print on

Demand" in English only. Countries are expanding the use of information and communications technologies in health systems, with a push towards eHealth and its different applications. Five publications have been released on mHealth, telemedicine, internet security, legal frameworks and management of patient information.

Collaborations included Telecom World 2011, the World Summit on the Information Society forum, and development of the WHO-ITU national eHealth strategy toolkit, co-organizing regional eHealth forums, and expansion of collaborating centers.

Health Academy courses were implemented in six countries. New contents have been prepared and some have been published on a CD ROM for sales/distribution.

A compendium of available eLearning modules developed by WHO technical units was prepared and published online. All eight Portuguese-speaking countries developed national virtual health libraries. The Collaborative Space, blog and discussion group were very active. In 2011, ePortuguese distance learning courses began to be disseminated. Four countries in the African Region have already benefited from the programme.

EVIPNet pursues an ongoing process of refining methodologies and tools for translation of research to policy in accordance with the current monitoring and evaluation process that is planned to run until 2014. The work focuses on the African Region and the Region of the Americas.

Health ministries in countries in the African Region became more aware of the urgent need to develop national eHealth strategies, policies and action plans. They also have a better understanding of the need for common data standards and metadata. Use of WHO collaborating centres in the eHealth area increased in some regions.

Assessing needs and measuring progress was problematic, particularly in knowledge management and access to information, owing to a lack of skilled and dedicated human resources, which led to a reduction in library services at the end of the biennium, creating an additional difficulty in providing open access to electronic scientific journals. For example, after two years of development, the Africa Health InfoWay and EURO-internal web-based country-information intelligence tool was mothballed in January 2010 because of insufficient available resources to maintain it.

To address such challenges, WHO endeavoured to improve coordination with regional offices and partners, as well as outreach to Member States in order to raise awareness of the value of WHO's work. The role of regional offices as an authoritative source and broker of evidence-based public health information and knowledge is becoming increasingly important with the current overload of health information and rise in the use of social networks. National and regional workshops were held to train personnel.

Despite the progress made, Organization-wide expected result 10.7 was "partly achieved" owing to different levels of

effort in countries and regions, especially in the European and South-East Asia Regions, national policies and interoperability. Indicator 10.7.1 was reported as being on track as the end of 2010 during the mid-term review as efforts were made during 2011 to find an alternative measurement methodology under the current definition. However, after consultations with regional and country offices, it was decided that this indicator would be discontinued and therefore no data are provided for 2010–2011.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
10.7.1 Number of Member States adopting knowledge management policies in order to bridge the "know-how" gap particularly aimed to decrease the digital divide.	87	100	Not available ¹⁶
10.7.2 Number of Member States with access to electronic international scientific journals and knowledge archives in health sciences as assessed by the WHO Global Observatory for eHealth biannual survey.	159	170	162
10.7.2 Proportion of Member States with eHealth policies, strategies and regulatory frameworks as assessed by the WHO Global Observatory for eHealth biannual survey.	53	75	75

10.8

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

Fully Achieved

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

In the African Region: 29 countries reported developing human resources for health country profiles and 13 countries had established national health workforce observatories. In the Eastern Mediterranean Region, four countries¹⁷ undergoing a workforce crisis strengthened existing or established new national observatories with financial support from the Global Health Workforce Alliance. In the European Region, all 53 countries submitted more than two national data points on human resources for health, which were reported in the Global Atlas of the Health Workforce. Significant progress was achieved by Member States of the Region in developing a joint data collection of health workforce statistics in order to harmonize data collection, promote the consistent use of international standard classifications, and improve the comparability of data. The first two rounds of the joint data collection have been completed with coverage of European Union and OECD countries in the Region. In the Western Pacific Region, 16 countries enhanced their information or databases on the health workforce, and two developed or reviewed their health workforce plans. In the Region of the Americas, progress was made in strengthening national and subregional policies and plans, and in the development information systems on the health workforce.

Technical support was provided to countries by regional offices, in collaboration with headquarters, in various areas governance and evidence generation relating to human resources for health, such as policy and plan development, setting up national observatories on the health workforce, and strengthening information systems and capacity building in planning. In the European Region, country case studies on migration were prepared through three European Commission funded research projects whose findings were published and disseminated, in collaboration with the European Observatory on Health Systems and Policies, at key international, regional and national events.

WHO continued to work with partners in the Health Workforce Information Reference Group to develop global guide-

lines for generating information on the health workforce; and to establish health workforce observatories to address current deficiencies. The Global Atlas of the Health Workforce was last updated in late 2010. The Atlas collects information from various sources in countries and is a global resource for health workforce statistics. 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 developed and disseminated. Capacity-building activities were carried out in health workforce governance, leadership and management, as well as in the use of tools and guidelines for policy and practice.

The Regional Office for Europe worked closely with the European Union to provide technical input and advice to the European Union working group on the health workforce, including to parliamentary hearings. The Region of the Americas organized the First Regional Forum on Human Resources for Health and Indigenous Peoples. In the Western Pacific Region, the Western Pacific Regional Action Framework for Human Resources for Health 2011–2015, together with accompanying national and regional indicators, was developed based on various reviews and evaluations and after a series of consultations at regional and subregional level.

The role of the Africa Health Workforce Observatory as a source and broker of evidence and knowledge is becoming increasingly important with the overload of health information. The strategy of cooperation through networks, such as the Observatory of Human Resources in Health and the Virtual Campus of Public Health proved to be successful, but demand a medium- to long-term institutional commitment to ensure sustainability and progressive decentralization. Initiatives, such as the Observatory and the Virtual Campus require regular evaluation and renewal in view of rapidly changing environments.

A major obstacle to progress was a shortage of staff at country and regional level, with a number of officers at country level covering multiple areas of technical work. Special attention was paid to building the capacity of national authorities to equip them with the knowledge and skills to manage programmes. A special effort was also made to mobilize additional resources to carry out all planned activities, using seconded staff, interns, volunteers and WHO collaborating centres to support programmes.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
10.8.1 Number of countries reporting two or more national data points on human resources for health within the past five years, reported in the Global Atlas of the Health Workforce.	85	96	127
10.8.2 Number of Member States with a national policy and planning unit for human resources for health.	41	50	90

10.9

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

Fully Achieved

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 in support of planning, improvement of information systems, including health workforce observatories, educational programmes for professionals, task shifting and retention strategies.

A total of 35 of the 57 countries (61%) with a critical health workforce shortage have multi-year human resources plans, a major increase compared to the baseline of 42% in 2010. In addition, 20 countries that have an investment plan for scaling up training and education of health workers increased from 16% in 2010 to 35% by the end of the biennium. More specifically, in the African Region, 22ⁱ of the 36 countries with a health workforce crisis have multi-year strategic plans, 12 countriesⁱⁱ developed health workforce policies, and 11ⁱⁱⁱ have an investment plan for scaling up training and education of health workers. All countries in the South-East Asia Region, particularly those facing a health workforce crisis, paid special attention to increasing the productivity of the health workforce and to improving the quality and relevance of health personnel education. In addition, greater opportunities were provided for health workers to upgrade their competencies and qualifications for career advancement. In the Region of the Americas, many ministries of health are restructuring their human resources units, with new strategic roles, including intersectoral coordination with ministries of education, finance and labour and the civil service. In addition, a number of countries elaborated proposals for legal regulation of careers in the health sector. In the Western Pacific Region, Cambodia and the Lao People's Democratic Republic, both of which are experiencing health workforce crises, established, in cooperation with the Republic of Korea and Philippines, country-led education development centres to build the capacity of university faculties and improve the quality of education. In the Western Pacific Region, 12 countries and areas received online continuing education courses through the Pacific Open Learning Health Network.

WHO's technical support to countries in strengthening the education and training of health workers covered four main areas:

- *Curriculum development and capacity building:* through training programmes, workshops and fellowships in countries in crisis, such as Afghanistan, Iraq, Pakistan, Somalia, South Sudan, Sudan, and Yemen.

- *Pre-service education improvement and scaling up production of nursing, midwifery and allied health professionals:* in Djibouti, Egypt, Iraq, Libya, Sudan, Somalia, United Arab Emirates, and Yemen. Support was provided to the Syrian Arab Republic in the area of career development through the establishment of a bridging programme at Tichrin University to allow nurses with a nursing diploma to proceed into a university degree. Support was provided to Bhutan to develop and implement the two-year Bachelor of Public Health programme for experienced health assistants to further build their capacity and advance their careers.
- *Accreditation and regulation in education:* in collaboration with the World Federation for Medical Education, the Regional Office for Europe provided support to Member States for strengthening their national accreditation systems (Belarus, Republic of Moldova, Turkmenistan), and training in evidence-based practice (Belarus, Turkmenistan). In the Eastern Mediterranean Region, technical support was provided to the nursing and midwifery councils in Oman, United Arab Emirates and Sudan to strengthen nursing and midwifery regulation. In West Africa, an assessment of the status of regulation for nursing and midwifery education and practice was carried out in 17 countries.
- *Strengthening quality assurance mechanisms:* technical support was provided for institute quality assurance mechanisms in health professional educational establishments (for example, medical, nursing or paramedical colleges) in Bangladesh, Democratic People's Republic of Korea and India. Models of collaboration between nursing education and health services were expanded in the Democratic People's Republic of Korea to improve the quality of nursing education and practice. In West Africa, 15 nursing and midwifery programmes from private and public training institutions were assessed for relevance and appropriateness.

At global level, and after three years of international consultations, the WHO Global Code of Practice on the International Recruitment of Health Personnel was adopted by the Sixty-third World Health Assembly.¹⁸

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. In addition, WHO is collaborating with the United States President's Emergency Plan for AIDS Relief on the trans-

formative 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.¹⁹

The Regional Office for Africa organized a regional consultation on scaling up capacity of the health workforce for improved health service delivery, and a regional road map on the health workforce was developed. The process of implementing an African initiative on learning and teaching resources for health worker education was initiated. In the Region of the Americas, several strategic documents were developed, such as a policy framework to improve the alignment of medical residency programmes with primary health care; a regional framework on essential public health competencies for health workers, and the Strategy for health personnel competency development in primary health-care-based health systems. In the Eastern-Mediterranean Region, a draft regional health workforce strategy was drawn up following a regional consultation; it will be submitted to the 59th session of the Regional Committee for adoption. The Regional Office for Europe supported the adoption and implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel. An interregional dialogue between “source” and “destination” countries to achieve consensus on the key issues of the WHO Code of Practice was organized in May 2010 in cooperation with the Global Health Worker Migration Policy Advisory Council. The Code of Practice was translated and disseminated

in national languages in a number of countries. In addition, two subregional workshops on health workforce retention in Europe were organized. Technical reports and policy briefs on attracting and retaining health workers were developed based on case stories developed by Member States. The workshops expanded the evidence base for retention strategies in the Region. In the South-East Asia Region, a regional consultation on quality assurance in continuing medical education was organized. Special attention was paid to strengthening the health workforce in the public sector. The Western Pacific Region organized three consultations with Member States focusing on health workforce regional action plans, educational quality standards, competences and faculty development. Evidence-based norms, tools and guidelines were widely disseminated.

Despite the progress made, there was strong resistance from the educational sector – especially medical education – to adopting a primary health-care oriented approach. The WHO Code of Practice is voluntary, and, despite policy acknowledgement of its importance, strong efforts and resources will therefore be required by countries and WHO to make it operational. Although the indicators were achieved, a lack of funding may hamper promotion of the Global Code of Practice in regions and countries. Efforts are being made to mobilize resources whose outcome will determine whether the goals set for the Organization-wide expected result will be fully achieved.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
10.9.1 Proportion of 57 countries with critical shortage of health workforce, as identified in The world health report 2006 with a multi-year HRH plan.	42%	30%	61%
10.9.2 Proportion of 57 countries with critical shortage of health workforce, as identified in The world health report 2006 which have an investment plan for scaling up training and education of health workers.	16%	25%	35%

10.10

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

Fully Achieved

There was a substantial increase in the number of countries seeking technical support to review or develop their health financing systems with a view to moving closer to or maintaining universal coverage. As at the end of 2011, 77 Member States had received technical and policy support, covering areas, such as raising more funds for health, reducing financial barriers to access and improving financial risk protection, and improving the efficiency and equity of resource allocation decisions. This was achieved in the face of a severe and continuing financial crisis in the higher-income countries, ageing populations, coupled with the increasing burden of non-communicable diseases, and the additional costs associated with the availability of new technologies.

WHO provided technical support to 67 Member States across all regions for assessing their position in terms of universal coverage and the functioning of their current health financing systems, and in developing and implementing strategies to move closer to universal coverage. Where possible, this was often linked to the development of national health plans or health-sector reviews. WHO helped to collate, analyse and disseminate information on best practices, and to facilitate the sharing of country experiences, through 103 information documents disseminated at special workshops and conferences (for example, the first Ibero-American Conference of Health Economics Units), and special sessions at a number of other conferences.

The World Health Report 2010 on Health Systems Financing: the Path to Universal Coverage not only focused attention on the role of health financing in ensuring that all people have access to the health services they need without fear of financial ruin, but also encouraged the sharing of positive and negative experiences across countries. A Health Financing Strategy for the Asia Pacific Region (2010–2015) was adopted in the Western Pacific Region, and a draft health financing strategy was prepared by the Regional Office for South-East Asia. In

response to resolution WHA 64.9 on Sustainable health financing structures and universal coverage, which calls on WHO, inter alia, to develop an action plan for health financing and universal coverage, an action plan was prepared with input from regions, country offices and other partners. WHO advocated strongly, in collaboration with partners, including civil society bodies, for lowering the financial barriers preventing access to health services, and for ensuring that universal coverage is recognized as a fundamental goal of both health policy and development strategies. The European Observatory on Health Systems and Policies published *Implementing health financing reform: lessons from countries in transition*, the Regional Office for Africa contributed to a study entitled *Investing for health in Africa: the case for strengthening systems for better health outcomes*, and the Regional Office for the Americas carried out a regional study on taking health-care claims to court.

Regional health financing strategies, resolution WHA64.9 and the *World Health Report 2010* all reflected, and contributed to, a growing acceptance of the need to develop health financing systems capable of moving closer to universal coverage, and to maintain the gains made in the past.

However, changes to health financing have a political, as well as a technical dimension. Hence, the need to involve finance ministries, as well as international financial institutions and specialized United Nations agencies. The demand for technical support following publication of *The World Health Report* could not be met fully with existing staff and resources, and many country offices lack technical expertise in the area of health financing. In order to address such challenges, WHO entered into more partnerships, such as the Providing for Health (P4H) partnership and Harmonization for Health in Africa, in order to catalyse technical and policy support for more countries than would be possible with its own resources alone. Strategies were developed to provide additional capacity building for staff in country offices.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
10.10.1 Number of Member States provided with technical and policy support to raise additional funds for health; to reduce financial barriers to access, incidence of financial catastrophe, and impoverishment linked to health payments; or to improve social protection and the efficiency and equity of resource use.	66	45	77
10.10.2 Number of key policy briefs prepared, disseminated and their use supported, which document best practices on revenue-raising, pooling and purchasing, including contracting, provision of interventions and services, and handling of fragmentation in systems associated with vertical programmes and inflow of international funds.	7 additional briefs	17 technical briefs	24 technical briefs, over 75 information products of other types

10.11

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

Fully Achieved

Countries increasingly tracked resources spent on health and sought to link them to results. More Member States also reviewed their position on universal coverage (particularly levels and distribution of funds for health, and the incidence of financial catastrophe and impoverishment linked to out of pocket health payments), assessed their health financing systems, developed or modified strategies, and examined the costs and resource constraints associated with particular health financing strategies and health plans.

Technical support began to be provided to countries wishing to use the new tools and guidelines described below. It continued for those wishing to track expenditures, including on particular diseases, assess the extent of financial catastrophe and impoverishment linked to out of pocket payments, evaluate the costs and impact of different strategies and health interventions, and assess their overall health financing systems.

The OneHealth cost and impact tool, jointly developed with five other international agencies, was finalized for the diseases and conditions linked to the Millennium Development Goals and for associated health system strengthening, and tested in countries. It will be used by all participating agencies in supporting countries to assess the costs and impact of national health plans and strategies. SHA2011 – the revised system of health accounts – was finalized jointly with OECD and EUROSTAT and translated by WHO into French, Russian and Spanish. A shorter, user-friendly version was also prepared. An

expenditure tracking tool for government expenditures related to reproductive, maternal, neonatal and child health interventions was developed, tested and disseminated.

WHO developed and disseminated guidelines and a tool (EPIC) on measuring the economic impact of disease, while a macroeconomics and health tool (Regional Office for the Western Pacific) and Guidelines for developing medium-term expenditure frameworks and gathering information on public expenditure and financial management – both in the African Region – were developed. WHO resource tracking experts participated in Working Group 2 of the Commission on Information and Accountability for Women's and Children's health with responsibility for helping countries track overall expenditure, as well as on women's and children's health, in the follow up activities. Finally, WHO-CHOICE (cost-effectiveness) contextualization studies were undertaken with three Member States, on breast cancer control and alcohol and tobacco control.

Collaboration with other agencies on producing tools and guidelines, while time consuming, was particularly successful as it attracted more support for the final product. However, a number of challenges were faced, including limited technical capacity in many countries and country offices, as well as limited staff and financial resources, to follow up in countries. To address these issues efforts were made to train WHO staff, as well as country experts, in the use of the tools.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
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.	Guidelines on economic burden completed; in progress: a United Nations costing and impact tool and revision of the national health accounts system	Tools and frameworks modified, updated and disseminated as necessary	Tools and frameworks modified, updated and disseminated as necessary ²⁰
10.11.2 Number of Member States provided with technical support for using WHO tools to track and evaluate the adequacy and use of funds, to estimate future financial needs, to manage and monitor available funds, or to track the impact of financing policy on households.	34	50	70

10.12

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

Partly Achieved

There was increasing demand from Member States for capacity building exercises linked to the various aspects of health financing: assessing financial catastrophe and impoverishment; tracking resources and linking to results, including disease-specific resource tracking; costing plans and strategies; and assessing financing options for moving closer to universal coverage. Most of the targets for WHO's country support, capacity building and development and dissemination of information products were achieved, including annual updates of country health expenditures in the Global Health Expenditure database for which WHO supported 67 countries as at the end of 2011.

WHO continued to support countries to track health expenditures and to improve their reporting. Estimates of key health expenditure indicators were revised and reported for all Member States each year after consultation with countries. Training courses on health financing policy were developed, for example, by the Barcelona office in the European Region, which was attended by participants from 30 countries. A capacity-building workshop was held on strategic purchasing for social protection for nine countries in the South-East Asia Region. A total of 16 countries in the African Region were supported to collect, analyse and report data to mark the tenth anniversary of the Abuja Declaration. A total of 15 countries in the Western Pacific Region were provided with capacity building on health financing policies and four countries in the Region of the Americas received support to evaluate equity and social health protection. Training on SHA2011, the One-Health tool, and on child, maternal and reproductive health resource tracking was provided to participants from five, 22 and 39 countries, respectively, across all regions.

At global level, WHO participated in the Providing for Health (P4H) and Harmonization for Health in Africa partnerships, as well as in formal partnerships to develop OneHealth, SHA2011 and institutionalize expenditure tracking. It engaged with regional agencies, such as the African Union, and the

United Nations Economic Commissions for Africa and Latin America and the Caribbean on questions of health financing, and with bilateral and multilateral partners on sector-wide approaches (Swaps).

The WHO Global Health Expenditure Database was revised to be more user-friendly and interactive,²¹ while country health financing profiles were made available online.²² An atlas on health financing in Africa containing data on health expenditures was prepared for 46 countries in the African Region and posted on the WHO web site. A new course dedicated to health financing, the Barcelona Course in Health Financing (European Region) was held in May 2011 with the theme of universal coverage and was attended by 200 participants from 30 countries. The Regional Office for the Eastern Mediterranean organized an inter-regional meeting on efficiency in health systems to promote universal coverage, involving 93 participants from 27 Member States and several international partners. Health financing experts in WHO provided estimates of the global price tag for control and prevention of noncommunicable diseases in low- and middle-income countries and advised on methods to cost family planning interventions.

There was great demand from Member States for technical support and capacity building. Where health policy or health economics units exist in Member States, capacities to evaluate and review health financing strategies are stronger. However, this Organization-wide expected result was partly achieved as the African and South-East Asia Regions reported their contributions as partly achieved even though the global targets were reached. The main challenge was a shortage of data on key components of universal coverage, especially on groups that are unable to use services for financial reasons. The Secretariat also faced a reduction in its capacity. The Organization needs to move away from intense, one-on-one capacity building to shorter less intense support activities involving more participants.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
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.	Participation in 6 partnerships. Support for long-term financing options to 27 countries	WHO participation in 4 partnerships	WHO participation in 5 partnerships and support on long-term financing options provided to 46 countries
10.12.2 Number of Member States provided with support to build capacity in the formulation of health financing policies and strategies and the interpretation of financial data, or with key information on health expenditures, financing, efficiency and equity to guide the process.	57 countries supported for health expenditures; annual updates of reports to all Member States	Annual updates of health expenditures for Member States, together with capacity building exercises in 60 countries	Annual updates of health expenditures produced after consultation with Member States. Capacity building in one or more of the WHO tools provided to 67 countries

10.13

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

Partly Achieved

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

Major achievements during the biennium included: improved surgical safety practices in over 4100 hospitals in countries in all six WHO regions stimulated by the WHO surgical safety checklist; improved hand hygiene practices in countries as a result of engagement with Global Hand Hygiene Day on 5 May with the theme of Save Lives Clean Your Hands; popularity of patient safety research projects in the Region of the Americas and the Eastern Mediterranean Region; improved patient safety practices in African hospitals in 14 countries; and improved medication safety and safe surgery practices in hospitals in nine countries taking part in the WHO “High 5s” hospital improvement project. Other achievements included: more research activities in institutions supported by small research grants for patient safety, with several new projects self-initiated and supported; and the engagement of eight countries in the Western Pacific Region in integrating the first global curriculum guide for patient safety for health professionals. The other regions will follow suit in 2012–2013.

In the African Region, the engagement of patients was promoted through the first workshop on patients for patient safety, which attracted participants from eight countries. A workshop on “safe surgery saves lives” was attended by senior clinical leaders from 15 countries. In the Eastern Mediterranean Region, the Patient Safety Friendly Hospital Initiative developed a patient safety improvement toolkit providing guidance on infection prevention and control, setting up a patient safety programme, reporting, implementation of safe surgery, safe clinical practices, blood transfusion, injection safety, and safe environment. In the European Region, specific patient safety initiatives were launched in eight countries on: piloting national safety standards; building capacity through hospital twinning; promoting safe blood management; piloting the WHO patient safety curriculum guide; training in health-care associated infection prevention; and implementation of the WHO safe surgery checklist. A multi-country set of activities on reporting of adverse events was initiated in the Czech Republic, Slovakia and Slovenia. In the South-East Asia Region, national campaigns on infection control and implementation of research tools for data-poor set-

tings were high priorities. Moreover, national patient safety and quality committees were established in five countries and the WHO patient safety curriculum guide was implemented in four countries. In addition, educational materials were prepared and emphasis placed on patient and provider rights and responsibilities within the ambit of “patients for patient safety”, through collaboration between patients and general practitioners.

The Secretariat carried out advocacy, provided leadership and technical support and developed global standards and tools. It also provided specific technical assistance to the regions, for example, for organizing the first workshop on “patients for patient safety” attended by participants from eight countries in the African Region. In the Eastern Mediterranean region, a patient safety improvement toolkit linked to the Patient Safety Friendly Hospital Initiative was launched. It provides guidance on infection prevention and control, setting up a patient safety programme, reporting, implementation of safe surgery, safe clinical practices, blood transfusion, injection safety and safe environment.

The global standards developed, included WHO standards that exceed International Organization for Standards (ISO) standards for Pulse Oximetry. Pulse Oximetry training materials comprising a manual, tutorials and a video in the six official languages were produced. A patient safety curriculum guide for medical students and a multi-professional curriculum guide on patient safety were launched, and information on priority areas for research on patient safety, as well as on core competencies, and a draft safe child-birth checklist were disseminated.

WHO developed numerous global tools on safe surgery, hand hygiene and patient safety, including: the safe surgery checklist; various tools promoting hand hygiene in support of the hand hygiene campaign, as well as a Webinar Infection Control Series, and videos postcards and posters on hand hygiene/clean care; the African partnership for patient safety plan template; the African partnership for patient safety evaluation framework; an introductory online course on patient safety research in English and French; an introductory series on classic patient safety research methods; a methodological guide on research in data poor hospitals, accompanied by tutorial and training materials; a compendium of policy options for combating antimicrobial resistance; and a WHO publication on the evolving threat of antimicrobial resistance.

The launch of the WHO Multi-professional Patient Safety Curriculum Guide by the Regional Office for the Western Pacific in October 2011 brought together health professionals and patient safety advocates from seven countries. It is currently being piloted in Malaysia for pharmacist training and in the Philippines across all five professions. In addition, the WHO safe surgery checklist is being implemented in hospitals across the Region.

The team working on this Organization-wide expected result in headquarters and in the Regional offices was able to elicit strong country engagement and technical leadership in the area of patient safety, mainly as a result of close collaboration between WHO regional offices and ministries of health through programmes and country partnerships to promote patient safety, such as the High 5s project and the African Partnerships for Patient Safety. However, running a major global programme requires significant engagement by external partners, especially in an era of limited resources. This has meant that the WHO Patient Safety Programme in both headquarters and the regions has sometimes had to balance the priorities of different partners. In addition, a greater effort is needed to ensure that quality of care and patient safety are integrated in all health programmes and are not seen as separate components in the health system. A first step has been taken with the organization of a regional meeting with the participation of

representatives of health ministries and key actors responsible for different programmes in order to identify mechanisms for further integrating quality of care across the health system.

In general, the team supporting Organization-wide expected result 10.13 has attempted to increase communication with regions through the appointment of a regional office facilitator within the headquarters team and establishment of annual "work planning" with the regional offices. In order to systematize priority setting, WHO has engaged in a strategic planning process on patient safety and has produced a strategic plan for the Patient Safety Programme for release in 2011. To increase awareness of patient safety as a WHO priority, the Director-General nominated Sir Liam Donaldson as WHO Envoy for Patient Safety. Moreover, some regional offices emphasized the success of making patient safety a health systems strengthening issue in order to obtain political and technical support for advancing patient safety at country level.

Despite all the achievements, the Organization-wide expected result was reported to have been partly achieved as the African and South-East Asia Regions reported their contributions as partly achieved. Further progress on the expected result was impeded by the introduction of new concepts of quality in health-care systems, so that quality measures, improvement tools and the global burden have not yet been estimated.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
10.13.1 Key tools, norms and standards to guide policy development, measurement and implementation disseminated and their use supported.	1 global safety standards and 10 major supporting tools	2 global safety standards and 20 major supporting tools	6 standards and 15 tools
10.13.2 Number of Member States participating in global patient safety challenges and other global safety initiatives, including research and measurement.	30	45	69

SUMMARY OF FINANCIAL IMPLEMENTATION

The total approved budget for the strategic objective was US\$ 474 million, of which US\$ 420 million (88%) were 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.

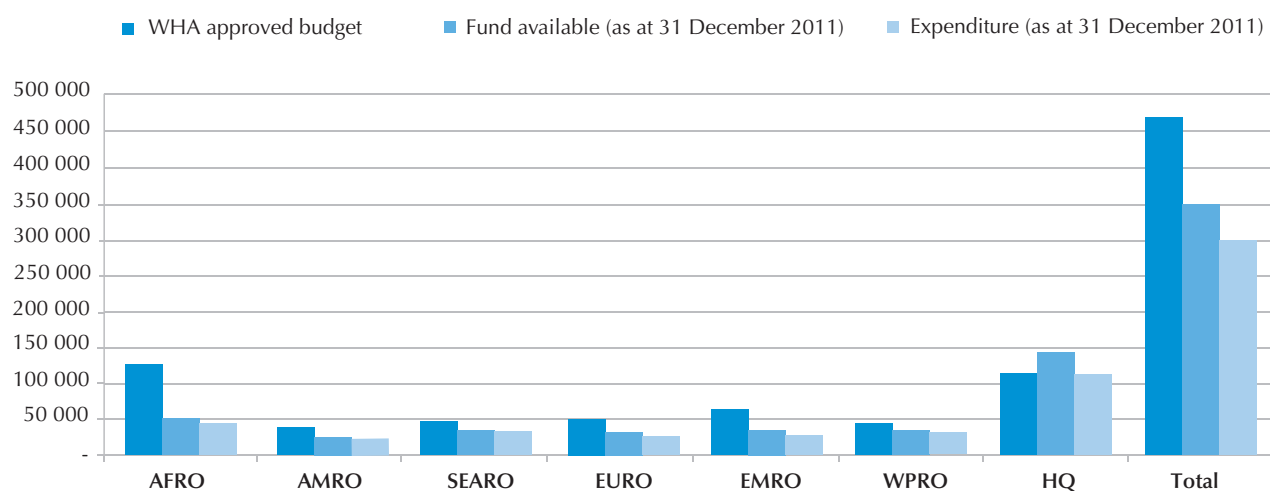
At the end of 2011, funding of US\$ 348 million was made available through assessed and voluntary contributions. Of this amount, US\$ 286 million were for WHO Base programmes (68% of the approved budget for Base programmes and US\$ 62 million for Special programmes and collaborative arrangements (115% of the approved budget for this budget segment). Of the available funds, US\$ 298 million (63% of the approved budget and 86% of available funds) were implemented by the end of 2011. Implementation for Base programmes was US\$

250 million (87% of available funds for Base programmes) and for Special programmes and collaborative arrangements US\$ 48 million (78% of funds available for this budget segment).

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 a few departments frequently tied to specific activities for which specified funding was available. Funding from the approved budgets for regional offices has also been uneven. In actual fact, although the budgets were «aspirational» and therefore funds available against the approved budget in Base programmes was less than 60% in four of the seven major offices, implementation against funds available was fairly high: 88% for the Regional Office for Africa, 99% for the Regional Office for the Americas, 90% for the Regional Office for Europe and 89% for the Regional Office for South-East Asia.

All Segments

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	124 035	32 224	44 321	50 528	60 968	42 441	119 687		474 204
Funds Available									
AC	18 933	16 003	21 234	7 181	18 209	15 910	27 968		125 438
VC	31 208	3 178	9 356	27 301	15 772	20 102	115 778	-	222 694
Total	50 140	19 181	30 590	34 482	33 981	36 011	143 746	-	348 132
Funds Available as % of approved budget	40%	60%	69%	68%	56%	85%	120%		73%
Expenditure	44 070	18 925	27 222	30 995	26 653	33 321	117 040		298 227
Expenditure as % of approved budget	36%	59%	61%	61%	44%	79%	98%		63%
Expenditure as % of funds available	88%	99%	89%	90%	78%	93%	81%		86%



Base programmes

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	123 022	32 224	42 007	40 728	59 568	41 441	81 297		420 287
Funds Available									
AC	18 933	16 003	21 234	7 181	18 209	15 910	27 968		125 438
VC	30 018	2 912	7 962	16 503	15 497	19 247	68 768	-	160 907
Total	48 951	18 915	29 196	23 684	33 706	35 156	96 736	-	286 345
Funds Available as % of approved budget	40%	59%	70%	58%	57%	85%	119%		68%
Expenditure	43 115	18 699	26 641	21 171	26 360	32 511	81 410		249 907
Expenditure as % of approved budget	35%	58%	63%	52%	44%	78%	100%		59%
Expenditure as % of funds available	88%	99%	91%	89%	78%	92%	84%		87%

Special programmes and collaborative arrangements

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	1 013	-	2 314	9 800	1 400	1 000	38 390		53 917
Funds Available									
AC	-	-	-	-	-	-	-		-
VC	1 189	266	1 395	10 797	275	855	47 010	-	61 787
Total	1 189	266	1 395	10 797	275	855	47 010	-	61 787
Funds Available as % of approved budget	117%	-	60%	110%	20%	85%	122%		115%
Expenditure	955	226	581	9 824	220	810	35 630		48 247
Expenditure as % of approved budget	94%	-	25%	100%	16%	81%	93%		89%
Expenditure as % of funds available	80%	85%	42%	91%	80%	95%	76%		78%

REFERENCES

- 1 Albania, Armenia, Czech Republic, Kyrgyzstan, Latvia, Republic of Moldova, The Former Yugoslav Rep of Macedonia, Romania, Slovenia, Tajikistan and Uzbekistan.
- 2 Ethiopia, Ghana, Kyrgyzstan, Malawi, Nepal, Rwanda, Togo, Uganda, Viet Nam and Zambia.
- 3 Argentina, Brazil, Colombia, Cuba, Belize, Dominican Republic, Ecuador, Honduras, Nicaragua, Peru, Trinidad and Tobago, and the French Departments in the Americas.
- 4 Albania, Armenia, Estonia, Georgia, Portugal, and Turkey.
- 5 Liberia, Moldova, Sierra Leone, Sudan, Togo, Tunisia and Viet Nam.
- 6 Benin, Niger, Nigeria, Sierra Leone, Uganda.
- 7 Benin, Cambodia, Democratic Republic of Congo, Nepal, Senegal and Sierra Leone.
- 8 Ethiopia, Ghana, Kyrgyzstan, Malawi, Nepal, Rwanda, Togo, Uganda, Viet Nam, and Zambia.
- 9 Regional strategies established in the African Region, the Region of the Americas, the Eastern Mediterranean and South-East Asia Regions. The Western Pacific and South-East Asia Regions have established an Asia Pacific Observatory on Health Systems and Policies, which is recognized as a leadership mechanism for evidence-based policy development.
- 10 <http://www.health-policy-systems.com/content/8/1/25>
- 11 <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001000>
- 12 <http://www.health-policy-systems.com/content/8/1/36>
- 13 <http://apps.who.int/tdr/svc/publications/training-guideline-publications/operational-guidelines-ethics-biomedical-research>.
- 14 Indicator 10.6.2 is not a precise measure of country support for research and development and therefore this indicator will be discontinued in 2012–2013. While it can be self-reported by countries WHO is unable, with its current resources, to verify these figures.
- 15 mHealth refers to the use of mobile and wireless technologies to support the achievement of health objectives.
- 16 Indicator 10.7.1 is being discontinued due to feedback from Member States stating that it was ambiguous and not easily measured. This indicator will be replaced in 2012–2013.
- 17 Afghanistan, Pakistan, Sudan and Yemen.
- 18 Resolution WHA63/16
- 19 Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Mali, Mozambique, Republic of Congo, Rwanda, Senegal and South Africa.
- 20 OneHealth cost and impact tool, SHA2011, RMNCH-GET tool, EPIC economic impact tool, macroeconomics and health tool and guidelines on Medium-Term Expenditure Frameworks and Public Expenditure and Financial Management.
- 21 <http://www.who.int/nha/country>

22 http://apps.who.int/nha/database/StandardReport.aspx?ID=REPORT_COUNTRY_PROFILE

DETAILS OF INDICATOR ACHIEVEMENT

10.1.1 African Region: Angola, Benin, Burkina Faso, Burundi, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Guinea Bissau, Liberia, Malawi, Mali, Mauritania, Mauritius, Namibia, Niger, Rwanda, Sao Tome and Principe, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia. **Region of the Americas:** Belize, Brazil, Canada, Chile, El Salvador, Mexico, United States of America. **South-East Asia Region:** Bangladesh, Democratic People's Republic of Korea, India, Maldives, Myanmar, Nepal, Sri Lanka, Thailand. **Western Pacific Region:** Australia, Brunei Darussalam, Cambodia, China (People's Republic of), Cook Islands, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, New Zealand, Niue, Palau (Republic of), Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam and, in addition, American Samoa.

10.2.1 African Region: Algeria, Benin, Botswana, Burkina Faso, Burundi, Cap Verde, Central African Republic, Chad, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gabon, Ghana, Guinea, Guinea Bissau, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Bahamas, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Ecuador, Panama, Peru, Trinidad and Tobago, Uruguay. **Eastern Mediterranean Region:** Afghanistan, Bahrain, Iran (Islamic Republic of), Iraq, Libya, Morocco, Oman, Pakistan, Saudi Arabia, Sudan, Syrian Arab Republic, Yemen. **South-East Asia Region:** Bhutan, India, Sri Lanka, Thailand. **Western Pacific Region:** Cambodia, China (People's Republic of), Fiji, Kiribati, Lao People's Democratic Republic, Malaysia, Nauru, Papua New Guinea, Philippines, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

10.2.2 African Region: Algeria, Benin, Burkina Faso, Burundi, Cap Verde, Central African Republic, Chad, Comoros, Congo, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Ghana, Lesotho, Liberia, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Eastern Mediterranean Region:** Egypt, Iraq, Jordan, Lebanon, Morocco, Oman, Saudi Arabia, Sudan. **European Region:** Armenia, Belgium, Estonia, Finland, France, Georgia, Hungary, Italy, Kyrgyzstan, Netherlands, Norway, Portugal, Republic of Moldova, Tajikistan, Turkey, United Kingdom of Great Britain and Northern Ireland. **South-East Asia Region:** Bhutan, Sri Lanka, Thailand. **Western Pacific Region:** Cambodia, China (People's Republic of), Fiji, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Philippines, Solomon Islands, Viet Nam.

10.3.1 African Region: Benin, Burkina Faso, Burundi, Central African Republic, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gabon, Ghana, Guinea Bissau, Malawi, Mali, Mauritania, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Guatemala, Panama. **Eastern Mediterranean Region:** Afghanistan, Djibouti, Egypt, Jordan, Pakistan, Somalia, Sudan, Yemen. **European Region:** Kazakhstan, Kyrgyzstan, Republic of Moldova, Tajikistan. **South-East Asia Region:** Bangladesh, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Cambodia, Lao People's Democratic Republic, Papua New Guinea, Viet Nam.

10.4.1 African Region: Cap Verde, Mauritius, Senegal, Seychelles, South Africa. **Region of the Americas:** Antigua and Barbuda, Argentina, Belize, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Uruguay, Venezuela (Bolivarian Republic of). **Eastern**

Mediterranean Region: Egypt, Tunisia. **European Region:** Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Montenegro, Republic of Moldova, Romania, Russian Federation, Tajikistan, The former Yugoslav Republic of Macedonia, Turkmenistan, Ukraine, Uzbekistan. **South-East Asia Region:** India, Maldives, Sri Lanka, Thailand. **Western Pacific Region:** Cook Islands, Fiji, Kiribati, Malaysia, Marshall Islands, Mongolia, Niue, Palau (Republic of), Philippines, Tonga, Tuvalu.

10.5.1 African Region: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States of America, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen. **European Region:** Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Brunei Darussalam, Cambodia, China (People's Republic of), Cook Islands, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Mongolia, Nauru, New Zealand, Niue, Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

10.5.2 African Region: Botswana, Burkina Faso, Ethiopia, Ghana, Kenya, Mozambique, Rwanda, Senegal, Sierra Leone, South Africa, Uganda, United Republic of Tanzania, Zambia. **Region of the Americas:** Brazil, Haiti, Honduras, Paraguay. **Eastern Mediterranean Region:** Afghanistan, Iraq, Libya, Oman, Qatar, Saudi Arabia. **European Region:** Armenia, Azerbaijan, Kyrgyzstan, Russian Federation, Turkey. **South-East Asia Region:** Bangladesh, India, Indonesia, Nepal. **Western Pacific Region:** Cambodia, China (People's Republic of), Philippines, Viet Nam.

10.6.1 African Region: Benin, Burkina Faso, Chad, Guinea Bissau, Malawi, Mali, Mauritania, Mauritius, Mozambique, Nigeria, Senegal, South Africa, Swaziland, Togo, United Republic of Tanzania, Zimbabwe. **Region of the Americas:** Argentina, Bolivia (Plurinational State of), Brazil, Costa Rica, Cuba, Ecuador, El Salvador, Mexico, Panama, Paraguay, Peru. **Eastern Mediterranean Region:** Jordan, Syrian Arab Republic, Tunisia, Yemen. **European Region:** Albania, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Romania, Russian Federation, Serbia, The former Yugoslav Republic of Macedonia, Turkey. **South-East Asia Region:** Bangladesh, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Fiji, Mongolia, Papua New Guinea, Philippines.

10.7.2 African Region: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru,

Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States of America, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Lebanon, Morocco, Oman, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen. **European Region:** Albania, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Hungary, Iceland, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Montenegro, Norway, Poland, Republic of Moldova, Romania, Russian Federation, Serbia, Slovakia, Slovenia, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Australia, Cambodia, China (People's Republic of), Fiji, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Papua New Guinea, Philippines, Samoa, Singapore, Solomon Islands, Tonga, Viet Nam.

10.7.3 African Region: Benin, Botswana, Burkina Faso, Burundi, Cap Verde, Comoros, Congo, Ghana, Madagascar, Mali, Mauritius, Niger, Nigeria, Senegal, Seychelles, Zimbabwe. **Region of the Americas:** Belize, Canada, Panama, Paraguay, Peru, United States of America. **Eastern Mediterranean Region:** Kuwait, Libya, Morocco, Oman, Pakistan, Qatar, Sudan, Syrian Arab Republic. **European Region:** Albania, Austria, Azerbaijan, Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Kyrgyzstan, Latvia, Lithuania, Malta, Montenegro, Norway, Poland, Portugal, Republic of Moldova, Slovakia, Slovenia, Spain, Switzerland, Turkey, Turkmenistan, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, India, Indonesia, Nepal, Thailand. **Western Pacific Region:** China (People's Republic of), Fiji, Malaysia, New Zealand, Republic of Korea, Singapore, Viet Nam.

10.8.1 African Region: Benin, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gambia, Ghana, Guinea Bissau, Kenya, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Rwanda, Senegal, Swaziland, Togo, Uganda, Zambia, Zimbabwe. **Region of the Americas:** Brazil, Canada, Chile, Colombia, Cuba, Mexico, Trinidad and Tobago, United States of America. **Eastern Mediterranean Region:** Afghanistan, Bahrain, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia, Yemen. **European Region:** Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, India, Myanmar. **Western Pacific Region:** Australia, Brunei Darussalam, Fiji, Japan, Kiribati, Marshall Islands, Micronesia (Federated States of), Nauru, New Zealand, Niue, Palau (Republic of), Republic of Korea, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

10.8.2 African Region: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guyana, Haiti, Jamaica, Nicaragua, Paraguay, Peru, Trinidad and Tobago, Uruguay, Venezuela (Bolivarian Republic of). **Eastern Mediterranean Region:** Afghanistan, Bahrain, Djibouti, Iran (Islamic Republic of), Iraq, Jordan, Morocco, Oman, Saudi Arabia, Sudan, Syrian Arab Republic, Yemen. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste.

10.9.1 African Region: Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the

Congo, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Uganda, United Republic of Tanzania, Zambia. **Region of the Americas:** El Salvador, Nicaragua, Peru. **Eastern Mediterranean Region:** Afghanistan, Iraq, Pakistan. **South-East Asia Region:** India, Indonesia, Myanmar, Nepal. **Western Pacific Region:** Cambodia, Lao People's Democratic Republic.

10.9.2 African Region: Burundi, Central African Republic, Congo, Democratic Republic of the Congo, Eritrea, Gambia, Ghana, Guinea, Madagascar, Malawi, Mali, Mozambique, Niger, Nigeria, Uganda, United Republic of Tanzania, Zambia. **Eastern Mediterranean Region:** Afghanistan, Djibouti, Somalia. **South-East Asia Region:** Bangladesh, Bhutan. **Western Pacific Region:** Cambodia, Lao People's Democratic Republic.

10.10.1 African Region: Benin, Botswana, Burkina Faso, Chad, Congo, Côte d'Ivoire, Guinea, Lesotho, Madagascar, Mali, Mauritania, Niger, Rwanda, Senegal, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania. **Region of the Americas:** Bolivia (Plurinational State of), Chile, Peru. **Eastern Mediterranean Region:** Bahrain, Iran (Islamic Republic of), Iraq, Oman, Sudan, Syrian Arab Republic. **European Region:** Albania, Andorra, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Estonia, France, Greece, Hungary, Ireland, Kazakhstan, Kyrgyzstan, Latvia, Montenegro, Poland, Republic of Moldova, Romania, Russian Federation, Serbia, Slovenia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Maldives, Myanmar, Nepal, Sri Lanka. **Western Pacific Region:** Cambodia, China (People's Republic of), Fiji, Kiribati, Lao People's Democratic Republic, Malaysia, Micronesia (Federated States of), Mongolia, Palau (Republic of), Papua New Guinea, Philippines, Samoa, Tonga, Vanuatu, Viet Nam.

10.11.2 African Region: Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gabon, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Brazil, Canada, Chile, Colombia, Ecuador, Mexico, Paraguay, Peru, United States of America. **Eastern Mediterranean Region:** Bahrain, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Oman, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, United Arab Emirates. **European Region:** Azerbaijan, Belarus, Estonia, Georgia, Kyrgyzstan, Montenegro, Republic of Moldova, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Uzbekistan. **South-East Asia Region:** Myanmar. **Western Pacific Region:** China (People's Republic of), Fiji, Micronesia (Federated States of), Mongolia, Samoa, Tonga, Vanuatu, Viet Nam.

10.12.2 African Region: Benin, Burkina Faso, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Gabon, Guinea, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Belize, Chile, Dominican Republic, Ecuador, Guatemala, Peru, Saint Lucia. **Eastern Mediterranean Region:** Afghanistan, Iran (Islamic Republic of), Iraq, Libya, Oman, Pakistan, Qatar, Sudan, Yemen. **European Region:** Estonia, Georgia, Republic of Moldova. **South-East Asia Region:** Maldives. **Western Pacific Region:** China (People's Republic of), Fiji, Kiribati, Lao People's Democratic Republic, Malaysia, Micronesia (Federated States of), Mongolia, Nauru, Palau (Republic of), Papua New Guinea, Philippines, Samoa, Solomon Islands, Tonga, Vanuatu, Viet Nam.

10.13.1 African Region: tools and standards produced during this reporting period can be made available upon request.

10.13.2 African Region: Burundi, Cameroon, Ethiopia, Ghana, Kenya, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, South Africa, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Brazil, Canada, Chile, Colombia, Costa Rica, Ecuador, Honduras, Mexico, Peru, Trinidad and Tobago, United States of America. **Eastern Mediterranean Region:** Bahrain, Egypt, Iran (Islamic Republic of), Jordan, Kuwait, Lebanon, Oman, Pakistan, Qatar, Saudi Arabia, Sudan, Tunisia, Yemen. **European Region:** Belgium, France, Germany, Israel, Italy, Netherlands, Poland, Portugal, Republic of Moldova, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Kingdom of Great Britain

and Northern Ireland. **South-East Asia Region:** Bangladesh, India, Myanmar, Nepal, Thailand. **Western Pacific Region:** Australia, China (People's Republic of), Malaysia, Mongolia, New Zealand, Philippines, Singapore, Viet Nam.

SO 1 1

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



ASSESSMENT OF THE ORGANIZATION-WIDE EXPECTED RESULTS

Of the three Organization-wide expected results for this strategic-objective, two were «fully achieved» and one «partly achieved».

Overview

About half the total health expenditure of Member States goes on medical products, yet in low and middle income countries, in particular the most vulnerable die from lack of access to such commodities because of high prices, inadequate financing and social protection and inefficient supply management. Weak regulatory systems in countries have increased the likelihood of sub-standard medical products, and, when combined with widespread irrational use of medicines, contribute to the spread of infections and growing risk of antimicrobial resistance.

WHO's efforts to ensure improved access to, and the quality and use of, medical products and technologies are guided by the Millennium Development Goals 4, 5, 6 and target 8E (access to affordable essential medicines); the third WHO Medicines Strategy 2008–2013; the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property; the Global immunization vision and strategy; and several resolutions. A number of regional strategies were also developed.

WHO aims to improve access to, and the quality of, assured medical products by supporting countries in the implementation of effective policies, which include promotion of

sustainable financing, efficient supply management and rational use. WHO also supports the strengthening of Member States regulatory and enforcement systems to counteract the likelihood of sub-standard and counterfeit medical products. In addition, WHO works to build capacity, technical guidance and commitment to addressing the growing risk of antimicrobial resistance.

WHO works closely with health and other ministries in countries to support the development and implementation of national medicines, vaccines and health products policies. WHO promotes policy dialogue in countries that involves national stakeholders such as academic, research and scientific institutions, professional associations, the private sector and national civil society organizations. There is a trend towards strengthening collaboration with regional economic communities, particularly in the African Region, the Region of the Americas and the European Region. WHO collaborated with international agencies such as, the GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the International Information Network on New and Emerging Health Technologies (EuroScan International Network), OECD, UNITAID and the World Bank.

11.1

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

Fully Achieved

Member States showed strong political commitment to developing national medicines policies and WHO provided technical assistance to 118 countries, surpassing the original target of 90. Some countries were focusing on implementation of reforms for equitable access to quality assured essential medicines. For example, China, Colombia, Malaysia, Philippines and Viet Nam were embarking on health-care reforms towards providing equitable access to quality essential medicines. Other countries were focusing on implementing programmes to improve transparency and good governance in pharmaceutical systems (31 countries). WHO supported 15 Member States of the European Region in policy formulation and implementation, and collaborates with all European Union countries on best practice approaches and information exchanges. Over 1000 publications on national medicines policies, including more than 200 country surveys, can now be found on the WHO web site, and a system is available for uploading key medicines data on the Global Health Observatory.

Technical advice, guidance material and support were provided to 68 Member States to design or strengthen comprehensive national procurement or supply systems. Six countries received direct support in the area of procurement and supply management; procurement and supply systems were assessed and support was provided to expand access to HIV/AIDS and tuberculosis medicines in collaboration with projects sponsored by the Global Fund to Fight AIDS, Tuberculosis and Malaria. For example, Haiti was supported through a central medical store managed by WHO, and the Democratic Republic of Congo received help to strengthen the central medical store in that country. Support was provided to the Caribbean for improving pooled procurement of quality assured medicines. Pharmaceutical sector assessments, mapping of procurement and supply, and medicines price surveys contributed to improving knowledge, policies and capacity in the pharmaceutical sector in countries, as well as to enhancing transparency, as more information is disclosed in the public domain.

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

Additionally, WHO collaborated with the Global Fund to develop harmonized pharmaceutical sector country profiles, which provide important information towards strengthening core regulatory functions for procurement and supply of health commodities. Profiles were completed in 120 countries.

The first WHO Global Forum on Medical Devices, held in 2010, was attended by participants from 107 countries. It served to put medical devices on the global health agenda and advance collaborative efforts to improve access to appropriate medical devices globally. A total of 161 countries responded to the Global Survey on Medical Devices, triggering the development of a WHO Medical Devices technical series. An increasing number of Member States are now committed to developing and implementing comprehensive national laboratory policies, plans and associated quality standards. There is increased awareness of the WHO procurement list for diagnostics, and the number of organizations and countries that procure diagnostics on the WHO list increased to 42, ensuring procurement of quality diagnostics at a reduced cost. Additionally, numerous countries developed or revised policies and plans for blood safety and there were significant gains in increasing voluntary donations and in the quality and screening of blood and blood products across regions.

The guiding principles laid out in the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property are gradually becoming an integral part of national pharmaceutical, research, and innovation policies in countries. Member States continued to exercise leadership in discussions worldwide on the Global Strategy, and in the Region of the Americas, in particular, subregional integration mechanisms, such as the Union of South American Nations, the Andean Health Agency and MERCOSUR (and Associated States) adopted elements of the Global Strategy.

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

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
11.1.1 Number of Member States receiving support to formulate and implement official national policies on access, quality and use of essential medical products or technologies.	88	90	118
11.1.2 Number of Member States receiving support to design or strengthen comprehensive national procurement or supply systems.	48	40	68
11.1.3 Number of Member States receiving support to formulate and/or implement national strategies and regulatory mechanisms for blood and blood products or infection control.	26	25	68
11.1.4 Publication of a biennial global report on medicine prices, availability and affordability, based on all available regional and national reports.	2 United Nations reports published in 2008 and 2009	Report published	1 report published (2011)

11.2

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

Fully Achieved

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

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

A number of countries worked towards completing assessments of core regulatory functions, among which, Argentina, Brazil, Colombia and Cuba were designated as national regulatory authorities for regional reference. In addition, institutional development programmes to strengthen the capacity of other national regulatory authorities in the Region of the Americas were under development and will be supported by the national reference regulatory authorities.

The last biennium saw growing activity and commitment among Member States to strengthen their regulatory capacity in order to ensure medicine quality and to combat substandard/spurious/falsely-labelled/falsified/counterfeit medical products. The Working Group of Member States on substandard/spurious/falsely-labelled/falsified/counterfeit medical products met twice in 2011, with more than 90 Member States participating. The Working Group examined the following matters from a public health perspective: (a) WHO's role in measures to ensure the availability of quality, safe, efficacious and affordable medical products; (b) WHO's role in the prevention and control of medical products of compromised quality, safety and efficacy, such as substandard/spurious/falsely-labelled/falsified/counterfeit medical products from a public health perspective, excluding trade and intellectual property considerations; and (c) WHO's relationship with the International Medical Products Anti-Counterfeiting Taskforce.

Additionally WHO took steps to draw the attention of country health authorities and policy makers to deaths and disabilities caused by snake bites with the launch of guidelines on the production, regulation and control of snake antivenoms and a database and image library identifying the most venomous snakes and their antivenoms.

Over 30 countries received technical support to improve their medicines adverse reaction reporting. Benin became a full member of the WHO Pharmacovigilance Programme and another seven countries were supported to become associate members. A new WHO Collaborating Centre on Drug Safety and Pharmacovigilance was established in Morocco. The most significant achievement in the African Region has been the signal on dystonia with Artesunate-Amodiaquine combination, derived exclusively of safety data from African countries. A Pharmacovigilance toolkit has been developed by WHO for use by countries and is hosted in WHO Collaborating Centre in Ghana.

A growing number of countries across all regions participated in regional external quality assurance schemes for blood and blood products. The Mauritius Blood Transfusion Service was certified by the International Organization for Standardization. The National Institute of Haematology and Blood Transfusion in Viet Nam has an external quality assurance programme on HIV and hepatitis testing. In Cambodia, the Prime Minister called for an increase in voluntary, non-remunerated blood donation. Burkina Faso, Mali, Niger and Senegal now have sufficient capacity for managing and maintaining the blood cold chain. The Lao People's Democratic Republic, Philippines and South Africa were improving their blood transfusion services and developing national blood policies, while Mauritius, Namibia and Tanzania were developing national policies on human organ transplantation.

In the area of immunization, vaccines and biologicals, all 12 countries in the Global Network for Post-marketing Surveillance of Prequalified Vaccines received financial and technical support to strengthen their capacity to monitor the safety of vaccines used in their immunization programmes and thereby ensure delivery of safe vaccines. In the African Region, 25 countries were implementing a "fast track" registration procedure for the newly licensed and prequalified meningitis A conjugate vaccine. Regulatory authorities in 33 out of 44 vaccine-producing countries were assessed as functional, and oversight

of vaccines in China, Egypt and Iran led to a 20% increase in the global availability of quality assured vaccine doses.

Numerous national regulatory authorities across regions were supported to prepare development plans in order to increase access to, and utilization of, new and underutilized vaccines. The regulatory agency in Senegal was supported to maintain its yellow fever vaccine prequalification status and Thailand began to produce measles vaccine prequalified for United Nations procurement. India strengthened its market authorization procedure through a parallel review of meningococcal vaccine, and Indonesia, another major source of WHO prequalified vaccines, was in the process of implementing a

quality management system. Sudan was introducing new vaccines into their expanded programme on immunization and training was provided on safety surveillance. Vaccine production capacity was also improved in Cuba, Brazil, Iran and Saudi Arabia, which is a new vaccine producer.

This Organization-wide expected result was fully achieved, and, in some instances, the targets were exceeded, possibly because they were realistic and because countries accorded high priority to medicines policies within their health and development agenda and, therefore, surpassed expectations for investment in medicines policies and requests for support from WHO.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
11.2.1 Number of new or updated global quality standards, reference preparations, guidelines and tools for improving the provision, management, use, quality, or effective regulation of medical products and technologies.	More than 30 additional	15 additional	Additional 61
11.2.2 Number of assigned International Nonproprietary Names for medical products.	8199	8500	8552
11.2.3 Number of priority medicines, vaccines, diagnostic tools and items of equipment that are prequalified for United Nations procurement.	239 medicines and 98 vaccines	300	320 (274 medicines 35 APIs 11 diagnostic tools 134 vaccines)
11.2.4 Number of Member States for which the functionality of the national regulatory authorities has been assessed or supported.	70	75	102

11.3

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

Partly Achieved

The Secretariat revised and published the 17th WHO Model List of Essential Medicines and the 3rd Model List of Essential Medicines for Children. WHO supported countries to successfully update their essential medicines lists and standard treatment guidelines, for example, Central African Republic, Democratic Republic of Congo, Ethiopia, Mali and Rwanda. Rational use was also promoted through the establishment of drugs and therapeutics committees. By the end of the biennium, 94 Member States had updated their national lists based on the WHO Model List.

On World Health Day 2011, WHO introduced a six-point policy package to combat the spread of antimicrobial resistance. A WHO Working Group on Antimicrobial Resistance will elaborate an Organization-wide collaborative work plan for 2012–2013. The Third International Conference for Improving Use of Medicines, held in Turkey in 2011, was attended by nearly 600 participants from 86 countries, testifying to the growing interest in promoting rational use of medicines at national and regional level. A situational analysis with a particular focus on promoting rational use of medicines, as recommended by resolution SEA/RC64/R5, was undertaken in seven out of 11 countries in the South-East Asia Region, and technical support was provided to Member States of the Region for promoting rational use of medicines in 10 countries. PAHO supported development of a regional strategy on national plans for rational use of medicines, and provided technical assistance to countries and subregional economic blocs, such as the Central American Integration System and the Andean Health Body.

In the area of essential health technologies, the capacity of countries to manage health technologies, including needs assessments, procurement, donations, maintenance and inventories, increased. WHO is leading global efforts to bring medical devices to the attention of policy makers and led the development of a number of tools to support countries in ensuring improved access, quality and use of medical devices. A feasibility study on establishing sustainable and affordable national quality assurance programmes for diagnostics was piloted in Tanzania and Zimbabwe, and countries were provided with technical information and guidance on appropriate diagnostics, in particular for HIV diagnosis and for monitoring the effectiveness of treatment regimes. All regional offices supported countries in undertaking health technology assessments and in develop-

ing norms for procurement, inventory and maintenance systems and health technology management. In PAHO, a network of 12 countries was established to support evidence-based decisions on the use of health technologies and Member States requested the Regional Office for the Americas to prepare a policy document on health technology assessment and the incorporation of health technologies in health systems. The Regional Office for Europe collaborated with international experts and headquarters in the development of training modules.

Efforts were made to increase the number of countries providing information to the database of the WHO Collaborating Centre for International Drug Safety Monitoring through the development of electronic bridges between existing national systems and the global reference data base in order to improve the common system for reporting vaccine safety events and meet the need for a vaccine-specific data entry tool. Based on recommendations from the WHO Global Advisory Committee on Vaccine Safety, the Secretariat facilitated international support for enhanced safety surveillance during introduction of the meningococcal A conjugate vaccine. The Global Strategy to Build and Enhance Capacity for Vaccine Safety, the 'Global Vaccine Safety Blueprint', was adopted by the WHO Strategic Advisory Group of Experts on Immunization in 2011. It provides a set of options for ensuring that vaccines are used safely, and that the focus is on vaccine safety after a product has been licensed for use, and, in particular, on the need to monitor vaccinated populations for the occurrence of adverse events following immunization. The WHO Global Advisory Committee on Vaccine Safety was convened four times during the biennium, to provide authoritative, independent scientific advice on vaccine safety.

The Organization-wide expected result was considered to have been partly achieved, in particular, in respect of the development and updating of essential medicines lists and therapeutic guidelines. Delays occurred in the development and review of medicines lists because of the complexity of the process, the analysis of evidence required and the difficulty of obtaining consensus on the essential medicines to be selected from the various experts involved. A shortage of funds led to a reduction in human resources capacity, limiting achievements in normative work and country support.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
11.3.1 Number of national or regional programmes receiving support for promoting sound and cost-effective use of medical products or technologies.	50	40	78
11.3.2 Number of Member States using national lists, updated within the past five years, of essential medicines, vaccines or technologies for public procurement or reimbursement.	125 (94% of reporting countries)	135	94

SUMMARY OF FINANCIAL IMPLEMENTATION

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).

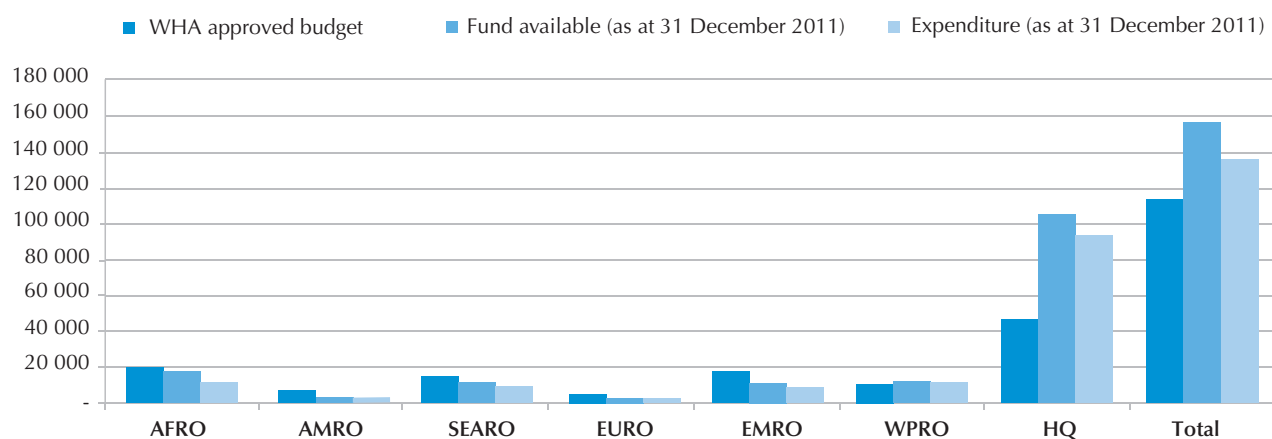
As at the end of December 2011, funding of US\$ 157 million (137%) had been made available through assessed and voluntary contributions. Of that, US\$ 121 million (77% of total available resources) was for WHO Base programmes and US\$ 36 million (23% of total available resources) for Special

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 230% of the approved budget because the original approved budget of US\$ 46 million did not take account of the costs and funding required for the vaccine, medicine and diagnostics prequalification programme. 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 against funds available was above 80%.

All Segments

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	19 663	7 731	10 002	5 952	15 069	10 227	46 483		115 127
Funds Available									
AC	5 328	1 427	3 330	911	2 984	2 823	10 121		26 923
VC	11 535	2 282	3 159	2 976	6 164	7 849	96 639	110	130 714
Total	16 863	3 708	6 490	3 887	9 148	10 672	106 760	110	157 637
Funds Available as % of approved budget	86%	48%	65%	65%	61%	104%	230%		137%
Expenditure	12 893	3 558	5 679	3 335	7 204	10 343	94 098		137 111
Expenditure as % of approved budget	66%	46%	57%	56%	48%	101%	202%		119%
Expenditure as % of funds available	76%	96%	88%	86%	79%	97%	88%		87%



Base programmes

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	19 663	7 731	10 002	5 952	15 069	10 227	46 483		115 127
Funds Available									
AC	5 328	1 427	3 330	911	2 984	2 823	10 121		26 923
VC	11 287	1 468	2 682	2 171	4 613	6 555	65 066	110	93 951
Total	16 614	2 894	6 012	3 082	7 597	9 378	75 187	110	120 875
Funds Available as % of approved budget	84%	37%	60%	52%	50%	92%	162%		105%
Expenditure	12 721	2 792	5 208	2 690	6 123	9 129	64 749		103 413
Expenditure as % of approved budget	65%	36%	52%	45%	41%	89%	139%		90%
Expenditure as % of funds available	77%	96%	87%	87%	81%	97%	86%		86%

Special programmes and collaborative arrangements

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	-	-	-	-	-	-	-		-
Funds Available									
AC	-	-	-	-	-	-	-		-
VC	248	814	477	805	1 551	1 294	31 573	-	36 762
Total	248	814	477	805	1 551	1 294	31 573	-	36 762
Funds Available as % of approved budget	-	-	-	-	-	-	-		-
Expenditure	172	767	471	645	1 078	1 214	29 349		33 695
Expenditure as % of approved budget	-	-	-	-	-	-	-		-
Expenditure as % of funds available	69%	94%	99%	80%	69%	94%	93%		92%

DETAILS OF INDICATOR ACHIEVEMENT

11.1.1 African Region: Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Lucia, Suriname, Trinidad and Tobago, Uruguay, Venezuela (Bolivarian Republic of). **European Region:** Albania, Armenia, Croatia, Estonia, Georgia, Hungary, Kyrgyzstan, Latvia, Malta, Montenegro, Republic of Moldova, Romania, Serbia, Tajikistan, The former Yugoslav Republic of Macedonia. **South-East Asia Region:** Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste. **Western Pacific Region:** Brunei Darussalam, Cambodia, China (People's Republic of), Cook Islands, Fiji, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, New Zealand, Niue, Palau (Republic of), Papua New Guinea, Philippines, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

11.1.2 African Region: Algeria, Angola, Benin, Burkina Faso, Burundi, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Ghana, Guinea Bissau, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guyana, Haiti, Honduras, Mexico, Nicaragua, Paraguay, Peru, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Venezuela (Bolivarian Republic of). **European Region:** Azerbaijan, Belarus, Kyrgyzstan, Republic of Moldova, Turkmenistan, Ukraine. **South-East Asia Region:** Bangladesh, Democratic People's Republic of Korea, India, Myanmar, Nepal, Thailand, Timor-Leste.

11.1.3 Region of the Americas: Antigua and Barbuda, Argentina, Brazil, Canada, Cuba, Guyana, Haiti, Nicaragua, Paraguay, Suriname, United States of America, Uruguay, Venezuela (Bolivarian Republic of). **European Region:** Albania, Armenia, Austria, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, Maldives, Nepal, Sri Lanka, Thailand.

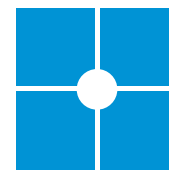
11.2.4 African Region: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gabon, Gambia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Costa Rica, Cuba, Mexico, Panama. **Eastern Mediterranean Region:** Afghanistan, Iran (Islamic Republic of). **European Region:** Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Croatia, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Montenegro, Poland, Republic of Moldova, Romania, Russian Federation, Serbia, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, Uzbekistan. **South-East Asia Region:** Bangladesh, Democratic People's Republic of Korea, India, Indonesia, Maldives, Nepal, Sri Lanka, Thailand. **Western Pacific Region:** Australia, Brunei Darussalam, Cambodia, China (People's Republic of), Cook Islands, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Micronesia (Federated States of), Mongolia, New Zealand, Palau (Republic of), Papua New Guinea, Philippines, Singapore, Tonga, Tuvalu, Viet Nam.

11.3.2 African Region: Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cap Verde, Central African Republic, Chad, Comoros, Congo, Côte

d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea Bissau, Kenya, Lesotho, Liberia, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. **Region of the Americas:** Argentina, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Grenada, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay. **European Region:** Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Croatia, Georgia, Kazakhstan, Kyrgyzstan, Poland, Republic of Moldova, Serbia, Slovakia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan. **South-East Asia Region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand.

SO 12

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



ASSESSMENT OF THE ORGANIZATION-WIDE EXPECTED RESULTS

All four Organization-wide expected results for this strategic-objective were «fully achieved».

Overview

Four key challenges were addressed during the biennium: a) enabling WHO to provide leadership in global health by reforming priority setting, governance, financing and management; b) increasing effectiveness in the way WHO provides support to all Member States; c) using WHO's convening power at global, regional and country level to reach agreement on key global

health issues in order to promote greater coherence among all development partners (particularly at country level) and to ensure the place of health in major global and regional forums; and d) using innovative technology and collaborative networks to make health-related information both more effective and accessible.

12.1

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

Fully Achieved

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

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

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

plemented. In 2011, the High-level meeting of United Nations General Assembly set a new international agenda on prevention and control of noncommunicable diseases.

Joint efforts continued between Member States and WHO to improve the health situation in the regions. Political instability and internal conflict in several countries in the Eastern Mediterranean Region, negatively influenced the development of health programmes. In addition, national disasters, including floods, famines, tsunamis and earthquakes elsewhere caused complex emergencies that made heavy demands on Member States. Although the Regional Office for the Americas saw a decline in its share of official development assistance, it initiated or participated in numerous alliances, partnerships and joint initiatives to promote equitable development in health. Regional initiatives developed specifically to promote the Millennium Development Goals include the Latin America and the Caribbean Newborn Health Alliance, the Regional Task Force on Maternal Mortality Reduction (GTR), the Safe Motherhood initiative, the Regional Initiative for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis, and the Pan American Alliance for Nutrition and Development. Media coverage of key WHO corporate events in the European Region, including regional committee meetings, immunization campaigns and World Health Days, increased significantly.

The High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases was held in New York on 19 and 20 September 2011. The Political Declaration adopted by the General Assembly in resolution 66/2 constituted a milestone in commitment by heads of states to combating a public health threat. It highlights the magnitude and agreements on ways to respond through whole-of-government and whole-of-society efforts. The Political Declaration clearly emphasizes WHO's leading role both in coordinating global action and in developing a comprehensive monitoring framework with a set of voluntary global targets, as well as in providing support and facilitating multisectoral collaboration to combat noncommunicable diseases.

Governing body meetings were conducted in all regions and in headquarters on policies and strategies for priority areas. The Secretariat provided Member States with regular briefings before governing body meetings to enable them to more effectively influence decision making.

The regular meetings of the Global Policy Group improved synergy and coherence across the three levels of the Organization. The Director-General initiated a consultative process focusing on achieving better alignment between objectives agreed by the Health Assembly and the resources available. From this beginning in early 2010 a comprehensive Member State-driven programme of reform has evolved. The Sixty-fourth World Health Assembly endorsed the overall objectives of reform and mapped out a process of analysis and consultation leading to a Special session of the Executive Board in November 2011. This session discussed three interconnected lines of work for reform, namely programme and priorities, governance and management reforms. A Member State-driven process on criteria for priority setting will allow the Secretariat to develop an outline for the next General Programme of Work and Programme Budget 2014–2015 in time for the Sixty-fifth World Health Assembly in May 2012.

High-level advocacy was undertaken by the Director-General and Regional Directors during different events to position health in global and regional agendas, as well as increase investment in strengthening national health systems in order to

achieve national and international health development goals.

Corporate communication services actively supported technical programmes. A detailed evidence-based perception audit was planned and will be rolled out at the beginning of 2012 to provide a solid picture of how well WHO is achieving its targets in the global public health arena. The result of the audit is expected before mid-2012 and will guide the future direction.

Legal Counsel provided support on corporate governance issues, including conflict of interest. The workplan of the Office of Internal Oversight Services was fully implemented. Implementation of the revised policy on prevention of harassment marked a major milestone in improving Organizational integrity. More resources were provided to strengthen the capacity of the Office of Internal Oversight Services for implementation of the recommendations made by the Independent Expert Oversight Advisory Committee, which included strengthening oversight services to increase capacity for supporting investigations of alleged harassment and covering high risk areas identified by the new Internal Oversight Services risk assessment model.

INDICATOR	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
12.1.1 Proportion of documents submitted to governing bodies within constitutional deadlines in the six WHO official languages.	90%	95%	95%

12.2

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

Fully Achieved

Technical and policy support for Member States: In addition to providing strategic guidance for WHO reform and other major policy issues, the Global Policy Group (GPG) provides a link between the Director-General, Regional Directors and Heads of WHO Country Offices (HWOs), enhancing the coherence of WHO's support to individual Member States. Country cooperation strategies (CCSs) were developed and updated in 144 countries, territories and areas where WHO has a physical presence. The country cooperation strategies are used: (i) to adjust the competency and skill mix of country offices in line with national policies, strategies and plans; and (ii) to inform WHO's planning process and better align technical support

from regional offices and headquarters. An improved competitive process for the selection, appointment and development of Heads of WHO Country Offices has contributed to enhancing WHO's leadership and capacity. The concept of country cooperation strategies will, in future, be used to define cooperation needs for all WHO Member States even where the Organization has no physical presence. The Sixth Global Meeting of Heads of WHO Country Offices with the Director-General and Regional Directors provided Heads of WHO Country Offices with the necessary knowledge and skills related to the emerging health agenda, such as WHO reforms, noncommunicable diseases and universal health coverage.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
12.2.1 Number of Member States where WHO is aligning its country cooperation strategy with the country's priorities and development cycle and harmonizing its work with the United Nations and other development partners within relevant frameworks, such as the United Nations Development Assistance Framework, Poverty Reduction Strategy Papers and Sector-Wide Approaches.	At least 145	33 of the 145 Country Cooperation Strategies updated/revised	33 Country Cooperation Strategies ¹
12.2.2 Proportion of WHO country offices which have reviewed and adjusted their core capacity in accordance with their country cooperation strategy.	At least 50%	70%	77%

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.

Fully Achieved

Global health partnerships and initiatives: Based on previous work by the Secretariat and reports to the Executive Board, in 2010, the World Health Assembly endorsed the policy on WHO's engagement with global health partnerships and hosting arrangements (resolution WHA63.10 and its Annex). The policy provides additional guidance to WHO, and ultimately to countries, to help harmonize global health and development

mechanisms. Implementation of the policy also includes further definition of WHO rules and practices concerning partnerships through an operational framework. Advancing WHO's work in partnering with various sectors, for the first time, the Global Policy Group² endorsed an internal WHO policy framework for private sector engagement beginning a process to improve clarity on WHO's interaction with this sector.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
12.3.1 Number of health partnerships in which WHO participates that work according to the best practice principles for Global Health Partnerships.	14	30	45
12.3.2 Proportion of health partnerships managed by WHO that comply with WHO partnership policy guidance.	100%	100%	100% ³
12.3.3 Proportion of countries where WHO is leading or actively engaged in health and development partnerships (formal and informal), including in the context of reforms of the United Nations system.	71%	80%	80%

12.4

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

Fully Achieved

Enhancing access to health information: To enhance the dissemination of timely health information to all who need it, WHO has put in place a consistent technology base to link all WHO offices. Progress was made through the creation of a web page for multilingualism. Work continued with external partners for translation of over 200 WHO publications into 40 official and non-official languages. A report on the implementation of WHO publications policy was presented to the 129th session of the Executive Board (EB129/4). The Bulletin of the World Health Organization was published once a month in multiple formats with abstracts in all official languages. More than 80 proposals for designation and 200 proposals for re-des-

ignation of WHO collaborating centres have been reviewed. The Guidelines Review Committee (GRC) met on a monthly basis and reviewed the initial proposals for guideline development prior to their publication, as well as final submissions to ensure the process and form of the recommendations followed WHO requirements. Pilot testing of a Compendium of National Expertise designed initially in close collaboration with the departments of information technology and telecommunications, knowledge management and sharing and human resources for health and six regional offices is under way, as well as mapping of the existing databases and their assessment.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
12.4.1 Average number of page views/visits per month to the WHO headquarters' web site.	Not available / 6.35 million visits/month	6.7 million	7 million
12.4.2 Number of pages in languages other than English available on WHO country and regional offices' and headquarters' web sites.	70 495	80000	More than 80000

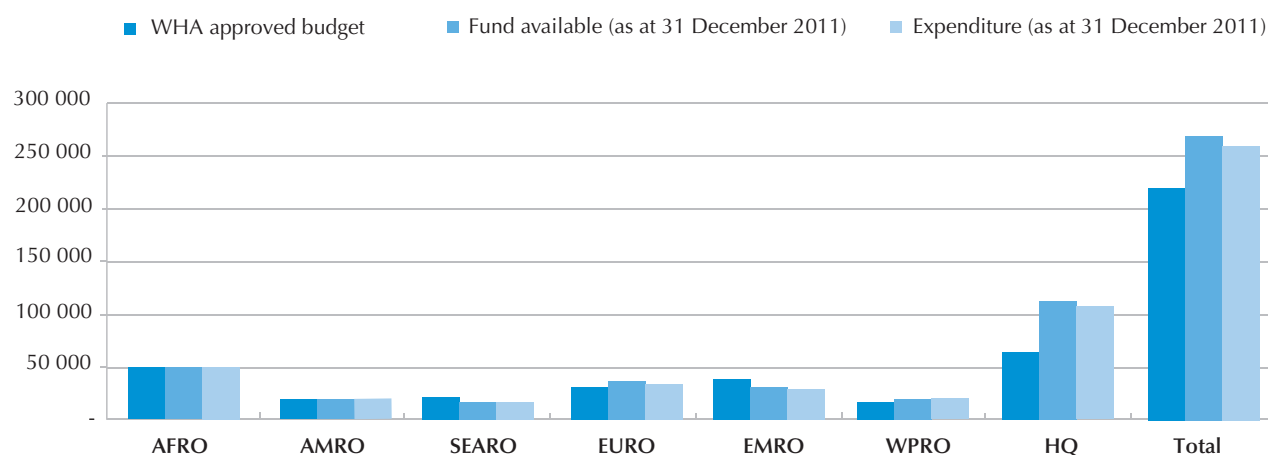
SUMMARY OF FINANCIAL IMPLEMENTATION

The WHA approved budget for strategic objective 12 was US\$ 223 million. Available funding by the end of the biennium was \$269 million (121% of the approved budget), of which US\$ 198 million were from assessed contributions and US\$ 71 million from voluntary contributions. Implementation across all locations as at 31 December 2011 was US\$ 264 million which corresponds to 119% of the approved budget and 98% of the available resources.

During 2010–2011, several adjustments were made under strategic objectives 12 and 13 to better harmonize the planning of expenditures in country offices with the two strategic objectives. As a result, strategic objective 13 shows under-implementation against the original approved budget, and strategic objective 12 shows over-implementation. The high availability of resources in headquarters of 167% 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.

All Segments

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	49 735	16 710	16 503	25 572	31 659	15 779	66 759		222 717
Funds Available									
AC	43 058	14 474	10 256	20 800	20 748	11 804	76 848		197 988
VC	6 640	2 287	4 874	10 608	4 342	7 751	34 563	-	71 065
Total	49 698	16 761	15 129	31 408	25 090	19 555	111 411	-	269 053
Funds Available as % of approved budget	100%	100%	92%	123%	79%	124%	167%		121%
Expenditure	49 056	16 551	14 832	30 921	24 513	19 043	109 292		264 208
Expenditure as % of approved budget	99%	99%	90%	121%	77%	121%	164%		119%
Expenditure as % of funds available	99%	99%	98%	98%	98%	97%	98%		98%



REFERENCES

- 1 A number of country cooperation strategies were extended to align the cycle with national plans/strategies and the cycle of UNDFs. Of the 33 country cooperation strategies, 10 are in the process of being updated/revised.
- 2 The group consists of the Director-General, Deputy Director-General and Regional Directors.
- 3 Resolution WHA63/16.

DETAILS OF INDICATOR ACHIEVEMENT

12.2.2 The African Region 74%, the Region of the Americas 96%, the Eastern Mediterranean region 100%, the European region 100%, the South-East Asia Region 65% and the Western-Pacific Region 50%.

12.3.2 WHA 63.10 ensures that all WHO-hosted partnerships comply with WHO Rules and Regulations. By the end of 2011 a total of 10 partnerships hosted by WHO have a separate governance mechanism.

SO 13

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



ASSESSMENT OF THE ORGANIZATION-WIDE EXPECTED RESULTS

Of the six Organization-wide expected results for this strategic-objective, two were «fully achieved» and four «partly achieved».

Overview

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

Extensive support was provided, and analyses prepared, for the WHO programme of reform, including programmatic, human resources and financial analyses for shaping proposals for future financing and human resources strategies, as well as for a revised priority-setting process.

13.1

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

Fully Achieved

This biennium has marked the mid-point of the Medium-term Strategic Planning 2008-2013 cycle. Progress was made in terms of improving the consistency of planning and assessment of results across the Organization.

In terms of planning, Programme Budget 2012-13 was prepared based on a more realistic projection of income and expenditure – while still emphasizing a number of priority areas identified by Member States. The performance targets of the Organization were also adjusted accordingly.

The schedule for producing the Programme budget performance assessment was accelerated to allow the report to be presented to the World Health Assembly in May, immediately following the end of the biennium. In addition, the method for assessing the achievement of country performance indicators now includes the identification and verification of individual countries.

The Mid-term review of implementation of the Programme budget 2010–2011 and the interim assessment of Medium-term strategic plan 2008–2013 were conducted and their findings were reviewed and discussed at the Programme Budget Administration Committee, the Executive Board and the World Health Assembly.

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

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
13.1.1 Proportion of country workplans that have been peer reviewed with respect to their technical quality, that they incorporate lessons learnt and reflect country needs.	95%	95%	100%
13.1.2 Office Specific Expected Results (OSERs) for which progress status has been updated within the established timeframes for periodic reporting.	74%	85%	85%

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

Partly Achieved

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

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

Implementation of new inventory management procedures was completed to ensure that systematic inventory control and valuation arrangements are in place, in accordance with International Public Sector Accounting Standards.

An informal consultation on the Future Financing of WHO was organized in order to ensure a more flexible and sustainable funding base for WHO and discussions on this topic were continued within the context of the Director-General's consultations on WHO Reform.

To ensure coherence of resources mobilization activities, 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.

This Organization-wide expected result was considered to have been partly achieved because the target for voluntary contributions classified as fully and highly flexible was not met. However, despite the constraints imposed by the financial crisis, the total amount of flexible resources raised increased from US\$ 187 million in 2008–2009 to US\$ 235 million in 2010–2011. This marks an overall trend in voluntary contributions towards multi-year agreements with a stronger focus on flexibility and predictability.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
13.2.1 Degree of compliance of WHO with International Public Sector Accounting Standards.	Compliance requires completion of introduction of the Global Management System in all regions	Systems and opening accounts fully compliant	Systems and opening accounts fully compliant
13.2.2 Amount of voluntary contributions that are classified as fully and highly flexible.	US\$ 187 million	US\$ 300 million	US\$ 235 million

13.3

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

Partly Achieved

The difficult exercise of reducing the head count, notably in the African Region and headquarters because of budget cuts and staff cost increases, was managed through a highly inclusive process that ensured that down-sizing was carried out fairly, with clear communication and the support of all staff members concerned. The process was aided by improved human resources planning, especially in offices where the Global Management System had been introduced during the biennium.

Further challenges included the large number of countries operating in emergency mode, many of which urgently required new positions to be created, recruitment to fill vacancies and placements for emergency assignments.

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

A global web-based medical database Préventiel was implemented in the Regional Offices for the Americas, Europe, South-East Asia and the Western Pacific, as well as IARC, in order to facilitate the monitoring of the health of staff members and the management of illnesses and conditions.

In collaboration with technical departments, United Nations medical emergency response teams, the United Nations

Critical Incident Stress Management Unit, and the health and medical teams at headquarters and regional level provided medical and counselling support to WHO staff members and their families affected by traumatic incidents, such as the nuclear accident at Fukushima, Japan, and the bomb attack on the United Nations building in Abuja.

With regard to policies, WHO issued a revised policy on the prevention of harassment within the Organization, following extensive consultations.

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

The Secretariat worked on detailed proposals for human resources reform, including a new staffing model for the Organization more in line with its financing.

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

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

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

Fully Achieved

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

The Organization-wide implementation of the Global Management System required the establishment of global information and communications technology infrastructure and support processes that are being further utilized to develop and deploy more information and communications technology services and disciplines in a globally consolidated manner. The operation and maintenance of the Global Private Network, which is critical for the delivery of information and communi-

cations technology services globally, was further strengthened. Its governance and security has been significantly improved, especially since the implementation of managed security services. Additional services, such as Global Synergy managed desktop, Global E-mail and Unified Communication services are being developed and deployed globally with the goal of improving service quality, facilitating user support and information exchange and reducing costs through economies of scale.

A new business model for the delivery of information and communications technology services for the Organization was developed and implemented. This model involves offshoring of services to the Global Service Centre in Kuala Lumpur combined with an increased use of outsourcing, as a way of lowering costs and providing a more flexible service delivery model.

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
13.4.1 Number of information technology disciplines implemented Organization-wide according to industry-best-practices benchmarks.	3	5	5
13.4.2 Proportion of offices using consistent real-time management information.	Headquarters and the Western Pacific regional offices and associated country offices	Headquarters, 5 regional offices and associated country offices	Headquarters, 5 regional offices and associated country offices

13.5

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

Partly Achieved

Global Service Centre operations began to run more smoothly as staff have become familiar with their role and with the System. The percentage of transactions processed according to published service level indicators increased to 85% despite a 40% rise in transactions as a result of the African, Eastern Mediterranean, European and South-East Asia Regions activating the Global Management System during the biennium. The unit cost for processing transactions has continued to decrease. Additional functions in finance and procurement have been moved from headquarters to the Global Service Centre, further reducing the overall cost of administration.

Long-term measures were taken to strengthen the financial security and governance of the Staff Health Insurance Scheme that reflect the challenges posed by demographic changes in the insured population and increasing health-care costs.

The structured adjustments to service delivery resulting from the downsizing of headquarters' administration are in the process of implementation in order to complete the cost reductions required for the reduced budget for strategic objective 13 (and higher staff costs) in Geneva. Further efforts will be made to harmonize service delivery practices across the Organization with a view to further cost containment, whilst at the same time protecting service levels and quality of services and enhancing internal controls. This may result in further adjustments to the allocation of tasks between headquarters, the Global Service Centre, and regional and country offices, wherever internal control improvements continue to be needed.

The Organization-wide expected result was rated as "partly achieved" owing to a combination of system and/or procedural inefficiencies in some service areas.

INDICATOR	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
13.5.1 Proportion of services delivered by the global service centre according to criteria in service-level agreements.	75%	90%	85%

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

Partly Achieved

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

Efforts to mitigate the impact of WHO offices on the immediate environment and to introduce further cost containment measures continued. For example, the introduction of managed print and copying services at headquarters reduced the

cost of office printing and copying in 2010–2011 from CHF 7.2 million to CHF 5 million and also contributed to a 50% reduction in paper consumption.

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

INDICATORS	BASELINE 2010	TARGET BY 2011	ACHIEVED BY 2011
13.6.1 Degree of satisfaction with quality of services in all major offices resulting from effective infrastructure support services.	Not available	75%	Not Available ¹
13.6.2 Proportion of offices that have conducted regular building evacuation exercises.	70%	70%	90%

SUMMARY OF FINANCIAL IMPLEMENTATION

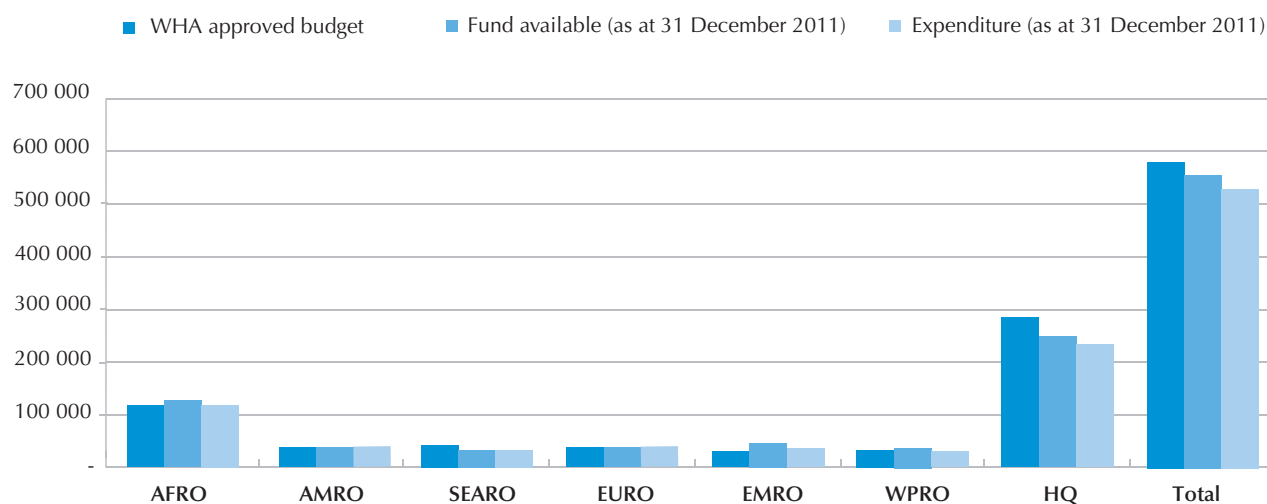
The total budgeted costs for strategic objective 13 were US\$ 582 million, composed of US\$ 524 million for strategic objective 13, plus additional costs under strategic objective 13bis of US\$ 58 million financed through a separate cost recovery mechanism (see summary table 6, Proposed programme budget 2010–2011, page 84). Available funds as at 31 December 2011 for costs relating to strategic objectives 13 and 13bis were US\$ 559 million, which included US\$ 276 million from assessed contributions, US\$ 144 million from voluntary contributions (mainly programme support charges) and US\$ 139 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 were 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\$ 533 million (95%) were implemented as at 31 December 2011.

During the period detailed plans were developed, then implemented to ensure cost reductions at HQ, given that the 2012-13 approved budget provided a 20% real terms reduction. This has resulted in the elimination of approximately 100 positions within SO 13 at HQ, with some functions transferred to the Global Service Centre, and some services moved to external providers

All Segments

	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	NOT YET DISTRIBUTED TO MAJOR OFFICES	TOTAL
(US\$ '000)									
WHA approved budget	125 187	29 550	44 508	36 593	31 008	32 910	224 131		523 887
Additional budget SO13 bis	-	-	-	-	-	-	58 200		58 200
WHA approved budget	125 187	29 550	44 508	36 593	31 008	32 910	282 331		582 087
Funds Available									
AC	63 222	13 136	22 354	18 620	20 583	17 263	120 410		275 587
VC	41 487	11 084	11 102	8 632	9 312	10 333	52 354	-	144 304
Made available through Post Occupancy Charge	23 363	3 962	7 383	8 371	10 217	6 281	79 500	-	139 076
Total	128 072	28 181	40 839	35 623	40 111	33 877	252 264	-	558 968
Funds Available as % of approved budget	102%	95%	92%	97%	129%	103%	89%		96%
Expenditure									
SO 13	99 837	24 250	31 999	25 834	28 302	26 384	168 885		405 490
SO 13bis	20 972	3 948	6 809	8 371	9 439	5 424	72 759		127 723
Total expenditure	120 809	28 199	38 808	34 205	37 741	31 808	241 644		533 213
Expenditure as % of approved budget	97%	95%	87%	93%	122%	97%	86%		92%
Expenditure as % of funds available	94%	100%	95%	96%	94%	94%	96%		95%



REFERENCES

1 Indicator 13.6.1 is being discontinued and is replaced in 2012-13.

DETAILS OF INDICATOR ACHIEVEMENT

13.1.1 2012-2013 country workplans have been peer reviewed in all regions. The achievement value across the regions ranged from 95% to 100%.

13.1.2 Most office specific expected results (OSERs) were monitored and reported. The achievement value across major offices ranged from 55% to 100%.

ANNEX

EXPENDITURE BY STRATEGIC OBJECTIVE AND LOCATION FOR ALL BUDGET SEGMENTS

STRATEGIC OBJECTIVE	LOCATION	COUNTRY	REGIONAL	HQ	TOTAL
					US\$ 000
01	AFRO	521 159	68 499		589 659
	AMRO	8 939	11 611		20 550
	EMRO	95 791	23 730		119 521
	EURO	13 560	11 802		25 362
	SEARO	135 911	19 520		155 431
	WPRO	35 310	22 278		57 588
	HQ			321 390	321 390
01 TOTAL		810 670	157 441	321 390	1 289 501
		63%	12%	25%	

02	AFRO	55 155	28 425		83 580
	AMRO	3 097	6 295		9 392
	EMRO	40 674	9 965		50 639
	EURO	12 912	8 028		20 940
	SEARO	37 186	8 635		45 820
	WPRO	28 662	12 140		40 802
	HQ			194 375	194 375
02 TOTAL		177 685	73 489	194 375	445 549
		40%	16%	44%	

03	AFRO	7 122	5 139		12 261
	AMRO	4 719	2 352		7 072
	EMRO	5 794	3 123		8 917
	EURO	4 291	6 217		10 508
	SEARO	3 277	2 870		6 147
	WPRO	9 665	4 239		13 903
	HQ			38 731	38 731
03 TOTAL		34 869	23 940	38 731	97 540
		36%	25%	40%	

04	AFRO	30 132	14 272		44 404
	AMRO	6 286	2 639		8 926
	EMRO	9 162	3 986		13 148
	EURO	5 562	1 864		7 426
	SEARO	4 288	3 391		7 679
	WPRO	9 813	3 023		12 836
	HQ			95 965	95 965
04 TOTAL		65 243	29 175	95 965	190 384
		34%	15%	50%	

STRATEGIC OBJECTIVE	LOCATION	COUNTRY	REGIONAL	HQ	TOTAL
					US\$ 000
05	AFRO	46 714	6 565		53 280
	AMRO	25 102	2 881		27 983
	EMRO	16 574	2 184		18 758
	EURO	7 406	1 465		8 871
	SEARO	121 544	5 664		127 208
	WPRO	5 476	1 808		7 283
	HQ			69 060	69 060
05 TOTAL		222 816	20 568	69 060	312 444
		71%	7%	22%	

06	AFRO	6 137	6 081		12 218
	AMRO	3 021	2 307		5 328
	EMRO	3 913	4 409		8 322
	EURO	2 458	5 365		7 823
	SEARO	2 417	4 346		6 763
	WPRO	7 017	4 685		11 702
	HQ			41 871	41 871
06 TOTAL		24 964	27 193	41 871	94 028
		27%	29%	45%	

07	AFRO	4 105	2 358		6 462
	AMRO	1 012	1 295		2 307
	EMRO	993	1 646		2 639
	EURO	1 813	3 880		5 693
	SEARO	2 559	1 701		4 259
	WPRO	774	924		1 698
	HQ			13 868	13 868
07 TOTAL		11 256	11 803	13 868	36 926
		30%	32%	38%	

08	AFRO	4 270	4 305		8 575
	AMRO	3 620	2 317		5 937
	EMRO	4 829	2 981		7 811
	EURO	2 866	12 912		15 778
	SEARO	1 102	4 845		5 947
	WPRO	7 647	1 987		9 634
	HQ			29 784	29 784
08 TOTAL		24 335	29 348	29 784	83 467
		29%	35%	36%	

STRATEGIC OBJECTIVE	LOCATION	COUNTRY	REGIONAL	HQ	TOTAL
US\$ 000					
09	AFRO	4 503	5 225		9 728
	AMRO	1 654	1 444		3 097
	EMRO	2 582	1 668		4 249
	EURO	2 355	2 688		5 044
	SEARO	1 124	2 312		3 436
	WPRO	4 168	2 439		6 607
	HQ			29 863	29 863
09 TOTAL		16 386	15 776	29 863	62 025
		26%	25%	48%	

10	AFRO	23 668	20 402		44 070
	AMRO	8 731	10 195		18 925
	EMRO	18 316	8 906		27 222
	EURO	7 892	23 103		30 995
	SEARO	16 762	9 891		26 653
	WPRO	21 724	11 597		33 321
	HQ			117 040	117 040
10 TOTAL		97 093	84 094	117 040	298 227
		33%	28%	39%	

11	AFRO	8 026	4 866		12 893
	AMRO	1 100	2 459		3 558
	EMRO	3 117	2 562		5 679
	EURO	1 496	1 839		3 335
	SEARO	4 151	3 053		7 204
	WPRO	6 413	3 931		10 343
	HQ			94 098	94 098
11 TOTAL		24 302	18 710	94 098	137 111
		18%	14%	69%	

12	AFRO	34 329	14 727		49 056
	AMRO	10 671	5 881		16 551
	EMRO	6 612	8 220		14 832
	EURO	11 271	19 651		30 921
	SEARO	9 307	15 206		24 513
	WPRO	9 801	9 242		19 043
	HQ			109 292	109 292
12 TOTAL		81 989	72 927	109 292	264 208
		31%	28%	41%	

STRATEGIC OBJECTIVE	LOCATION	COUNTRY	REGIONAL	HQ	TOTAL
US\$ 000					
13	AFRO	41 362	58 475		99 837
	AMRO	4 898	19 353		24 250
	EMRO	18 066	13 933		31 999
	EURO	4 989	20 846		25 834
	SEARO	18 120	10 182		28 302
	WPRO	12 332	14 052		26 384
	HQ			168 885	168 885
13 TOTAL		99 766	136 840	168 885	405 490
		25%	34%	42%	

GRAND TOTAL		1 691 374	701 303	1 324 224	3 716 901
		46%	19%	36%	

