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Programme budget 2008–2009: Performance assessment report



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Programme budget 2008–2009: performance assessment

Summary report

FOREWORD BY THE DIRECTOR-GENERAL

This document provides a systematic assessment of WHO's performance during 2008–2009 according to each of the Organization's 13 strategic objectives set out in the programme budget. Its preparation is in line with my personal commitment to results-based management and other reforms that can make WHO fit-for-purpose given the unique challenges of the twenty-first century.

The biennium was an eventful one for public health. Health around the world was affected by the most severe economic downturn since the Great Depression began in 1929, the first influenza pandemic in four decades, large losses of life from conflicts and natural disasters, some spectacular outbreaks of foodborne disease, more evidence that the climate is changing, and soaring food prices that hit the poor the hardest. Undernutrition and uncertain food security persisted, while the number of obese and overweight people, including children, continued to grow, as did evidence that the burden of chronic noncommunicable diseases is now overwhelmingly concentrated in the developing world.

But the biennium also brought substantial progress and good news on many fronts. In general, WHO and its Member States made the greatest measurable gains through scaling up the delivery of interventions, like medicines, vaccines, and bednets. This success shows the power of ambitious time-bound goals, such as the Millennium Development Goals, to secure resources and focus the efforts and ingenuity of multiple partners.

The epidemics of HIV/AIDS and tuberculosis showed slow but sure declines. The number of childhood deaths from vaccine-preventable diseases dropped significantly, with reductions in measles deaths surpassing international targets. More countries adopted the Integrated Management of Childhood Illness as the principal strategy for child survival. Some countries made headway against malaria, suggesting that good use of existing tools, in line with recommended strategies, can indeed turn this disease around. On the heels of this success, the goal of malaria eradication was revived. Steady progress suggested that some ancient tropical diseases could be eliminated by 2015, with dracunculiasis already on the verge of eradication. While the initiative to eradicate poliomyelitis experienced some setbacks, the determination to finish the job remained steadfast.

At the same time, stalled progress despite good interventions and solid financial support underscored the urgent need to strengthen health systems and services. Single-disease initiatives revealed some serious problems that were broadly addressed during the biennium: weak health infrastructures, inadequate systems for health information, a critical shortage of health-care workers, stock-outs of essential medicines, and counterfeit and substandard products. Significantly, reductions in maternal and newborn mortality, which depend absolutely on a well-functioning health system, were disappointing.

Large health initiatives also revealed the difficulty of changing human behaviours – getting people to practise safe sex, finish a course of treatment, or use bednets correctly.

The shift in the burden of chronic diseases to the developing world helped show what weak health systems really mean: the burden of chronic care on facilities and staff, the need for steady supplies of quality-assured medicines, and the high costs of chronic care that drive households below the poverty line at a time when the international community is committed to poverty reduction. The rise of chronic diseases also reinforced the importance of health promotion for behaviour change.

Efforts to make aid for health development more effective continued, emphasizing the importance of harmonizing aid and aligning it with national priorities and capacities. WHO and its regional and country offices worked closely with countries to formulate national health strategies, but also to prepare and test plans for responding to emergencies, such as those caused by outbreaks and natural disasters. Greater effectiveness was also sought through integrated approaches and the better use of networks and region-wide collaboration, whether for research or the sharing of laboratory services.

Health research brought some important innovations. For example, new pneumococcal and rotavirus vaccines were introduced to combat the two biggest killers of young children in the developing world.

Impressive results were achieved with other less spectacular innovations, such as better growth charts for assessing childhood nutrition and a simple surgical checklist for reducing medical errors.

At a time when international agreement on non-health issues seemed increasingly elusive, WHO Member States reached consensus on a number of difficult issues, including the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property. In my view, getting international agreement on potentially divisive issues is an indication of how much governments, rich and poor, want to see public health strengthened.

As a contribution to prevention, the biennium also saw efforts to address fundamental determinants of health that arise in other sectors. Some efforts followed traditional concerns: improving water supply and sanitation, managing chemicals in the environment and the workplace, and safeguarding the public from the hazards of contaminated food and water. But other efforts followed new ambitions. They sought to address the root causes of health inequities that arise from the very policies that influence economic, social, and environmental conditions in the first place. In its final report, the Commission on Social Determinants of Health placed the ultimate responsibility for gaps in health outcomes squarely on the shoulders of policy-makers. As that report argued, health inequities are not matters of fate. They are markers of flawed policies.

Like the Declaration of Alma-Ata and the Millennium Declaration and its Goals, the recommendations of the Commission on Social Determinants of Health are all about fairness. In my view, a desire for greater fairness in access to health care and greater equity in health outcomes drives some of the strongest efforts to improve world health. I believe that many of the diverse problems addressed during the biennium find convergence in the values, principles, and approaches of primary health care. The fact that the Member States in all WHO regions are committed to a renewal of primary health care augers well for the future.

PERFORMANCE ASSESSMENT OVERVIEW

The Programme budget 2008–2009 performance assessment is the first to be carried out within the framework of the Medium-term strategic plan 2008–2013. The exercise had two main purposes: to evaluate the Secretariat’s performance in achieving the Organization-wide expected results, for which the Secretariat is fully accountable; and to identify the overall progress and main accomplishments of the Member States in relation to the strategic objectives.

The performance assessment was conducted and reported in accordance with the decision taken by the governing bodies to change its format and the timelines for its submission.¹ The aim was to make the Programme budget assessment report available to the World Health Assembly in the year following each biennium. Although this represented a challenge, certain benefits ensued, including its use in the preparation of the Proposed programme budget 2012–2013 and in adjusting operational plans for the 2010–2011 biennium.

The assessment report provides an analysis of the results achieved by the Secretariat, measuring them against the Organization-wide expected results and performance indicators set out in the amended Medium-term strategic plan 2008–2013,² which was endorsed by the Sixty-second World Health Assembly.³ Of the 81 Organization-wide expected results, 42 were “fully achieved”, 39 “partly achieved” and none “not achieved”. The breakdown by strategic objective is as follows:

Strategic objective	Organization-wide expected results		
	Fully achieved	Partly achieved	Total
1. Communicable diseases	6	2	8
2. HIV/AIDS, tuberculosis and malaria	3	3	6
3. Chronic noncommunicable conditions	4	2	6
4. Child, adolescent, maternal, sexual and reproductive health, and ageing	3	5	8
5. Emergencies and disasters	3	3	6
6. Risk factors for health	4	2	6
7. Social and economic determinants of health	4	1	5
8. Healthier environment	0	5	5
9. Nutrition and food safety	3	3	6
10. Health systems and services	6	6	12
11. Medical products and technologies	1	2	3
12. WHO leadership, governance and partnerships	4	0	4
13. Enabling and support functions	1	5	6
Total	42	39	81

¹ Document EB124/3.

² See http://apps.who.int/gb/e/e_amtsp3.html.

³ See resolution WHA62.11.

The degree of success in achieving the Organization-wide expected results was assessed primarily on the basis of the following indicator criteria:

- **Fully achieved** – All indicator targets for the Organization-wide expected result were met or surpassed;¹
- **Partly achieved** – One or more indicator targets for the Organization-wide expected result were not met;
- **Not achieved** – No indicator targets for the Organization-wide expected result were met.

As in previous bienniums, the assessment exercise was primarily a self-assessment process. It began with the evaluation by individual offices (country, regional and headquarters) of their performance in achieving the office-specific expected results. All teams and units reviewed the delivery of planned products and services, tracked and updated indicator values for the expected results and provided narrative information on the achievements, lessons learnt and way forward.

The performance assessments at office level were consolidated and synthesized into reports on 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. The provision of evidence relating to the delivery of results and a systematic measurement of the agreed performance indicators at each level were the major requirements. The achievements in countries were given particular attention.

In order to improve the reliability and accuracy of the assessment outcomes, a quality assurance mechanism was established. Draft reports were shared among individual strategic objective teams before being reviewed by peers from both technical units and the planning and performance assessment team. The reports on all 13 strategic objectives were scrutinized in order to identify inconsistencies and omissions, and to ensure that achievements and not just actions were the main focus of attention, and that the reports accurately reflected the work being carried out in countries. Systematic feedback on the quality review completed the iterative process.

SUMMARY OF FINANCIAL IMPLEMENTATION

WHO's approved budget for the biennium 2008–2009 was US\$ 4.2 billion. Available funds distributed for implementation in the biennium were US\$ 4.6 billion, including funds received in 2006–2007 for use in 2008–2009. A total of US\$ 3.9 billion was implemented (i.e. US\$ 3.8 billion expenditure and US\$ 0.1 billion encumbrance). The breakdown of financial implementation by strategic objective is as follows:

¹ Appraisals were also adjusted where despite the Organization-wide target having been met, the results were not fully achieved across all regions, in which case the global appraisal was changed to "partly achieved".

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SUMMARY OF FINANCIAL IMPLEMENTATION (US\$ million)

Strategic objective	Approved budget 2008–2009	Funds available for 2008–2009	Funds available as % of approved budget	Expenditure 2008–2009	Expenditure as % of approved budget	Expenditure as % of funds available
1. Communicable diseases	894	1 482	166%	1 236	138%	83%
2. HIV/AIDS, tuberculosis and malaria	707	645	91%	488	69%	76%
3. Chronic noncommunicable conditions	158	107	68%	87	55%	82%
4. Child, adolescent, maternal, sexual and reproductive health, and ageing	360	226	63%	191	53%	84%
5. Emergencies and disasters	218	453	207%	369	169%	82%
6. Risk factors for health	162	118	73%	96	59%	81%
7. Social and economic determinants of health	66	43	66%	35	53%	80%
8. Healthier environment	130	110	84%	86	66%	78%
9. Nutrition and food safety	127	55	44%	46	37%	84%
10. Health systems and services	514	426	83%	318	62%	75%
11. Medical products and technologies	134	160	120%	127	94%	79%
12. WHO leadership, governance and partnerships	214	235	110%	218	102%	93%
13. Enabling and support functions	542	513	95%	490	90%	95%
Total	4 227	4 594^a	109%	3 789^b	90%	82%

a This figure includes US\$ 20 million of funds which were undistributed as at 31 December 2009.

b Total expenditure does not include US\$ 111 million of commitments (encumbrances) made for goods/services which were not delivered as at 31 December 2009.

The biennium 2008–2009 saw, for the first time, the division of the approved budget into three segments. The first covers Base programmes, where WHO has exclusive strategic and operational control over the activities, as well as the Organization's normative work. At the time the budget was approved, this budget segment was estimated at US\$ 3.7 billion. The second segment, Partnerships and collaborative arrangements, covers activities that are within WHO's results hierarchy and over which it has executive authority, but where activities are carried out collaboratively, which can affect the amount of available resources and expenditure.

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The third budget segment, Outbreak and crisis response, covers activities that are governed by acute external events, making it difficult to predict either the location of activities, or the resources to be implemented.

During the biennium, the Organization improved its methods for tracking funds received and how they were spent according to the three segments, and will continue to work towards greater accuracy in monitoring funds by segment in the future. The breakdown of financial implementation by budget segment is estimated as follows:

SUMMARY OF FINANCIAL IMPLEMENTATION (US\$ million)

Segment	Approved budget 2008–2009	Funds available for 2008–2009	Funds available as % of approved budget	Expenditure 2008–2009	Expenditure as % of approved budget	Expenditure as % of funds available
Base programmes	3 742	3 079	82%	2 524	67%	82%
Partnerships and collaborative arrangements	370	1 060	286%	812	220%	77%
Outbreak and crisis response	116	455	392%	453	391%	100%
Total	4 227	4 594	109%	3 789^a	90%	82%

^a Total expenditure does not include US\$ 111 million of commitments (encumbrances) made for goods/services which were not delivered as at 31 December 2009.

Base programmes were estimated to be underfunded in relation to the approved budget, which impacted on implementation in all regions. It is estimated that about 67% of the Base programme segment of the budget was implemented, representing an implementation level of about 82% of the available funds for this segment.

The level of funds available for the Partnerships and collaborative arrangements segment was higher than originally estimated, amounting to about 286% of the original budget estimate. The increase in funds available for the original budget was mostly for poliomyelitis activities under strategic objective 1. Total expenditure for this segment is estimated at US\$ 812 million, compared to the US\$ 370 million originally budgeted. While the original estimate for this segment was less than 10% of the total budget, expenditure represented more than 20% of total expenditure.

The Outbreak and crisis response segment of the budget also increased, with expenditure amounting to about US\$ 453 million compared with the original budget estimate of US\$ 116 million. About 30% of the expenditure was for outbreak response activities under strategic objective 1, including those connected with pandemic (H1N1) 2009. The balance was for crisis response activities under strategic objective 5, of which nearly two thirds were implemented in the Eastern Mediterranean Region. Consequently, the overall expected results for the Region were affected as large portions of the budget were allocated to either activities connected with outbreak and crisis response or partnerships and collaborative arrangements for activities against poliomyelitis. Therefore, expenditure and the amount of available funds were both greater than in the original budget.

In most offices, overall available funds were sufficient to meet budget estimates, however, their distribution, and, therefore, implementation, across strategic objectives varied. Strategic objectives 3, 4, 7 and 9 were the least well funded, while strategic objectives 1 and 5 received the most funding, although this was mainly for activities outside the Base programmes segment. The availability of a higher level of total funds for

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these two strategic objectives masks the shortfall in resources for Base programmes in several offices, notably the Regional Offices for Africa and the Eastern Mediterranean, where significantly larger proportions of the funds for strategic objectives 1 and 5 were made available for Partnerships and collaborative arrangements, especially those for poliomyelitis eradication, and for various activities under Outbreak and crisis response. The breakdown of financial implementation by location against the Programme budget is as follows:

SUMMARY OF FINANCIAL IMPLEMENTATION (US\$ million)

Region	Approved budget 2008–2009	Funds available for 2008–2009	Funds available as % of approved budget	Expenditure 2008–2009	Expenditure as % of approved budget	Expenditure as % of funds available
African Region	1 194	1 112	93%	1 007	84%	91%
Region of the Americas	279	148	53%	135	49%	91%
South-East Asia Region	492	458	93%	363	74%	79%
European Region	275	251	91%	203	74%	81%
Eastern Mediterranean Region	465	632	136%	531	114%	84%
Western Pacific Region	348	296	85%	213	61%	72%
Headquarters	1 176	1 655	141%	1 337	114%	81%
Total	4 227	4 594^a	109%	3 789^b	90%	82%

a This figure includes US\$ 42 million of funds which were undistributed as at 31 December 2009.

b Total expenditure does not include US\$ 111 million of commitments (encumbrances) made for goods/services which were not delivered as at 31 December 2009.

Expenditure in 2006–2007 against the substantive areas of work of the Programme budget was US\$ 3.1 billion. There was a 22% overall increase in 2008–2009 over 2006–2007, with a 21% increase in headquarters and a 23% increase in the regions. The African Region showed the highest percentage increase in expenditures, at 31%.

The 2008–2009 audited financial report shows a carry-forward from 2006–2007 of US\$ 1.6 billion, and US\$ 3.8 billion in income earned, making a total of US\$ 5.4 billion. The income earned includes for purposes outside the Programme budget, including the Global Drug Facility (US\$ 122 million), the Framework Convention on Tobacco Control (US\$ 10 million), reimbursable procurement undertaken on behalf of Member States (US\$ 53 million), and other operating income (US\$ 71 million). The total amount available for Programme budget implementation was US\$ 5 billion. Of this, US\$ 4.6 billion had been made available for implementation in the current biennium, and the balance, some of which arrived late, remained for implementation in later periods.

The carry-forward in accounting income is US\$ 1.5 billion. There is a minimum estimated requirement of approximately US\$ 800 million to open the biennium in order to ensure staff salaries for six months and continuity of activities. In practice, the high degree of specification of funds, and the fact that some income is received and specified for multi-year projects, means that a higher carry-forward is in place.

Of the total of US\$ 5 billion available for programme budget implementation, 19% was provided through assessed contributions from Member States. The Core voluntary contribution account mechanism, which is fully flexible funding to support the Programme budget, provided 3% of the total. An additional 7% of the funding is considered medium flexible, that is, funding earmarked at high level, such as for a strategic objective. A further 6% came through Programme support costs and is used to support strategic objectives 12 and 13 only. The balance, or 65% of the total funds available, is specified to various degrees, often tightly. The Organization continues to work with donors to increase the proportion of flexible funds, as well as to improve mechanisms for using flexible funds in order to reduce funding gaps in less well-funded strategic objectives.

The expenditure analysis was prepared on 3 March 2010, before the final closure of accounts for the biennium 2008–2009, and may not include final adjustments made. The figures provided include expenditure only. In addition, encumbrances (approved commitments where delivery of goods or services was expected in 2010) amounting to about an additional 3%, or US\$ 111.3 million, have been recorded at the end of the biennium.

ACHIEVEMENTS OF STRATEGIC OBJECTIVES AND ORGANIZATION-WIDE EXPECTED RESULTS

For each strategic objective, the following report provides the key highlights of the progress made by, and achievements of, Member States, particularly those to which the Secretariat was expected to provide technical assistance. The outcome of the overall assessment of each Organization-wide expected result was appraised as fully or partly achieved, and the main achievements of the Secretariat in delivering the Organization-wide expected results were summarized. For each strategic objective, the report analyses the financial implementation and highlights the success factors and significant impediments, lessons learnt and way forward.

These summary reports were prepared on the basis of comprehensive reports submitted by the 13 strategic objective teams. A full report is in preparation;¹ it provides further details, particularly of the achievement of results at country level, key deliverables, and the priority areas designated for technical assistance during the biennium. Most importantly, it captures how the work relates to the indicators laid down in the Medium-term strategic plan 2008–2013.

¹ Document WHO/PRP/10.1, in press.

STRATEGIC OBJECTIVE 1

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

The pandemic (H1N1) 2009 dominated the Organization’s activities and led to the fine tuning of national preparedness plans across all Member States and the establishment of national rapid response teams, including at subnational level. Member States and the Secretariat responded by collaborating more closely in accordance with the International Health Regulations (2005), and by stepping up information sharing, consultation and decision-making. From the replies submitted by 119 Member States to the Secretariat’s 2008 and 2009 questionnaires on the Regulations, it appeared that cross-sectoral links continued to be created, and that awareness of their requirements was increasing among health-sector personnel. By the end of 2009, contributions from Member States and other donors, through the pandemic vaccine development initiative, allowed WHO to establish a logistical and legal framework to provide 95 developing countries with access to vaccines against infection with pandemic influenza A (H1N1) 2009 virus.

The positive trends in global vaccination coverage continued, with an estimated global coverage of 82% in 2009. Approximately five million deaths in all age groups were averted by immunization during the biennium. During 2000–2008, measles deaths worldwide fell by 78% from an estimated 733 000 deaths in 2000 to 164 000 in 2008. By late 2008, pneumococcal and rotavirus vaccines had been introduced in 31 and 19 Member States respectively.

Despite continuing indigenous wild poliovirus transmission in Afghanistan, India, Nigeria and Pakistan, progress was made towards eradication in these four countries. The recurrent re-introduction or persistence of the viruses in 19 countries that had previously been free of poliomyelitis further complicated the situation.

WHO’s work in controlling neglected tropical diseases, including leprosy, human African trypanosomiasis and onchocerciasis, attracted wider attention and recognition as a result of regional plans associated with the Global Plan to Combat Neglected Tropical Diseases 2008–2015. Dracunculiasis is on the verge of eradication.

Countries were increasingly leading research through networks such as the African network for drugs and diagnostics innovation. Four regional reference research training centres were established in Colombia, Indonesia, Kazakhstan and Rwanda. The high-level political commitment demonstrated at the Ministerial Conference on Research for Health in the African Region, held in Algiers, 23–26 June 2008 and the Global Ministerial Forum on Research for Health, held in Bamako, 17–19 November 2008, served to raise the priority given to health research.

ASSESSMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

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

Fully achieved (6)						Partly achieved (2)	

1.1	<p>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.</p> <p><i>Partly achieved</i></p> <p>Support from WHO and other partners in the GAVI Alliance resulted in a marked increase in global vaccination coverage. Support for carrying out routine immunization was centred on supporting countries to address gaps or setbacks in coverage, particularly in the African and South-East Asia regions, where inadequate delivery systems restrict access to vaccination, and lack of capacity for planning and service delivery at operational level compromise primary health care renewal efforts. WHO facilitated decision-making on the use of new vaccines in eligible developing countries and assisted initial adopters of pneumococcal and rotavirus vaccines in planning their introduction. In 2009, WHO recommended the inclusion of rotavirus vaccination in all national programmes across the regions. However, the price of new vaccines limits their introduction in low- and middle-income countries. Partnerships, bilateral agencies, private companies and civil society organizations contributed to increasing social mobilization and advocacy and improving quality assurance in immunization programmes.</p>
1.2	<p>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.</p> <p><i>Partly achieved</i></p> <p>As a result of persistent endemic poliovirus transmission in the four remaining poliomyelitis-endemic countries, namely, Afghanistan, India, Nigeria and Pakistan, and further international spread from these areas and new secondary poliovirus reservoirs in Angola, Chad, Democratic Republic of the Congo and Sudan, the timeline for eventual certification, containment and oral poliomyelitis vaccine cessation activities was delayed by at least 12 to 24 months. In response to the serious poliomyelitis epidemiological situation that pertained in mid-2008, and resolution WHA61.1 requesting the Director-General to develop a new strategy for poliomyelitis eradication, WHO and the Global Polio Eradication Initiative partners suspended the multi-year, medium-term strategic plan and replaced it with the one-year, three-part Global Polio Eradication Initiative Programme of Work 2009 designed to rapidly pilot and assess new approaches for providing oral poliomyelitis vaccine to more children in each of the four remaining endemic disease areas, develop and evaluate new vaccine formulations and delivery routes, and independently assess the major barriers to completing the interruption of wild poliovirus transmission globally. In addition, vigorous outbreak control measures were implemented across the 19 re-infected countries. Consequently, at a special consultation of the Advisory Committee on Polio Eradication, convened by WHO in November 2009, and attended by implementing Member States and partners, it was acknowledged that major breakthroughs in the tools and operational approaches for completing poliomyelitis eradication warranted the formulation and implementation of a new Global Polio Eradication Initiative Strategic Plan 2010–2012 in order to interrupt remaining wild poliovirus transmission globally.</p> <p>Despite these positive developments and even though the target number of Member States was met for both indicators, the overall expected result was assessed as partly achieved because by late 2009 the results had not been fully attained in the two regions with the highest incidence of poliomyelitis cases.</p>

1.3	<p>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.</p> <p><i>Fully achieved</i></p> <p>The Global Plan to Combat Neglected Tropical Diseases 2008–2015 was endorsed by all technical agencies and affected countries and it has served to attract international recognition of the public health implications of these diseases. WHO prepared a report evaluating countries' experiences of integrated preventive chemotherapy, including approaches for scaling up interventions. A framework for mobilizing resources for controlling neglected tropical diseases was designed and implemented, and support was provided to disease-endemic countries in order to build up the global reference database on the subject. Actions targeted at specific diseases included: strengthening surveillance in dracunculiasis-free areas and supporting certification; consolidating leprosy elimination and preparing subnational and district level elimination plans; evaluating existing tools and strategies for leishmaniasis surveillance and control for closer harmonization of policies; developing new diagnostic tools for human African trypanosomiasis through collaboration with the Foundation for Innovative New Diagnostics (FIND); devising a WHO global information and surveillance system for Chagas disease and the launch of the five-year WHO global network for Chagas disease; assessing Buruli ulcer national programmes in five West African countries; drawing up a global strategic action plan for integrated vector management in collaboration with key partners; and supporting the preparation of national plans for the sound management of pesticides in 10 priority countries in different regions. A donation of praziquantel enabled WHO to support the use of preventive chemotherapy in the treatment of schistosomiasis in highly disease-endemic countries in Africa. In the Region of the Americas, WHO control initiatives helped to reduce the number of cases of rabies in humans and dogs and created conditions for eliminating human rabies transmitted by dogs within a short time frame.</p>
1.4	<p>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.</p> <p><i>Fully achieved</i></p> <p>A global sentinel surveillance network for rotavirus and invasive bacterial diseases to monitor the impact of <i>Haemophilus influenzae</i> type b (Hib), pneumococcal and meningococcal vaccines was launched in 2009 and will provide national decision-makers with crucial information. With its partners, WHO released new <i>Haemophilus influenzae</i> type b (Hib) and pneumococcal disease burden estimates for children under the age of five. The global measles and rubella laboratory network was expanded to include 678 laboratories serving 164 Member States. In countries experiencing emergency, communicable diseases surveillance and response was strengthened, through adapted technical guidance and risk assessment, field support, contingency planning, training, and the provision of supplies and financial assistance. Support was provided to countries for specific initiatives: in the African Region for measles case-based surveillance with laboratory confirmation; in the Region of the Americas for disease surveillance protocols and tools; in the Eastern Mediterranean Region for training in surveillance and outbreak response; in the European Region for a regional surveillance platform for influenza; in the South-East Asia Region for hospital preparedness in infection control and for laboratory infrastructure strengthening; and in the Western Pacific Region for surveillance and monitoring of communicable diseases of public health importance.</p>

1.5	<p>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.</p> <p><i>Fully achieved</i></p> <p>Six new or improved tools and implementation strategies with WHO input were introduced in at least one developing country. The inclusion in the WHO Bulk Procurement Scheme of three new dengue diagnostic tests, obtained at negotiated prices, allowed many countries to detect and monitor dengue outbreaks more effectively. Information gleaned through a multi-country study enabled countries to make decisions on the optimum praziquantel dosage for schistosomiasis treatment. Research supported by WHO demonstrated the feasibility of onchocerciasis elimination in some disease-endemic areas of Africa and will inform the development of elimination strategies. A meningitis A conjugate vaccine, developed jointly by WHO and the Program for Appropriate Technology in Health (PATH) was registered in 2009, paving the way for its introduction in the African Meningitis Belt in 2010. A total of 11 vaccine manufacturers from developing countries were given seed grants and technical assistance to produce influenza vaccines. A target product profile for new pneumococcal vaccines for developing countries was also adopted. In the African Region, national regulatory authorities in 19 countries endorsed common guidelines for the submission and review of vaccine clinical trials applications; in the Region of the Americas, a new tool, with a focus on “ecohealth”, to combat Chagas disease was validated; in the Eastern Mediterranean Region, an evaluation of four strategies, tools and/or public health policies produced evidence to support policy changes; and in the Western Pacific Region, progress was made in the preparation of a regional research action plan.</p>
1.6	<p>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.</p> <p><i>Fully achieved</i></p> <p>WHO developed materials addressing particular aspects of the International Health Regulations (2005), such as raising awareness, approaches to implementation, for example through regional strategies, laboratory system quality, dissemination of technical information and guidelines, including on management of pandemic (H1N1) 2009, through the IHR E-Library on the WHO web site, and adapting national legislation to facilitate implementation of the International Health Regulations (2005) by countries. In addition, the regional offices conducted intercountry workshops on implementation of the Regulations, and provided support for national assessments and action plans and regional surveillance initiatives, for example in the Caribbean, Indian Ocean and Mekong Basin. Collaboration has been strengthened with WHO Collaborating Centres, including United States Centers for Disease Control and the Pasteur Institutes, as well as with, inter alia, FAO, the International Maritime Organization, OIE, the World Tourism Organization and the European Centre for Disease Prevention and Control.</p>
1.7	<p>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.</p> <p><i>Fully achieved</i></p> <p>In response to pandemic (H1N1) 2009, WHO supported Member States in drawing up national preparedness plans and integrating rapid response teams in them, including at subnational level. In</p>

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	<p>all regions, laboratory capacity was expanded and technical networks, including the Global Influenza Surveillance Network, reinforced. WHO also supported influenza research globally and in specific affected countries, for example, on influenza H5N1 in Indonesia and pandemic influenza A (H1N1) 2009 virus in Thailand. WHO worked with UNICEF to highlight the crucial role of effective communications during emergencies, and with FAO and OIE to reinforce intersectoral collaboration for communicable disease control at the human/animal interface. During 2009, progress was made with initiatives to control and manage other serious communicable disease threats, including the Yellow Fever Initiative, the Meningitis Environment and Risk Information Technologies (MERIT) initiative, the Meningitis African Carriage Studies Project and the WHO Smallpox Vaccine Stockpile. Donations from the pharmaceutical industry enabled WHO to provide antiviral medicines to 72 developing countries within three weeks of the identification of the pandemic influenza A (H1N1) 2009 virus, and to replenish or enlarge the stocks. Donations from vaccine manufacturers and governments allowed WHO to begin implementing a large-scale pandemic vaccine deployment initiative to provide access to vaccines for low- and middle-income countries.</p>
1.8	<p>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.</p> <p><i>Fully achieved</i></p> <p>In response to pandemic (H1N1) 2009, WHO introduced the global event management system in all regional and some country offices, mainly in the African Region, the Region of the Americas and the European Region. In 2008–2009, WHO responded to all requests from Member States for support in controlling disease outbreaks, including cholera, Crimean-Congo haemorrhagic fever, dengue, ebola, hepatitis A, leptospirosis and norovirus, and supported the Global Outbreak Alert and Response Network. Communication channels and protocols were reinforced in accordance with the International Health Regulations (2005), and the capacity of national focal persons and WHO as a whole enhanced.</p>

SUMMARY OF FINANCIAL IMPLEMENTATION (US\$ thousand)

2008–2009	African Region	Region of the Americas	South-East Asia Region	European Region	Eastern Mediterranean Region	Western Pacific Region	WHO headquarters	Total
Approved budget	316 203	32 387	134 742	29 925	101 095	53 525	226 166	894 043
Funds available ¹	543 339	25 442	175 335	32 449	208 601	76 194	379 944	1 481 538
<i>Funds available as a % of approved budget</i>	<i>172%</i>	<i>79%</i>	<i>130%</i>	<i>108%</i>	<i>206%</i>	<i>142%</i>	<i>168%</i>	<i>166%</i>
Expenditure	485 905	20 923	127 430	26 094	171 038	50 999	353 693	1 236 082

¹ Includes US\$ 40 million, of which about 75% is for eradication of poliomyelitis, which has not yet been distributed to major offices.

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<i>Expenditure as a % of approved budget</i>	154%	65%	95%	87%	169%	95%	156%	138%
<i>Expenditure as % of funds available</i>	89%	82%	73%	80%	82%	67%	93%	83%

The total approved budget for the strategic objective was US\$ 894 million, of which US\$ 626 million was for Base programmes, US\$ 237 million for Partnerships and collaborative arrangements and US\$ 31 million for Outbreak and crisis response.

Of the approved budget, US\$ 1482 million (166%) were made available through assessed and voluntary contributions. About US\$ 620 million was for Base programmes and US\$ 780 million for Partnerships and collaborative arrangements. Approximately 74% of the funds available for Partnerships and collaborative arrangements was for the Global Polio Eradication Initiative and the balance for other partnerships, in particular, the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases.

Of the available funds, US\$ 1236 million (83%) were implemented during the biennium. About US\$ 473 million were for Base programmes, US\$ 624 million for Partnerships and collaborative arrangements and US\$ 138 million for Outbreak and crisis response. The budget for outbreak and crisis response was estimated at the beginning of the biennium and increased as needs arose. The funding and expenditure for this segment includes significant in-kind contributions of medicines against infection with pandemic influenza A (H1N1) 2009 virus.

LESSONS LEARNT AND KEY CHALLENGES

Although overall progress was made in increasing routine immunization coverage, global figures conceal persisting gaps and even setbacks in many countries, particularly in the African and South-East Asia regions. Weak delivery systems are a major impediment to sustaining and accelerating the progress made, for example, in measles control and elimination. Planning and service delivery needed strengthening at operational level in line with the renewed interest in primary health care. National commitment and ownership were key elements in achieving immunization goals. Joint planning and coordination between headquarters and regional and country offices, including integration with other WHO programmes, greatly facilitated the implementation of activities.

The Global Polio Eradication Initiative Strategic Plan 2010–2012 builds on the lessons learnt during 20 years of poliomyelitis eradication. Of these, four are essential for completing eradication: an awareness that wild poliovirus transmission can persist in smaller geographical areas and population subgroups than previously thought, requiring the development and implementation of new area- and issue-specific plans; the apparent predictability of the national and international spread of wild polioviruses, following known migration routes and exploiting weaknesses in health systems, facilitating prevention activities; the evolving epidemiology of poliomyelitis, supported by mathematical modelling, demonstrates that the population immunity thresholds needed to interrupt wild poliovirus transmission differ between the remaining infected areas – they are higher in Asia than Africa – facilitating the adaptation of strategies in accordance with local circumstances; and that although monovalent oral poliovirus vaccines have provided the Global Polio Eradication Initiative with more powerful tools for rapidly building population immunity, optimizing their balance has proved more difficult than anticipated, which has led to alternating outbreaks of type 1 and 3 poliovirus in certain settings and prompted the fast-track development of a new “bivalent” oral poliovirus vaccine. These four elements have directly influenced the way in which the Strategic Plan 2010–2012 has been tailored to meet geographical requirements and to employ common operational methods, thereby providing a multi-pronged approach to addressing longstanding barriers to completing eradication. Key challenges will be to ensure funding for the Strategic Plan, the

availability of suitable tools and reaching children in areas affected by conflict and/or insufficient programme management capacity.

A marked increase in financial resources and production of new tools for treating infectious diseases in developing countries over past decades has not been matched by a corresponding increase in funding for WHO, thus constraining its ability to meet the demand for support for research and development. A high funding implementation level created additional challenges: for example, funds and written pledges or agreements, upon which funds may be drawn, for the Special Programme for Training and Research in Tropical Diseases sometimes arrive later than anticipated. A stronger link between receipt of funds and contract disbursements and other expenditure is required in order to improve financial and cash flow management. The negotiation of multi-year funding agreements contributes to alleviating the problem. A new collaborative framework will improve coordination between the Special Programme and regional offices.

There has been a growing recognition, due in part to the progress made in treating Chagas disease, lymphatic filariasis, schistosomiasis and trachoma, that interventions to control neglected tropical diseases can improve the lives of millions of people and at a lower cost than those required to treat many other infectious diseases. Such interventions, which depend on donor support and donations from industry, must be underpinned by efficient administrative procedures.

Capacity for managing acute public health emergencies requires reinforcing through investment in systems and human resources, as well as the establishment of joint operations centres. Recent experiences have highlighted the difficulty of integrating all three WHO levels in epidemic alert and response activities and public health emergency management. Full implementation of the International Health Regulations (2005) will require a clearer Organization-wide strategy for building an integrated alert and response capability encompassing international collaboration, rapid, timely and transparent sharing of critical information, preparedness plans and exercises, and appropriate risk communication. The lessons learnt from pandemic (H1N1) 2009 and the consequent revision of pandemic preparedness plans and processes will further strengthen WHO's knowledge base and response capacity. In the Region of the Americas, 70% of events covered by the Regulations involved zoonoses, diseases affecting humans and animals and food safety issues, emphasizing the importance of intersectoral coordination at the human/animal interface.

STRATEGIC OBJECTIVE 2

To combat HIV/AIDS, tuberculosis and malaria

Member States facing a high burden of HIV, tuberculosis and/or malaria have made progress in tackling the diseases by focusing on medium-term plans linked to the targets of the Millennium Development Goals, and responding to the specific needs of at-risk and highly vulnerable populations, including women, children, the very poor and marginalized groups. Innovation, increased financing and technical assistance, and closer collaboration among global partners have contributed to the result. Efforts were stepped up to measure, and respond to emerging drug-resistance. However, major challenges remain to expanding universal access to care, including weak health systems, uneven political commitment and resources constraints.

By late 2008, antiretroviral therapy had been made available to more than four million people across Member States. Emphasis was placed on strengthening health systems to effectively deliver HIV programmes by addressing, inter alia, human resources capacity, information systems for managing procurement and supply of HIV-related medicines and diagnostics, laboratory diagnostic capacity for HIV and tuberculosis, and treatment monitoring and prevention of mother-to-child transmission of HIV. Coverage of the latter in low- and middle-income countries increased from 35% in 2007 to 45% in 2008; HIV prevention methods for most at-risk populations, inter alia, through expansion of male circumcision programmes, were promoted in 13 high-burden countries in sub-Saharan Africa.

All regions saw a slow decline in tuberculosis incidence such that the relevant target in Millennium Development Goal 6 has effectively been met and the world is on track to sustain the decline. DOTS services and application of the Stop TB Strategy were expanded worldwide. Between 1995 and late 2008, 36 million people were cured through DOTS treatment and over 6 million lives have been saved. By late 2008, 22% of tuberculosis patients had been tested for HIV, and the 32% who tested positive received antiretroviral therapy. However, only an estimated 3% of multidrug-resistant tuberculosis cases annually are known to be receiving quality care. Extensively drug-resistant tuberculosis was reported in 58 countries. A major shift in policies on universal health-care coverage is, therefore, urgently needed in order to increase access to modern diagnostics and proper treatment, and to improve drug quality regulation and promote rational use within strengthened health systems.

International commitment to funding malaria control increased. Member States also scaled up their response by distributing long-lasting insecticide-treated bednets, and, to some extent, rapid diagnostics tests and artemisinin based combination therapy. Implementation and its impact have been greatest in less populated countries with high per capita investment in malaria elimination. Strong political support for elimination from countries with low endemicity was emerging, triggered by evidence showing the link between malaria and slower development. Innovation and improved technologies have been the subject of greater attention and strategic interest, triggered by investments by the Bill & Melinda Gates Foundation, and positive experiences with public private partnerships, such as the Medicines for Malaria Venture, FIND and the Innovative Vector Control Consortium.

ASSESSMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

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

Fully achieved (3)			Partly achieved (3)		

2.1	<p>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.</p> <p><i>Partly achieved</i></p> <p>WHO produced guidelines and tools to support countries to scale up priority HIV/AIDS interventions, including antiretroviral therapy for adults, adolescents and infants. The guidelines were adapted to accommodate all regions. Support was provided to countries to prioritize their interventions on the basis of evidence and scale up their HIV responses accordingly, for example, between 2007 and 2008, in the African Region, there was an increase of 51% in the number of health facilities providing antiretroviral therapy and treatment coverage rose from 33% to 44%.</p> <p>The International Standards for Tuberculosis Care and the WHO infection control policy were updated, and the Stop TB Strategy was enhanced, particularly the components dealing with case detection, vulnerable populations, social determinants, involvement of all care providers and communities, and universal access to care regardless of the type of tuberculosis. The regional offices adapted tuberculosis/HIV guidelines to suit specific regional conditions. WHO jointly organized a meeting of ministers from countries with high burdens of multidrug-resistant and extensively drug-resistant tuberculosis, held in Beijing on 1–3 April 2009.</p> <p>New or updated policy recommendations and guidelines contributed to the adoption of treatment policies in all disease-endemic countries, and a significant increase in coverage with insecticide-treated bednets, resulting in a 50% decrease in malaria cases in more than one third of them. Global policy guidance and technical guidelines for malaria elimination led to the formulation of regional and intercountry policies and guidelines on malaria elimination in Southern African Development Community countries, and in the Eastern Mediterranean, European and Western Pacific Regions. The Regional Committees for Africa and the Western Pacific endorsed plans for accelerated malaria control and elimination. Consultations were taking place with partners to develop a regional strategic plan for malaria in the Americas 2011–2015. The Regional Offices for South-East Asia and the Western Pacific, supported by headquarters, made progress in preparing a strategy to detect and contain artemisinin resistance.</p>
2.2	<p>Policy and technical support provided to countries towards expanded gender-sensitive delivery of prevention, treatment and care interventions for HIV/AIDS, tuberculosis and malaria, including integrated training and service delivery; wider service-provider networks; and strengthened laboratory capacities and better linkages with other health services, such as those for sexual and reproductive health, maternal, newborn and child health, sexually transmitted infections, nutrition, drug-dependence treatment services, respiratory care, neglected diseases and environmental health.</p> <p><i>Partly achieved</i></p> <p>Knowledge hubs for HIV/AIDS surveillance, prevention, care and treatment in the African, Eastern Mediterranean and European regions were supported to increase their capacity to provide training and technical assistance; to scale up the prevention of mother-to-child transmission in 11 countries; and to secure increased commitment to nutrition and HIV/AIDS interventions, including through a regional consultation for 21 African countries. A total of eight countries, including Cambodia, China, and Fiji, received guidance and technical support for, inter alia, quality laboratory testing for HIV and sexually transmitted diseases, and the prevention and treatment of sexually transmitted diseases. The Regional Office for the Americas launched an elimination initiative to prevent mother-to-child transmission of HIV and congenital syphilis. A regional consultation on HIV testing and counselling policies was held in the Eastern Mediterranean Region. Partnerships have been established at all levels and meetings held in five regions to implement the Global Strategy for the Prevention and Control of Sexually Transmitted Infections.</p>

	<p>Through the TB Technical Assistance Mechanism, headquarters and regional offices coordinated technical support for a wide range of partners. Efforts were focused on revising and updating national strategic plans in high-burden countries; expanding laboratory network capacity, including external quality assurance mechanisms; access to drug-susceptibility testing; enhanced tools; and multidrug-resistant tuberculosis and tuberculosis/HIV interventions. WHO as a whole provided robust support to Member States in accessing new resources, particularly through the Global Fund to fight AIDS, Tuberculosis and Malaria, for expanded tuberculosis care and control, and resources for tuberculosis control almost doubled.</p> <p>The strong support provided by regional malaria units for country programmes that address the growing demand for technical support has resulted in increased coverage of most-in-need populations, in line with WHO guidelines and recommendations. Regional offices, supported by headquarters, pioneered ways of gearing up support for responses to drug resistance and laboratory strengthening, especially through enhanced laboratory quality assurance. The new regional action plan in the Western Pacific Region is leading the field in malaria elimination. The UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases and the Regional Office for Africa are building countries' capacity to define priority research topics, develop appropriate research proposals and conduct research to resolve implementation challenges. Coordination of the Regional Strategic Plan for Malaria in the Americas (2006–2010) with the Gender, Ethnicity and Health Unit activities led to the integration of a gender, ethnicity and health perspective in malaria work in the Region. Gender and ethnicity are among the cross-cutting issues being promoted in the Regional Strategic Plan for Malaria in the Americas 2011–2015.</p> <p>Collaboration between HIV, malaria and tuberculosis was intensified, especially through technical cooperation with Member States to leverage new resources for these diseases.</p>
2.3	<p>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.</p> <p><i>Fully achieved</i></p> <p>In the African Region, 30 countries received support to strengthen their procurement and supply management systems, and access to affordable HIV/AIDS medicines has increased as a result. In the Region of the Americas, 19 countries were supported to procure medicines through PAHO's Strategic Fund. WHO Collaborating Centres in the Western Pacific Region provided laboratory support to ensure quality HIV rapid test strategies. WHO promoted equitable access to essential medicines through demand forecasts, price reports and newsletters, indicators, updates and a revised handbook on procurement and supply management. Training workshops on quality assured screening of donated blood for transfusion-transmissible infections were conducted in 11 countries in the African Region and 13 in the South-East Asia and Western Pacific regions.</p> <p>WHO, as a whole, worked with the Stop TB Partnership Global Drug Facility, the Green Light Committee Mechanism and Member States to attract support for expanded access to affordable, quality-assured first and second-line medicines against tuberculosis, as well as to ensure their timely delivery through more efficient supply cycles. To date, 110 countries have been served by the Global Drug Facility and projects in 67 countries have received support from the Green Light Committee Mechanism. Regional and country offices conducted workshops on rational pharmaceutical management for drug-resistant tuberculosis, in line with the revision of the WHO tuberculosis treatment guidelines, expansion of drug resistance surveillance, scaling up treatment for tuberculosis and multidrug-resistant tuberculosis, and encouraging providers to adhere to the</p>

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	<p>International Standards of Tuberculosis Care and use medicines safely and effectively.</p> <p>Progress was made in monitoring the quality of antimalarial medicines and combating counterfeit products. Standards and procedures were developed for quality assurance and control of commodities and services, as well as manuals on case management and indoor residual spraying, and guidelines and training materials for strengthening malaria microscopy and rapid diagnostic tests. Monitoring the quality of antimalarial drugs in the Greater Mekong Subregion, with support from partners and activities coordinated by the Regional Office for the Western Pacific highlighted the importance of combating counterfeit and substandard antimalarial medicines. WHO provided support to most malaria-endemic countries to procure quality antimalaria medicines and commodities. The Global Malaria Programme continued to promote the phasing out of artemisinin monotherapies with the end goal being a total ban.</p>
<p>2.4</p>	<p>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.</p> <p><i>Fully achieved</i></p> <p>WHO continued to monitor and report on the global HIV epidemic and the health sector's response.^{1,2} It also developed a monitoring and reporting tool with UNICEF and UNAIDS. In the African Region, HIV/AIDS surveillance protocols were reviewed in 18 countries and 13 national HIV/AIDS programmes were revised accordingly. In the Western Pacific Region, nine countries have surveillance systems incorporating WHO recommendations. In the South-East Asia Region, 10 countries have national monitoring and evaluation plans and regularly report on health-sector progress in that area. HIV drug resistance monitoring was improved through the accreditation of 24 laboratories and the strengthening of laboratory capacity.</p> <p>Up-to-date data on the global tuberculosis epidemic and on progress in tuberculosis control was published in annual reports.^{3,4} The WHO global task force on tuberculosis impact measurement issued recommendations on measuring the disease burden up to 2015. A tuberculosis planning and budgeting tool has been promoted in all regions, and resource tracking has been further enhanced. More than 100 countries with 94% of global tuberculosis cases reported financial data in 2009.</p> <p>As a result of enhanced surveillance in countries, the first report of artemisinin resistance was released. Publication by WHO of the <i>World malaria reports</i> in 2008 and 2009 established a system of annual updates, including global financial flows for malaria control.</p>

¹ *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector: progress report 2008.* Geneva, World Health Organization, 2008.

² *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector: progress report 2009.* Geneva, World Health Organization, 2009.

³ *Global tuberculosis control: surveillance, planning, financing: WHO report 2008.* Geneva World Health Organization, 2008.

⁴ *Global tuberculosis control: epidemiology, strategy, financing: WHO report 2009.* Geneva, World Health Organization, 2009.

2.5	<p>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.</p> <p><i>Partly achieved</i></p> <p>Strategic global partnerships were reinforced through improved advocacy and communication, for example, the publication of two reports on universal access to HIV/AIDS prevention, treatment and care,^{1,2} and through increased funding for HIV/AIDS prevention and control activities. The Regional Office for Africa prepared a guidance document on partnerships and mobilizing resources; in the Western Pacific Region, partnerships with key players involved in HIV treatment and prevention were enhanced through their active participation in regional task forces.</p> <p>Membership of the Stop TB Partnership grew to 1100 partners, and the number of national Stop TB partnerships doubled to reach 25. There is strong demand for a Stop TB civil society grant facility and a new grant mechanism, TB REACH, hosted by the Partnership will support innovations for full case detection, especially in low-income countries and among vulnerable groups. Support for advocacy and wider collaboration was stepped up and ministerial discussions were held on adopting a coordinated approach to addressing the growing threat posed by multidrug-resistant tuberculosis.</p> <p>Global advocacy on the harm caused by malaria and efforts to increase resources to control it were supported and standards updated. Although financial commitments for malaria control exceeded US\$ 1400 million in 2009, global funding falls far short of the US\$ 5000–6000 million a year needed to fully utilize the existing tools. All regional offices celebrated World Malaria Day, which elicited a notable response, particularly in disease-endemic populations. They were also working with Roll Back Malaria partners and the United Nations Secretary-General’s Special Envoy for Malaria.</p> <p>In all regions, WHO endeavoured to support the development of Global Fund proposals, facilitate bilateral agreements and form partnerships.</p>
2.6	<p>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.</p> <p><i>Fully achieved</i></p> <p>WHO developed and tested approaches to informing young men about male circumcision and to providing psychosocial support for young people living with HIV. In the African Region, protocols and tools for assessing the quality of care were finalized. In the Western Pacific Region, research resulted in improved HIV testing strategies. In the Eastern Mediterranean Region, eight teams of researchers were supported to carry out operational and epidemiological research into HIV. In the South-East Asia Region, WHO worked with national AIDS programmes to define an HIV/AIDS research agenda, and in the Region of the Americas, studies comparing AIDS case definitions were conducted. At an expert consultation organized jointly by WHO, in collaboration with UNAIDS, the</p>

¹ *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector: progress report 2008.* Geneva, World Health Organization, 2008.

² *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector: progress report 2009.* Geneva, World Health Organization, 2009.

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	<p>Global HIV Vaccine Enterprise and the Africa Regional Nutrition Strategy, a document was produced that has helped national regulatory authorities to make decisions about recent large-scale HIV vaccine trials, particularly those conducted in developing countries.</p> <p>WHO supported the Stop TB Partnership’s Research Movement and the updating of the Global Plan to Stop TB 2006–2015. A disease reference group on tuberculosis was established by the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases in collaboration with the Stop TB Partnership to define research priorities. Multi-country trial studies on shortening and simplifying tuberculosis treatment also received WHO support. A protocol on laboratory assays for use in tuberculosis vaccine clinical trials, jointly developed by WHO, is being implemented in Africa, Europe and the United States.</p> <p>The results of the first comprehensive evaluation of market rapid test diagnostics were guiding WHO’s procurement services and decision-making for malaria diagnostics. WHO conducted a scientific consultation in Senegal in 2009 in order to provide consensus-based recommendations on whole-organism malaria vaccine research for endemic countries. A guidance document on clinical evaluation of <i>P. vivax</i> vaccines in endemic populations was also published. A multi-country evaluation project to measure the impact of community case management of malaria, pneumonia and diarrhoea on childhood mortality was launched in Cameroon, Democratic Republic of the Congo and Malawi. WHO continued to accelerate the production of vaccines against malaria. A landscape exercise on the current players in safety, real-life effectiveness and access to antimalarial medicines, including themes, geographical distribution and gaps, was completed in 2009.</p>
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SUMMARY OF FINANCIAL IMPLEMENTATION (US\$ thousand)

2008–2009	African Region	Region of the Americas	South-East Asia Region	European Region	Eastern Mediterranean Region	Western Pacific Region	WHO headquarters	Total
Approved budget	242 912	48 673	80 979	35 926	53 769	59 332	185 341	706 932
Funds available ¹	126 495	16 527	84 322	27 267	66 065	57 447	265 343	644 637
<i>Funds available as % of approved budget</i>	<i>52%</i>	<i>34%</i>	<i>104%</i>	<i>76%</i>	<i>123%</i>	<i>97%</i>	<i>143%</i>	<i>91%</i>
Expenditure	109 780	14 463	66 961	23 057	50 019	38 205	184 849	487 335
<i>Expenditure as % of approved budget</i>	<i>45%</i>	<i>30%</i>	<i>83%</i>	<i>64%</i>	<i>93%</i>	<i>64%</i>	<i>100%</i>	<i>69%</i>
<i>Expenditure as % of funds available</i>	<i>87%</i>	<i>88%</i>	<i>79%</i>	<i>85%</i>	<i>76%</i>	<i>67%</i>	<i>70%</i>	<i>76%</i>

¹ Includes US\$ 1.2 million, which has not yet been distributed to major offices.

The total approved budget for the strategic objective was US\$ 707 million, of which US\$ 635 million was for Base programmes and US\$ 72 million for Partnerships and collaborative arrangements. Of the approved budget, US\$ 645 million (91%) were made available through assessed and voluntary contributions. A total of US\$ 525 million was for Base programmes and US\$ 119 million were for Partnerships and collaborative arrangements. The increase in available funds for Partnerships and collaborative arrangements was mainly because the budget approved by the Joint Coordinating Board of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases was higher than had been anticipated at the time WHO submitted the budget. Subsequently, the Special Programme raised an additional US\$ 109 million to implement the budget approved by the Joint Coordinating Board.

The higher-than-expected level of funding received compared to the budget allocations for headquarters and the Eastern Mediterranean Region was mainly because some of the funds were for multi-year implementation rather than for 2008–2009 as shown. For example, US\$ 12 million pledged by USAID and US\$ 3.5 million from miscellaneous donors were received in late 2009 and can only be utilized in 2010–2011. Other funds were also raised in 2008–2009 for multi-year projects, but the amounts could not be broken down annually. The resources are raised for current biennium requirements and a part is retained to cover the beginning of the next biennium, particularly staff costs and continuing activities. However, resource mobilization remains a challenge across the Organization, with the biggest gap between resources received and planned budget being in the African Region. A total of 64% of the resources for the strategic objective are strictly earmarked: 36% is medium flexible, despite being designated for particular regions, countries and major offices, but it cannot be transferred between offices. Raising sufficient funds to implement the budget of US\$ 243 million, amounting to 34% of the budget for the strategic objective, in the African Region posed the greatest challenge.

Of the available funds, US\$ 487 million (76%) were implemented during the biennium. A total of US\$ 402 million was for Base programmes and US\$ 85 million were for Partnerships and collaborative arrangements. Lower than expected implementation compared to funds received for Base programmes in headquarters and the Western Pacific Region was primarily due to multi-year pledges recorded in 2008–2009.

LESSONS LEARNT AND KEY CHALLENGES

Strong, sustained political commitment, firm stakeholder partnerships and coordination of technical support across WHO have been key success factors in achieving the strategic objective. The engagement of a wide range of scientific experts and other stakeholders in policy development has contributed to building consensus and ownership of policies, strategies and tools. Ensuring synergies and complementarity among the increasingly diverse array of partners involved in fighting the three diseases was a continual challenge. WHO's active support for countries in their efforts to leverage funding from global mechanisms for combating HIV/AIDS, tuberculosis and malaria has resulted in increased resources and a corresponding surge in demand for technical assistance. However, the increases in funding were not always matched by adequate human resources capacity in WHO, which tended to affect its core work and shift the balance between earmarked projects and supporting Member States to carry out priority work. Hence, support needed to be better aligned with core function. The demand for technical assistance would require more careful prioritization and identification of areas for particular emphasis, such as, empowering country offices and building their capacity, particularly in human resources, increasing investment in countries' routine health information systems to track progress in implementation of interventions, monitoring drug and insecticide resistance and assessing the impact of interventions, guaranteeing standards of care and the quality of commodities, and collaborating with health services and systems to develop an integrated response and a primary health care approach. In this context, the unpredictability and earmarking of funds represent the principal obstacles to targeting technical support to meet Member States' priorities, particularly where WHO country offices are responsible for large-scale procurement and significant implementation support.

STRATEGIC OBJECTIVE 3

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

The commitment of Member States was demonstrated by the adoption of resolution WHA61.14 on prevention and control of noncommunicable diseases: implementation of the global strategy, and resolution WHA62.1 on prevention of avoidable blindness and visual impairment, as well as numerous regional committee resolutions, for example, on road traffic injury prevention in the Eastern Mediterranean Region,¹ on a regional cancer control strategy in the African Region,² and on a regional noncommunicable diseases prevention plan in the Western Pacific Region,³ and of a regional Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment in the Region of the Americas.⁴ A regional framework for injury prevention in the Western Pacific Region was agreed and an assessment of the progress made in implementing a resolution on the prevention of injuries in the European Region completed.⁵ The First Global Ministerial Conference on Road Safety, held in Moscow on 19 and 20 November 2009, resulted in the adoption of the Moscow Declaration, which identified good practices and emphasized the need to strengthen policies worldwide. WHO’s mental health Gap Action Programme was launched to scale up health services for people suffering from mental, neurological and substance use disorders. WHO made progress in implementing the key actions included under the six objectives of the action plan adopted through resolution WHA61.14. Although more Member States appointed national focal persons and improved their health and social systems to better monitor and manage noncommunicable diseases and related health conditions, these are still not accorded high priority in many countries. Therefore, the technical capacity and resources of national focal persons and units need further strengthening. Gaps in health information systems should also be addressed in order to ensure correct prioritization and effective targeting of interventions in countries.

ASSESSMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

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

Fully achieved (4)				Partly achieved (2)	
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¹ Resolution EM/RC56/R.7.

² Resolution AFR/RC57/RT/1.

³ Resolution WPR/RC59.R5.

⁴ Resolution CD49.R11.

⁵ Resolution RC55/R9.

3.1	<p>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.</p> <p><i>Partly achieved</i></p> <p>Strengthening the capacity of focal points for injuries and violence prevention appointed in more than 100 Member States was a priority and support was provided through a global meeting held in 2008, regional network meetings and training workshops. The <i>World report on child injury prevention</i>¹ was published and a nongovernmental organization road safety network created. Regional and thematic consultations were held to prepare the draft <i>World report on disability and rehabilitation</i>. The mental health Gap Action Programme was launched to scale up health services for people suffering from mental, neurological and substance use disorders, especially in low- and middle-income countries, and it has proved effective in raising the profile of mental health and attracting more funding. Several key activities, including consultations and preparation of a monograph on links between noncommunicable diseases and injuries and development, were carried out in accordance with element 1 of the Global Strategy and Action Plan on Public Health, Innovation and Intellectual Property in order to raise the priority accorded to noncommunicable diseases and injuries in development work. Integrating the prevention of noncommunicable diseases and injuries into the development agenda was also the subject of two ministerial meetings organized in collaboration with the United Nations Department of Economic and Social Affairs and the High-Level Segment of the United Nations Economic and Social Council, held in Geneva, 6–9 July 2009. The International Conference on Diabetes and Associated Diseases, held in Port-Louis, Mauritius, 12–14 November 2009, adopted the Mauritius Call for Action. Additional blindness prevention activities at national level were implemented in collaboration with WHO-led international partnerships, including VISION 2020: The Right to Sight, and the Alliance for the Global Elimination of Blinding Trachoma by the year 2020.</p> <p>Although the target number of focal points or units for injuries and violence prevention, and for the prevention and control of noncommunicable diseases were met, the expected result was assessed as “partly achieved” because they do not all have dedicated budgets and staff.</p>
3.2	<p>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.</p> <p><i>Fully achieved</i></p> <p>Technical assistance provided by the Secretariat to Member States covered the preparation and implementation of: strategies and policies for violence and injury prevention and prevention and control of noncommunicable diseases; strategies and regulations to improve the life of people living with disabilities; and mental health policy and legislation based on human rights principles and best practice. With support from WHO, the first one-year International Diploma on Mental Health Law and Human Rights was launched in 2008. China and India received support to implement the Primary Ear and Hearing Care Training Resource, which was also introduced in Brazil, Burkina Faso, Indonesia, Nepal and Thailand in order to facilitate the preparation of national plans.</p>

¹ Peden M. et al., eds. *World report on child injury prevention*. Geneva, World Health Organization, 2008.

<p>3.3</p>	<p>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.</p> <p><i>Partly achieved</i></p> <p>Technical guidance on noncommunicable disease surveillance and its integration in national health information systems also covered core indicators for monitoring risk factors and mortality and assessing national capacity in Member States. WHO provided technical assistance and support to countries to strengthen systems and capacity for injuries and violence surveillance, including through regional training workshops. The preparation of the <i>Global status report on road safety</i>¹ and the second update of the World report on disability and rehabilitation led to a significant increase in the quantity and quality of the road safety and disability data available. Particular attention was paid to enhancing countries’ capacity in conducting surveys to generate more reliable estimates on mental health morbidity; the data was then used for planning and programme implementation, and for scaling up risk factor surveillance, including in the context of integrated noncommunicable diseases strategies. A global network to combat noncommunicable diseases was launched and the first planning meeting held in October 2009. As a result, there was a measurable increase in the engagement of stakeholders and in support for implementation of the action plan. A tool for assessing national capacity to tackle cancer is being validated.</p>
<p>3.4</p>	<p>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.</p> <p><i>Fully achieved</i></p> <p>An evaluation of the available evidence relating to the effectiveness of interventions for the priority conditions identified in the mental health Gap Action Programme resulted in recommendations for interventions in non-specialized health-care settings, particularly in low- and middle-income countries. A package of essential interventions for noncommunicable diseases was assembled, and feasibility studies for their integration in primary care were conducted in selected countries in the African, Eastern Mediterranean, European, South-East Asia and Western Pacific regions. In August 2008, researchers, international nongovernmental organizations, donor agencies and WHO Collaborating Centres discussed research priorities, mechanisms for strengthening research capacity in low- and middle-income countries and enhancing international collaboration for advancing a coordinated, coherent research agenda on the prevention and control of noncommunicable diseases. In collaboration with OECD, WHO published a working paper entitled, “Improving lifestyles, tackling obesity: the health and economic impact of prevention strategies”, and jointly with the United States Centers for Disease Control and Prevention, a manual for estimating the economic costs of injuries due to interpersonal and self-directed violence.²</p>

¹ *Global status report on road safety: time for action*. Geneva, World Health Organization, 2009.

² Butchart A. et al. *Manual for estimating the economic costs of injuries due to interpersonal and self-directed violence*. Geneva, World Health Organization, 2008.

3.5	<p>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.</p> <p><i>Fully achieved</i></p> <p>Within the framework of the 2009–2013 strategic plan for capacity building for violence and injury prevention, several new products were disseminated, including a compendium of evidence for effective violence prevention strategies; a plan for burn prevention and care; and road safety good practice manuals on seat-belts and child restraints, speed management and drink-driving. WHO's TEACH-VIP modular training curriculum on injury prevention and control was widely requested and several regional train-the-trainer sessions were organized; an on-line version of TEACH-VIP was produced to expand uptake. WHO's global mentoring programme for injury and violence prevention, MENTOR-VIP, matched 25 less experienced injury prevention practitioners from low- and middle-income countries with skilled mentors. The mental health Gap Action Programme was disseminated to Member States in preparation for its implementation in 2010–2011, and preparatory work was carried out in the African and Eastern Mediterranean regions. Of the 88 Member States that developed national blindness prevention plans aligned with WHO strategies for the prevention of visual impairment, 13 were supported in implementing the WHO SAFE strategy for trachoma control, and 25 in implementing the WHO strategy on community-directed treatment with ivermectin to eliminate onchocerciasis.</p>
3.6	<p>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.</p> <p><i>Fully achieved</i></p> <p>WHO updated the methods for conducting the third global survey on assessment of national capacity for noncommunicable diseases surveillance, the results of which will make a valuable contribution to the first global status report to be prepared in 2010. A framework for country-level action to address noncommunicable diseases was drafted based on the outcome of two expert meetings. WHO published guidelines for trauma quality improvement,¹ to complement existing guidelines on pre-hospital care systems and essential trauma care. The first Global Forum on Trauma Care, held in Rio de Janeiro, Brazil, on 28 and 29 October 2009, provided an opportunity for identifying affordable and sustainable improvements in trauma care services that could be applied globally. WHO also published a document on the provision of manual wheelchairs in less-resourced settings.² People with disabilities have begun to advocate for improved services based on the guidelines, and some donors have made funding conditional on their implementation. The WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) was promoted in countries and a report on mental health in primary care published. Support continued to be provided to countries in all regions for adopting integrated primary-health-care strategies for screening for cardiovascular risk and for the integrated management of noncommunicable diseases. A core set of effective and affordable interventions was identified for integrating major noncommunicable diseases into health systems in resource-constrained settings through a primary-health-care approach. Support was also provided to 37 Member States in all regions for the strengthening of eye-care systems, and to Brazil, China,</p>

¹ *Guidelines for trauma quality improvement*. Geneva, World Health Organization, 2009.

² *Guidelines on the provision of manual wheelchairs in less-resourced settings*. Geneva, World Health Organization, 2008.

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	India and Indonesia for hearing-care systems. Diagnostic criteria for myocardial infarction and diabetes were reviewed. Technical products, including training materials for health-system managers and health-care professionals, were delivered to support countries in implementing Article 14 of the WHO Framework Convention on Tobacco Control, and pilot studies were conducted in Brazil and Nepal to integrate tobacco-cessation services in tuberculosis control programmes.
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SUMMARY OF FINANCIAL IMPLEMENTATION (US\$ thousand)

2008–2009	African Region	Region of the Americas	South-East Asia Region	European Region	Eastern Mediterranean Region	Western Pacific Region	WHO headquarters	Total
Approved budget	20 723	9 848	17 679	15 909	19 808	21 735	52 402	158 104
Funds available	14 214	6 469	10 295	12 105	6 673	13 085	44 156	107 091
<i>Funds available as % of approved budget</i>	<i>69%</i>	<i>66%</i>	<i>58%</i>	<i>76%</i>	<i>34%</i>	<i>60%</i>	<i>84%</i>	<i>68%</i>
Expenditure	13 509	6 760	9 662	8 053	5 713	9 902	33 895	87 494
<i>Expenditure as % of approved budget</i>	<i>65%</i>	<i>69%</i>	<i>55%</i>	<i>51%</i>	<i>29%</i>	<i>46%</i>	<i>65%</i>	<i>55%</i>
<i>Expenditure as % of funds available</i>	<i>95%</i>	<i>105%</i>	<i>94%</i>	<i>67%</i>	<i>86%</i>	<i>76%</i>	<i>77%</i>	<i>82%</i>

The total approved budget for the strategic objective was US\$ 158 million, of which US\$ 107 million (68%) were made available through assessed and voluntary contributions. While donors' interest has increased in the areas covered by the strategic objective, in particular road safety and tobacco control, some, including chronic disease prevention, mental health, violence prevention and disability and rehabilitation, remain seriously underfunded. There were also insufficient resources available to fund country-level activities, which has resulted in a shortage of dedicated staff in country offices to deal with chronic diseases prevention, noncommunicable diseases, mental disorders, violence and injuries, and visual impairment. Consequently, capacity at regional and country levels is inadequate to meet Member States' requests for technical support.

Of the available funds, US\$ 87 million (82%) were implemented during the biennium.

LESSONS LEARNT AND KEY CHALLENGES

High-level attention and a clear political mandate, evidenced by World Health Assembly resolutions, ministerial declarations, regional committee resolutions and regional frameworks and networks, served to strengthen Member States' commitment to noncommunicable diseases, injury and violence prevention, disability and rehabilitation, and mental health. Greater awareness among health planners of the impact on public health of

these conditions has increased demand for technical assistance, while improved coordination of work across the Organization and clearly defined roles and responsibilities have contributed to the progress made. Integration of the work of the Tobacco Free Initiative in the Tuberculosis Programme has accelerated cessation of tobacco use.

The allocation of human and financial resources remains inadequate compared with the seriousness of the situation and the potential for action by WHO, particularly at regional- and country-office level. The lack of priority accorded to noncommunicable conditions by development agencies and donors is a major constraint for countries that need support to address these conditions. It has proved difficult to stimulate intersectoral action and involve non-health sectors and this has hampered prevention efforts. Gaps in health information systems inhibit evidence-based public-health decision-taking and effective targeting of interventions, and attention should be focused on ensuring implementation of evidence-based guidelines to improve health outcomes.

STRATEGIC OBJECTIVE 4

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

In order to achieve Millennium Development Goals 4 and 5, WHO worked more closely with UNFPA, UNICEF and the World Bank to secure funding and improve coherence in the 25 countries with the highest burden of maternal mortality. The “countdown to 2015” initiative contributed to efforts to track progress being made in increasing the coverage of interventions to reduce mortality in children under five years of age. A total of 16 of the 68 countries that account for more than 97% of maternal, newborn and child deaths globally are on track to reach Millennium Development Goal 4. Although progress towards achieving Millennium Development Goal 5 has been slower, since the beginning of the biennium the number of countries in the African Region where skilled attendants are present at more than 50% of births has increased from 21 to 28. The Integrated Management of Childhood Illness strategy has now been implemented in at least 75% of districts in 50 countries, and in five countries in the Eastern Mediterranean Region the strategy also includes child development and well-being. In the European Region, 35 Member States shared experiences and agreed on additional actions to strengthen health systems in order to improve the health of young people. Member States in the Region of the Americas adopted a regional strategy and action plan for improving adolescent health, and, in the Western Pacific Region, an adolescent health framework was developed. All countries in the South-East Asia Region and five in the Eastern Mediterranean Region have implemented strategies to achieve universal access to sexual and reproductive health interventions. Advances were made in promoting healthier ageing globally through the adoption by 28 Member States of active healthy ageing programmes.

ASSESSMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

Of the **eight Organization-wide expected results** for this strategic objective, three were “fully achieved” and five “partly achieved”.

Fully achieved (3)				Partly achieved (5)			

4.1	<p>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.</p> <p><i>Partly achieved</i></p> <p>In all regions, technical support for policy formulation and strategy development was provided to Member States, including for the preparation of road maps to accelerate the reduction of maternal and newborn mortality in 42 countries in the African Region. In the European Region, additional tools for implementation of the European strategy for child and adolescent health and development were prepared and employed by Member States. The target in Millennium Development Goal 5 on achieving universal access to reproductive health by 2015, and the principles enshrined in the WHO Global Reproductive Health Strategy, provided the impetus for revising or developing national reproductive health strategies.</p>
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4.2	<p>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.</p> <p><i>Fully achieved</i></p> <p>Support continued to be provided to a network of national research institutions, and new centres from all regions joined the network. Greater importance was given to building capacity in operational research and in conducting surveys that reflected countries' need for evidence to inform programme planning. New findings relating to, for example, the prevention and treatment of postpartum haemorrhage and antiretroviral treatment to reduce mother-to-child transmission of HIV during delivery and breastfeeding, were published and incorporated in clinical and programme guidelines. Implementation of the research outcomes guided programme design and support, such as new recommendations on treating diarrhoea in Mali, and new approaches for scaling up sexual and reproductive health services.</p>
4.3	<p>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.</p> <p><i>Partly achieved</i></p> <p>Support was provided to more than 74 countries for policy formulation, strategy development, programme implementation and monitoring of progress. WHO collaborated with eight Member States in the African Region and the Region of the Americas to implement a programme supported jointly by the European Commission and the African, Caribbean and Pacific Group of States.</p> <p>Human resources projection tools for supporting countries to prepare plans for maternal and newborn health-care services were developed. Further support was provided for enhancing the skills of health-care providers in managing normal and emergency pregnancy, childbirth, the postpartum period, newborn care, and in improving the quality of care. Country profiles illustrating achievements in maternal and newborn health services and intra-country disparities in 75 countries were published. Parliamentarians were mobilized to allocate adequate budgets for improving maternal and newborn health and care. Cooperation between WHO and UNICEF, UNFPA and the World Bank in providing support to countries for improving maternal and newborn health and survival rates was further strengthened.</p> <p>The expected result was assessed as partly achieved even though the target number of countries supported was exceeded because resource constraints disrupted the continuity of the support provided.</p>
4.4	<p>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.</p> <p><i>Fully achieved</i></p> <p>Guidelines on the management of newborn normal and emergency care were updated and a training course on essential newborn care was delivered in 15 countries in the African and South-East Asia regions. Regional situation analyses were conducted, and, with the support of WHO, a total of 70 countries across all regions began extending coverage of interventions for newborn health and survival. Increasing the coverage of newborn care during the first week of life through home visits was also promoted, and training in conducting such visits was implemented in some regions and countries.</p>

<p>4.5</p>	<p>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.</p> <p><i>Partly achieved</i></p> <p>Coverage of the Integrated Management of Childhood Illness strategy was extended in all regions, and the provision of related activities increased at community and hospital levels. New and updated clinical guidelines on the treatment of diarrhoea and pneumonia were applied at community level. Guidelines on infant feeding in the context of HIV were updated. Tools for conducting short programme reviews and household surveys connected with maternal, newborn and child health (with the option of adolescent health) were tested and implemented. Some 25 universities and training institutions in the African Region and 40 in the Eastern Mediterranean Region received support to incorporate the strategy into training curriculums, and the Regional Office for the Western Pacific invested in computer-based adaptations and training. Across all regions, technical and financial support for community-based activities were increased in order to widen access to care.</p> <p>The expected result was assessed as partly achieved even though the target number of Member States was met for both indicators because the quality of implementation of the strategies was unclear and because of inconsistencies in the assessments at district level.</p>
<p>4.6</p>	<p>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.</p> <p><i>Partly achieved</i></p> <p>In all regions, more coherent support was provided to Member States, including in the promotion of a systematic approach to improving health service delivery to adolescents at country level. All regional offices now have a dedicated technical officer. Progress was made in reaching consensus on key adolescent health indicators with United Nations partners, and a system for reviewing interventions for adolescent pregnancy prevention and care was initiated. The health sector's response to HIV/AIDS in young people was articulated in guidance material on young people living with HIV and AIDS and "most at-risk" adolescents. Tools, including an adolescent job aid and quality assessment guidebook were prepared.</p> <p>The expected result was assessed as partly achieved even though the target number of Member States was met because the assessment criteria were not uniform across the regions.</p>
<p>4.7</p>	<p>Guidelines, approaches and tools made available, with provision of technical support to Member States for accelerated action towards implementing the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health, with particular emphasis on ensuring equitable access to good quality sexual reproductive health services, particularly in areas of unmet need, and with respect for human rights as they relate to sexual and reproductive health.</p> <p><i>Fully achieved</i></p> <p>With support from regional offices and headquarters, an interagency framework for monitoring progress towards universal access to reproductive health, with a focus on the indicators in Millennium Development Goal 5, was adapted in 16 countries. Various approaches were used in all regions to widely disseminate, adapt and use evidence-based guidelines, tools and best practice to improve the quality and broaden access to services in all priority areas of reproductive health. Collaboration was also strengthened with partners working in related areas, including the</p>

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	International Planned Parenthood Federation, UNFPA, UNICEF and USAID and its collaborating agencies.
4.8	<p>Guidelines, approaches, tools and technical assistance provided to Member States for increased advocacy for consideration of ageing as a public health issue, for the development and implementation of policies and programmes aiming at maintaining maximum functional capacity through the life course and for the training of health-care providers in approaches that ensure healthy ageing.</p> <p><i>Partly achieved</i></p> <p>A total of 52 Member States from four regions reported having a functioning active healthy ageing programme consistent with resolution WHA58.16. Healthy ageing was a priority area for Phase V of the WHO European Healthy Cities Network and was the subject of two publications launched at the International Healthy Cities Conference, held in Zagreb, 15–18 October 2008.^{1,2} <i>Global age-friendly cities: a guide</i> was made available electronically in numerous languages. A series of publications was issued on, inter alia, elder abuse, older persons in emergencies and age-friendly primary health care.</p> <p>The expected result was assessed as partly achieved even though the target number of Member States was met because only four regions have so far addressed healthy ageing.</p>

SUMMARY OF FINANCIAL IMPLEMENTATION (US\$ thousand)

2008–2009	African Region	Region of the Americas	South-East Asia Region	European Region	Eastern Mediterranean Region	Western Pacific Region	WHO headquarters	Total
Approved budget	115 695	27 414	50 614	14 418	39 815	25 216	86 761	359 933
Funds available ³	58 910	9 144	14 235	7 514	8 008	11 505	116 795	226 185
<i>Funds available as a % of approved budget</i>	51%	33%	28%	52%	20%	46%	135%	63%
Expenditure	55 331	9 227	11 423	6 973	6 325	8 562	93 269	191 109
<i>Expenditure as a % of approved budget</i>	48%	34%	23%	48%	16%	34%	108%	53%
<i>Expenditure as % of funds available</i>	94%	101%	80%	93%	79%	74%	80%	85%

¹ Anna Ritsatakis, ed. *Demystifying the myths of ageing*. Copenhagen, World Health Organization Regional Office for Europe, 2008.

² Lena Kanström et al., eds. *Healthy ageing profiles: guidance for producing local health profiles of older people*. Copenhagen, World Health Organization Regional Office for Europe, 2008.

³ Includes \$0.07 million, which has not yet been distributed to major offices.

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The total approved budget for the strategic objective was US\$ 360 million, of which US\$ 319 million were for Base programmes and US\$ 40.5 million for Partnerships and collaborative arrangements, primarily the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, and the Partnership for Maternal, Newborn and Child Health.

Against the approved budget, US\$ 226 million (63%) were made available through assessed and voluntary contributions. Of the available funds, US\$ 167 million (52% of the approved budget) were for Base programmes and US\$ 58.6 million (145% of the approved budget) for Partnerships and collaborative arrangements. The lower than expected level of available funding for Base programmes, compared with the approved budget, was mainly due to the difficulty of raising financial resources for country-level support; consequently, funding for country-level activities was reduced. However, through partnerships within and outside the Organization, country office staff were able to continue supporting Member States using in-country partner funds. The higher-than-expected level of available funds in headquarters, compared with the approved budget, was primarily because of increased funding for partnership activities. This has allowed advocacy for Millennium Development Goals 4 and 5 to be strengthened and research in sexual and reproductive health to be stepped up.

Of the available funds, US\$ 191 million (85%) were spent during the biennium. Of the total expenditure, US\$ 147 million were for Base programmes and US\$ 44 million for Partnerships and collaborative arrangements. The lower than expected implementation level for Partnerships and collaborative arrangements was mainly because much of the funding received was for multi-year implementation, which will continue into the biennium 2010–2011.

LESSONS LEARNT AND KEY CHALLENGES

Global advocacy for maternal, newborn, child and adolescent health served to focus attention on the activities covered by the strategic objective, including as part of the effort to attain the Millennium Development Goals, and this, in turn, increased the demand for technical assistance from Member States. Close collaboration between governments and partners at country level has improved outcomes.

Regional strategies proved valuable in developing national strategies and action plans and guiding related activities. WHO's normative work continues to influence the actions carried out by stakeholders to support Member States.

To be effective, planning and implementation strategies for scaling up in order to achieve universal access to, and increase coverage of, maternal, newborn, child, adolescent, and sexual and reproductive health services need to be country led.

The promotion of an integrated approach to health services, and clear articulation with work being carried out to develop and strengthen health systems, proved effective strategies.

Many activities conducted at all levels of the Organization were implemented on the basis of cost sharing with partner organizations. The unpredictability and inflexibility of the available funding continues to have a direct effect on the quality and coverage of the support given to Member States. Strengthening human resources, especially at country level, is essential if effective support is to be given to the implementation of activities.

STRATEGIC OBJECTIVE 5

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

A total of 102 Member States have national emergency preparedness plans, at least 60% have preparedness, alert and response plans for chemical, radiological and environmental health emergencies, and 46 have programmes for improving safety in health facilities during emergencies. In total, 75% of Member States have focal persons for the International Food Safety Authorities Network (INFOSAN) and for environmental health emergencies. Among the 27 countries with protracted emergencies and humanitarian coordinators, 26 have health clusters led by WHO. Communicable disease control interventions, including the establishment of early warning and surveillance systems, were implemented during all acute natural disasters and conflict situations. A total of 12 countries in transition formulated a recovery strategy for health.

ASSESSMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

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

Fully achieved (3)			Partly achieved (3)		

5.1	<p>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.</p> <p><i>Partly achieved</i></p> <p>With its partners, WHO scaled up support for risk and capacity assessments, contingency planning, public health emergency and mass casualty management, and hospital and pandemic preparedness. Greater emphasis was placed on advocacy for safe and better prepared health facilities, in line with the theme of World Health Day 2009: “Save lives. Make hospitals safe in emergencies”. With the United Nations International Strategy for Disaster Reduction Secretariat, WHO launched the global thematic platform on disaster risk reduction for health. The capacity of headquarters, regional and country office staff and partners to respond swiftly to humanitarian crises was strengthened. A training/learning platform was established at the WHO Mediterranean Centre for Health Risk Reduction in Tunis, where the Vulnerability and Risk Assessment and Mapping unit has initiated projects in five WHO regions.</p> <p>The expected result was assessed as partly achieved even though the targets were met for both indicators, because it was not fully achieved in two regions.</p>
5.2	<p>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.</p> <p><i>Partly achieved</i></p> <p>WHO’s work in this area, which included collaborating with humanitarian health partners in the Health Cluster, resulted in the formulation and implementation of the health components of several flash appeals, including for major emergencies in China (Sichuan), Democratic Republic of the</p>

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	<p>Congo (eastern Congo), Georgia, Haiti, Myanmar, the Philippines, Zimbabwe, and in addition, the Gaza Strip. To increase the pool of staff available for emergency deployment, WHO conducted two-week public health pre-deployment courses and continued to build a central logistics platform for its responses to humanitarian crises and public health emergencies under the International Health Regulations (2005). Regional and country level training courses on public health operations and emergency response were held. Minimum emergency kits were stored in United Nations supply hubs in five regions.</p>
5.3	<p>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.</p> <p><i>Partly achieved</i></p> <p>WHO's experience in emergency and recovery situations informed the health component of about 30 country-specific consolidated appeal processes. The Health Cluster mechanism covers most countries experiencing protracted emergencies and has been activated in 26 of the 27 countries with humanitarian coordinators. The <i>Health cluster guide</i> was prepared to clarify the roles and responsibilities of humanitarian health actors in emergency situations. With its partners, WHO devised methodologies and tools for the health component of joint needs assessments, including the intersectoral rapid assessment tool and the health resource availability mapping system (HeRAMS). A training course on analysing disrupted health systems has been instrumental in helping humanitarian professionals and country officials address the root causes of weak health systems. The provisions of the Granada Consensus on sexual and reproductive health in chronic emergencies and recovery situations, prepared at the global consultation held in September 2009, were being used in related advocacy and technical work.</p>
5.4	<p>Coordinated technical support provided to Member States for communicable disease control in natural disaster and conflict situations.</p> <p><i>Fully achieved</i></p> <p>All levels of the Organization worked with national authorities, other United Nations agencies and nongovernmental and international organizations to establish early warning and surveillance systems, as well as to provide training for communicable diseases control, and produce standards and guidelines, for instance on disease risk assessment and public health prioritization, for crisis affected countries and territories, including Afghanistan, Georgia, Indonesia (western Sumatra), Iraq, Myanmar, Nepal, Pakistan, the Philippines, Somalia, Sri Lanka, Sudan, and Yemen and, in addition, the West Bank and the Gaza Strip. Communicable disease-based risk profiles were prepared within the first 48 to 76 hours of the outbreak of crises in Afghanistan, Haiti, Pakistan, Philippines, Yemen and, in addition, the West Bank and Gaza Strip. In Darfur, Sudan, WHO and its partners identified and dealt with 85% of outbreaks of acute watery diarrhoea and cholera through a system linking 144 reporting sites.</p>
5.5	<p>Support provided to Member States for strengthening national preparedness and for establishing alert and response mechanisms for food safety and environmental health emergencies.</p> <p><i>Fully achieved</i></p> <p>Expert networks for environmental health, water and sanitation emergencies have been strengthened, including the ChemiNet and Poison Center Networks, the Radiation Emergency Medical Preparedness and Assistance Network (REMPAN) and BioDoseNet. In accordance with the International Health Regulations (2005), the WHO alert and response systems for chemical and radiological incidents were reinforced and information about such incidents was routinely forwarded to regional offices and countries for further investigation. Additional technical assistance related to</p>

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	public health management of environmental emergencies was delivered, including through the publication of a WHO manual. ¹ National focal points for both the Strategic Approach to International Chemicals Management and the International Health Regulations (2005) received up-to-date briefing on chemical emergencies. WHO's International Food Safety Authorities Network (INFOSAN) was instrumental in dealing with international food safety events, such as melamine in infant formula and dioxins in pork.
5.6	<p>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.</p> <p><i>Fully achieved</i></p> <p>The value of WHO's leadership of the Health Cluster in crisis situations is now widely recognized. Understanding and exercising the responsibilities associated with cluster leadership are becoming institutionalized throughout the Organization through training sessions, workshops, and meetings and missions at country level. Health clusters led by WHO are now established in the 26 countries with protracted emergencies and humanitarian coordinators, and their presence is systematic in all major sudden-onset emergencies. WHO is actively involved in 40 interagency mechanisms, including the Inter-Agency Standing Committee. By late 2009, all acute crises and 50% of protracted emergency situations had received media coverage, including of WHO's role. Partnerships have been strengthened, for example, with the Global Facility for Disaster Reduction and Recovery, and contingency planning and consultations in connection with keeping health facilities safe have taken place.</p>

SUMMARY OF FINANCIAL IMPLEMENTATION (US\$ thousand)

2008–2009	African Region	Region of the Americas	South-East Asia Region	European Region	Eastern Mediterranean Region	Western Pacific Region	WHO headquarters	Total
Approved budget	66 021	19 931	24 356	20 914	40 912	16 722	29 557	218 413
Funds available ²	96 678	10 587	53 802	14 515	208 854	11 821	56 180	452 770
<i>Funds available as a % of approved budget</i>	<i>146%</i>	<i>53%</i>	<i>221%</i>	<i>69%</i>	<i>510%</i>	<i>71%</i>	<i>190%</i>	<i>207%</i>
Expenditure	87 522	9 931	37 393	10 609	175 931	7 085	40 750	369 221
<i>Expenditure as a % of approved budget</i>	<i>133%</i>	<i>50%</i>	<i>154%</i>	<i>51%</i>	<i>430%</i>	<i>42%</i>	<i>138%</i>	<i>169%</i>
<i>Expenditure as % of funds available</i>	<i>91%</i>	<i>94%</i>	<i>70%</i>	<i>73%</i>	<i>84%</i>	<i>60%</i>	<i>73%</i>	<i>82%</i>

¹ *Manual for the public health management of chemical incidents*. Geneva, World Health Organization, 2009.

² Includes US\$ 0.3 million for the strategic objective that has not yet been distributed to major offices.

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The total approved budget for the strategic objective was US\$ 218 million, of which US\$ 134 million were for Base programmes and an initial estimated budget of US\$ 84 million for Outbreak and crisis response, allowing for funding received against specific country-level appeals in response to crises.

Of the approved budget, US\$ 453 million (207%) were made available through assessed and voluntary contributions. Of the available funds, US\$ 369 million (82%) were implemented during the biennium. The implementation rate shows an absorption capacity well above the approved budget ceiling, which is a marked increase over the 67% rate in the previous biennium.

An estimated 15% of total funds was for Base programmes. The remainder was received in response to specific country crisis appeals and was implemented in over 40 countries, including in the major sudden-onset emergency in Myanmar in May 2008 and in the prolonged crisis in Pakistan caused by mass population movements. However, during the biennium, an adequate mechanism did not exist for clearly differentiating between funding for Base programmes and that for Outbreak and crisis response.

Although overall country-level outbreak and crisis response funding was adequate, base programmes were under-funded. Indeed, funding for country-level activities continues to increase, while that for essential base programmes is shrinking. Predictable, secure and flexible funding for base programmes is critical if the strategic objective is to be met as Organization-wide demands in the area of work expand.

LESSONS LEARNT AND KEY CHALLENGES

Close cooperation between departments, clusters and other agencies has facilitated the implementation of relevant activities. The launch of the common technical platform at the Mediterranean Centre for Health Risk Reduction in Tunis has added value in terms of cost effectiveness and the pooling of technical resources.

The provision of support for communicable disease control in crises requires close cooperation across the Organization and with other agencies that can result in supplementary activities and the establishment of coordination mechanisms at regional and subregional levels.

Recent major emergencies, including the pandemic (H1N1) 2009, have demonstrated the benefits, including for health systems, of country and community preparedness, and fuelled a growing recognition of the need to invest in this area.

The technical assistance provided to countries for developing their core capacities in line with the provisions of the International Health Regulations (2005) on chemical events should be stepped up.

Successful leadership of the Health Cluster at country level reflects the dedication and ability of heads of WHO country offices to engage the entire humanitarian health community in a coherent way in support of Member States.

Predictable funding and suitable human resources, particularly full-time staff and dedicated focal points, are a prerequisite for sustaining preparedness and response activities.

STRATEGIC OBJECTIVE 6

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

The Seventh Global Conference on Health Promotion, held in Nairobi, 26–30 October 2009, reviewed the progress made in five areas of health promotion: health behaviour and health literacy, community empowerment, health-promoting health systems, partnership and intersectoral action, and building capacity for health promotion. By late 2009, use of the urban Health Equity Assessment and Response Tool had led to inequities in health outcomes and determinants being re-evaluated, and to the selection and prioritization of interventions in 17 cities in 10 pilot countries. A total of 89 countries now use the WHO STEPwise approach to surveillance of noncommunicable disease risk factors in their adult populations, and 56 countries are employing the Global School-based Student Health Survey to monitor risk factors among adolescents. By late 2009, 167 Member States had become Parties to the WHO Framework Convention on Tobacco Control, 20 had approved comprehensive smoke-free legislation, and 26 a comprehensive ban on tobacco advertising, promotion and sponsorship. The Global Survey on Alcohol and Health for 2008 was implemented and the data collected provide a valuable baseline for monitoring progress towards attainment of the strategic objective. Regional frameworks for reducing the harmful use of alcohol are in place or being formulated. The draft global strategy to reduce harmful use of alcohol was developed by the Secretariat, in collaboration with Member States, for consideration by the Executive Board at its 126th session. Although regional and country implementation methods varied, the Global Strategy on Diet, Physical Activity and Health received a high level of attention in all regions. Interventions to address violence against women and girls – a major determinant of unsafe sex – are now included among the nine priority areas in the UNAIDS Outcomes Framework 2009–2011.

ASSESSMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

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

Fully achieved (4)				Partly achieved (2)	

6.1	<p>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.</p> <p><i>Fully achieved</i></p> <p>All regions endeavoured to strengthen countries’ health promotion strategies and capacity in accordance with different regional perspectives ranging from documenting national health promotion policy, through devising virtual courses on health promotion and social determinants, to drafting applicable legislation. Progress in obtaining financing for health promotion was made in several countries, for example, through the allocation of tobacco taxes. The Nairobi Call to Action, issued at the Seventh Global Conference on Health Promotion identified five specific areas. Intersectoral action was extended through, for example, noncommunicable disease prevention training, the creation of intersectoral committees, and national reviews of social determinants. A global consultation was held at which examples of intersectoral action for noncommunicable disease</p>
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	<p>prevention and the lessons learnt were reviewed. By late 2009, 17 cities had implemented the urban Health Equity Assessment and Response Tool to assess health inequities and identify priority interventions.</p>
<p>6.2</p>	<p>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.</p> <p><i>Partly achieved</i></p> <p>Core indicators for monitoring risk factors were developed. Guidance on risk factor surveillance covering tobacco, diet, physical activity, high blood pressure, raised blood glucose, anthropometric measurements and alcohol was presented in a technical document on noncommunicable diseases surveillance. A project to include risk factor monitoring in the global status report on noncommunicable diseases was initiated through inter-regional cross-cluster collaboration. A total of 89 countries are using the WHO STEPwise approach to surveillance for noncommunicable disease risk factors in their adult population. A total of 18 new surveys were conducted and 14 country missions provided advice, support and training to Member States establishing or expanding their risk factor surveillance systems. Technological advances were made in analysing and reporting risk-factor data through the use of hand-held personal digital devices. A total of 22 new surveys were conducted using the Global School-based Student Health Survey methodology, with training and technical support from WHO and the United States Centers for Disease Control and Prevention.</p> <p>The expected result was assessed as partly achieved even though the initial target number of Member States was met for both indicators, because, in practice, the baselines were higher and the achievements slightly lower than expected.</p>
<p>6.3</p>	<p>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.</p> <p><i>Fully achieved</i></p> <p>Technical assistance was provided to countries to implement the WHO Framework Convention on Tobacco Control and proven demand-reduction measures as part of the operational component of the WHO Action Plan for Prevention and Control of Noncommunicable Diseases. By late 2009, 57 countries had reliable, up-to-date data on adult tobacco prevalence. The Secretariat prepared and implemented a new methodology for assessing the capacity of Member States to implement effective tobacco-control policies, and a report analysing their progress was published.¹ WHO completed field-level implementation of the Global Adult Tobacco Surveys. Technical assistance was provided on tobacco taxation and a price database, and through toolkits for estimating the economic and health-care costs of tobacco-attributable mortality and morbidity. WHO continued to support the work of the Conference of the Parties to the Framework Convention in formulating recommendations and adopting guidelines for specific articles of the Framework Convention and</p>

¹ WHO report on the global tobacco epidemic, 2009: implementing smoke-free environments. Geneva, World Health Organization, 2009.

	negotiating a protocol on illicit trade in tobacco products. Partnerships were sought with both the private and public sectors and efforts made to strengthen them.
6.4	<p>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.</p> <p><i>Fully achieved</i></p> <p>The draft global strategy to reduce the harmful use of alcohol was prepared in collaboration with Member States and taking into account the outcomes of a broad consultation process. New research activities in the area of alcohol, health and development were initiated. Data on alcohol consumption, alcohol-related harm and national policy responses by Member States were collected and by late 2009 regional systems had been developed by the Regional Offices for Africa, the Americas, South-East Asia and the Western Pacific and integrated in the Global Information System on Alcohol and Health. A regional plan of action for the reduction of alcohol-related harm was prepared in the Western Pacific Region. In March 2009, the WHO/United Nations Office on Drugs and Crime launched a joint programme on drug dependence treatment and care for initial implementation at country level in Europe. The WHO alcohol, smoking and substance involvement screening test project was further developed and training activities were held in the African and Eastern Mediterranean regions. The indicators for national, regional and global systems for monitoring the effects of alcohol on health were refined and implemented, and indicators and data collection tools for treatment resources for substance use disorders further developed.</p>
6.5	<p>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.</p> <p><i>Fully achieved</i></p> <p>In all regions, mechanisms and tools were prepared for adapting healthy diets and physical activity strategies and plans to suit national requirements. Regional networks were formed to promote physical activity and salt reduction, and the health risks of marketing foods and non-alcoholic beverages to children. A total of 66 countries reported having a multisectoral strategy or plan based on the Global Strategy on Diet, Physical Activity and Health. Several new tools were prepared to support Member States in the development and implementation of strategies to improve diets and increase physical activity, including, systematic reviews of effective interventions, documents to guide policies and programmes in settings, for example, schools and workplaces, and for monitoring and evaluating implementation of relevant policies.</p>
6.6	<p>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.</p> <p><i>Partly achieved</i></p> <p>Evidence on the prevalence, determinants and consequences of unsafe sex, and on interventions to reduce risks was collected from different countries. Measures to address violence against women and girls have been included in the nine priority areas of the UNAIDS Outcome Framework 2009–2011. A standard tool for unsafe sex surveillance compatible with the STEPwise approach was developed and introduced in countries. Guidance on generating surveillance data for adolescent health programmes was made available through interregional meetings. The Regional Office for</p>

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	<p>Europe produced a set of sex education standards, and also devised sexual health policies and adapted WHO guidelines on contraception, unsafe abortion and sexually transmitted diseases. Linkages between different sexual and reproductive health services were established in countries in the Western Pacific Region. The Regional Office for the Americas developed a strategy targeting “most at-risk” youth, and tools for evaluating the role of health services in promoting safer sex.</p> <p>The expected result was assessed as partly achieved because the targets were not fully met in two regions and no specific results were reported by two other regional offices.</p>
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SUMMARY OF FINANCIAL IMPLEMENTATION (US\$ thousand)

2008–2009	African Region	Region of the Americas	South-East Asia Region	European Region	Eastern Mediterranean Region	Western Pacific Region	WHO headquarters	Total
Approved budget	25 566	13 862	14 590	9 959	24 809	31 729	41 542	162 057
Funds available	15 100	7 583	12 473	11 495	9 743	12 950	49 026	118 381
<i>Funds available as a % of approved budget</i>	<i>59%</i>	<i>55%</i>	<i>85%</i>	<i>115%</i>	<i>39%</i>	<i>41%</i>	<i>118%</i>	<i>73%</i>
Expenditure	14 494	6 175	10 919	9 559	7 731	10 270	37 049	96 196
<i>Expenditure as a % of approved budget</i>	<i>57%</i>	<i>45%</i>	<i>75%</i>	<i>96%</i>	<i>31%</i>	<i>32%</i>	<i>89%</i>	<i>59%</i>
<i>Expenditure as % of funds available</i>	<i>96%</i>	<i>81%</i>	<i>88%</i>	<i>83%</i>	<i>79%</i>	<i>79%</i>	<i>76%</i>	<i>81%</i>

The total approved budget for the strategic objective was US\$ 162 million, of which US\$ 118 million (73%) were made available through assessed and voluntary contributions. The level of funding was lower than expected mainly because of difficulties in securing contributions for country-level support for multisectoral and multidisciplinary collaboration. Although many targets were met, the funding levels represent a threat to the coverage, depth and sustainability of some of the expected results. Of the available funds, US\$ 96 million (81%) were implemented during the biennium. In particular, recruitment delays at regional and country level hampered the scaling up of tobacco control activities in countries and resulted in programmes being postponed. Efforts are continuing to ensure that the area of alcohol and drugs in mental health and substance abuse programmes is adequately staffed in all regions.

LESSONS LEARNT AND KEY CHALLENGES

Intersectoral action and community empowerment are areas of health promotion that need further strengthening and documenting. To compensate for the lack of emphasis in the past on translating health promotion concepts into effective guidelines for concrete action, and on building the capacity of developing countries to evaluate health promotion, the workplan for 2010–2011 will focus primarily on those areas. Suitable frameworks,

technical support for local counterparts and stronger collaboration with the relevant United Nations agencies are also required.

Working with the Convention Secretariat in a coordinated and coherent manner has contributed to Parties' implementation of the WHO Framework Convention on Tobacco Control and such collaboration will be further strengthened during 2010–2011. Investment in public health infrastructure and capacity building remains critical for full implementation of the Framework Convention, given the continuing efforts of the tobacco industry to undermine control activities.

The progress made in developing a policy on alcohol has been due to effective collaboration across the Secretariat and with Member States, as well as to multisectoral action to address diet, physical activity and health. The experiences of other areas in dealing with the relevant industry sectors should be taken into account in the future.

Actions to promote safer sex are urgently required since many new cases of HIV are occurring in people aged between 15 and 24 years.

It has emerged that addressing urban health inequities involves intersectoral coordination at municipal level. Scaling up urban health equity assessments and responses will require strong government commitment and policies.

WHO's role and leadership in the priority areas of the strategic objective are constrained by insufficient funding and staff shortages at all levels. Resource allocation for both tobacco and alcohol control and diet and physical activity programmes remains inadequate in relation to the magnitude of the problems. Further prioritization of tasks, and division of responsibilities and resources within WHO, as well as with collaborating centres and other networks, will help in achieving the expected results.

STRATEGIC OBJECTIVE 7

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

Increased awareness of and interest in health equity by Member States led to concrete actions for implementing key recommendations of the Commission on the Social Determinants of Health, in coordination with a wide range of stakeholders, including international partners. Such actions included: mainstreaming social determinants of health in public health programmes in Chile; establishing multisectoral commissions on health equity in Brazil, Morocco and Sri Lanka; and analysing the potential health impacts of non-health policies in eight countries. Member States enhanced their capacity to, inter alia: track and analyse the potential opportunities and challenges of trade and trade agreements for health-sector performance and health outcomes; conduct a disaggregated analysis of health equity; analyse other social determinants of health that prevent access to health services; apply a human-rights based approach, for example in preventing HIV/AIDS; and integrate ethical considerations and gender mainstreaming into public health programmes. The adoption of resolution WHA62.14 on reducing health inequities through action on the social determinants of health was followed up in some 40 Member States by the incorporation of social determinants in their country cooperation strategies.

ASSESSMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

Of the **five Organization-wide expected results** for this strategic objective, four were “fully achieved” and one was “partly achieved”.

Fully Achieved (4)				Partly Achieved (1)

7.1	<p>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.</p> <p><i>Partly achieved</i></p> <p>All WHO regional offices took steps to define strategies and initiatives to address the social determinants of health: the South-East Asia, European and Eastern Mediterranean regions completed their work on the subject while the African Region is in the process of doing so. At least five countries organized consultations or drafted reports based on the recommendations of the Commission, while several accorded strategic priority to addressing social determinants. Up to January 2009, the full report¹ had been downloaded 56 000 times; it has also been translated into the official WHO languages, as well as Hungarian, Japanese, Norwegian, Slovakian, Slovenian, Swedish and Vietnamese.</p> <p>The expected result was assessed as partly achieved because consultations on a regional strategy to address social and economic determinants of health were postponed in one region.</p>
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¹ Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health: final report of the Commission on Social Determinants of Health*. Geneva, World Health Organization, 2008.

7.2	<p>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.</p> <p><i>Fully achieved</i></p> <p>The experiences of 31 countries in tackling social determinants of health were published, including through collaboration with the Public Health Agency of Canada, providing WHO with evidence for discussing ways of arranging intersectoral collaboration at national level. Tools were developed and tested, for example, for assessing the capacity of institutions in Member States to address social determinants of health inequalities, for improving coherence between trade and health policies in order to maximize benefits and minimize risks to health, and for assessing the impact of trade liberalization on health services.</p>
7.3	<p>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).</p> <p><i>Fully achieved</i></p> <p>WHO headquarters and regional and country offices organized regional and national training sessions to build capacity in conducting disaggregated analysis of health equity. All regions improved their frameworks for evaluating and disaggregating socioeconomic determinants, including gender, as causes of health inequities. The work was based on some 45 national profiles across all regions and documented in two collaborative regional reports. Increased technical support was provided for monitoring and generating evidence on interventions that enhance equity when addressing noncommunicable diseases, tuberculosis and urban health. A global mechanism was established to channel international expertise from all regions in order to increase the use of WHO norms and standards for disaggregated data collection, monitoring and analysis.</p>
7.4	<p>Ethics and human rights based approaches to health promoted within WHO and at national and global levels.</p> <p><i>Fully achieved</i></p> <p>Collaboration between WHO and the United Nations human rights bodies was enhanced through formal high-level meetings. A human rights based approach was further integrated into WHO's technical work, including the Stop TB Partnership and Health Action in Crises, and ethical considerations were introduced into its public health programmes, such as those on tuberculosis and pandemic influenza, and in research. Technical assistance was provided to countries for identifying national health priorities and developing programmes on health and human rights and for ensuring that human rights and gender considerations are included in the planning, implementation and evaluation of national strategies and plans. Training workshops were conducted on: ethical considerations in biomedical HIV prevention trials, with UNAIDS; ethical issues in pandemic preparedness and response in Burkina Faso, the Congo and Uganda, through the WHO Global Influenza Programme; and coordinating national regulatory authorities and research ethics committees in Nigeria and Thailand.</p>

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7.5	<p>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.</p> <p><i>Fully achieved</i></p> <p>A baseline assessment was completed for monitoring WHO gender mainstreaming efforts in all regions and headquarters. A report on the health of women and girls¹ and guidelines on gender and HIV were published, and a train-the-trainer workshop on prevention of gender-based violence and injuries was held in Salzburg, Austria, 23–27 November 2009. Integrating a gender perspective in WHO’s operational planning and performance monitoring was further supported through new planning tools and training programmes. Across all regions, numerous gender-related training sessions and country support activities were completed.</p>
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SUMMARY OF FINANCIAL IMPLEMENTATION (US\$ thousand)

2008–2009	African Region	Region of the Americas	South-East Asia Region	European Region	Eastern Mediterranean Region	Western Pacific Region	WHO headquarters	Total
Approved budget	9 116	6 937	4 838	5 975	11 975	2 496	24 568	65 905
Funds available	8 782	2 292	3 016	6 797	4 828	1 339	16 378	43 433
<i>Funds available as a % of approved budget</i>	96%	33%	62%	114%	40%	54%	67%	66%
Expenditure	8 071	2 291	2 169	4 165	3 942	683	13 618	34 938
<i>Expenditure as a % of approved budget</i>	89%	33%	45%	70%	33%	27%	55%	53%
<i>Expenditure as % of funds available</i>	92%	100%	72%	61%	82%	51%	83%	80%

The total approved budget for the strategic objective was US\$ 66 million, of which US\$ 43 million (66%) were made available through assessed and voluntary contributions. The gap in funding in relation to the approved budget has limited WHO’s ability to respond to a growing number of requests for support from Member States, in particular, for reducing health inequities through action on the social determinants of health in accordance with resolution WHA62.14. Of the available funds US\$ 35 million (80%) were implemented during the biennium. The lower than expected implementation level in the South-East Asia, European and Western Pacific regions was primarily a result of delays in staff recruitment and to the earmarking of funds for 2010–2011, even though they were recorded during 2008–2009.

¹ *Women and health: today’s evidence tomorrow’s agenda*. Geneva, World Health Organization, 2009.

LESSONS LEARNT AND KEY CHALLENGES

The strategic objective covers a spectrum of closely interrelated subjects that have been widely acknowledged as having the highest potential for equitable health outcomes. Consensus building and advocacy proved fruitful in creating an effective platform for promoting closer collaboration across concerned areas of work, pursuing mainstreaming efforts, for example in gender and health and human rights, and developing partnerships with stakeholders outside WHO. In consequence, demand from Member States for technical assistance has increased.

The absence of an Organization-wide human rights strategy has limited WHO's ability to respond to increased internal demand for guidance on integrating ethical issues into technical areas. The expectations raised by the recent publication of several reports will need to be properly followed up. A lack of adequate human and financial resources for the strategic objective hampered implementation of the workplan across the Organization. In order to improve efficiency in the future, innovative solutions should be explored, for example in the areas of staff development, collective approaches and coherence, including through mapping available activities and resources, identifying a critical mass of staff across all levels and working with partners to achieve the objectives.

STRATEGIC OBJECTIVE 8

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

A multipronged effort was directed at addressing the 25% burden of disease caused by environmental risk factors. WHO and UNEP collaborated in convening the First Inter-Ministerial Conference on Health and Environment in Africa, held in Libreville, Gabon, 26–29 August 2008, as part of a global plan to address inter-linked health and environmental issues through preventive action. The resulting Libreville Declaration called for the establishment of a health-and-environment strategic alliance for Africa, to which 10 countries have responded by compiling situation analyses and needs assessments as a basis for national plans of joint action. A new interagency project to reduce reliance on DDT for vector control was launched in the context of the Stockholm Convention, and, in 2009, a “mercury-free health care” global initiative, supported by the UNEP Global Mercury Partnership, stimulated rapid national health-sector responses, including announcements by Argentina and the Philippines that they were phasing out mercury use in medical products. The second session of the International Conference on Chemicals Management, held in Geneva, 11–15 May 2009, approved a resolution calling for, inter alia, strengthening the engagement of the health sector in the Strategic Approach to International Chemicals Management. In accordance with resolution WHA60.26, (Workers’ health: global plan of action), interagency collaboration to eliminate asbestos-related diseases was strengthened. In response to resolution WHA61.19 on climate change and health, a draft workplan was submitted to, and endorsed by, the Executive Board at its 124th session.¹ The theme of World Health Day 2008, “Protecting health from climate change”, was the subject of advocacy activities across the regions, as well as of WHO contributions to the Fifteenth Conference of the Parties to the United Nations Framework Convention on Climate Change.

ASSESSMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

All **five Organization-wide expected results** for this strategic objective were “partly achieved”.

Partly Achieved (5)				

8.1	<p>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.</p> <p><i>Partly achieved</i></p> <p>Tools for assessing risk from exposure to chemical and radiation hazards were developed. Publications were issued on drinking-water quality,² sanitation and hygiene in aviation,³</p>
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¹ Resolution EB124.R5.

² *Guidelines for drinking-water quality [electronic resource]: incorporating 1st and 2nd addenda, Vol.1, Recommendations.* 3rd ed. Geneva, World Health Organization, 2008.

³ *Guide to sanitation and hygiene in aviation.* 3rd ed. Geneva, World Health Organization, 2009.

	<p>environmental health standards in health care,¹ and water, sanitation and hygiene standards in low-cost settings.² Technical assistance was provided to countries to implement binding and non-binding international agreements on sound management of chemicals. Difficulties in applying guidelines at country level have been partly addressed through workshops and information kits, such as the third edition of the <i>Guidelines for the safe use of wastewater, excreta and greywater in agriculture and aquaculture</i>. Work was carried out in all regions to support the application of WHO drinking-water guidelines and a water safety plan manual was widely disseminated. The WHO/UNICEF Joint Monitoring Programme established a strategic advisory group and formulated a strategy for 2010–2015, in order to enhance the monitoring of progress made towards achieving the target in Millennium Development Goal 7 on reducing the proportion of people without sustainable access to safe drinking-water and basic sanitation. The UN-Water Global Annual Assessment of Sanitation and Drinking-Water initiative led by WHO published its first pilot report.³ The global monitoring of solid fuel use was improved substantially with 144 countries now reporting.</p> <p>The expected result was assessed as partly achieved even though the target number of Member States was met for both indicators, because the results were not fully achieved in two regions.</p>
<p>8.2</p>	<p>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).</p> <p><i>Partly achieved</i></p> <p>WHO provided technical support and guidance to Member States in the following domains: health-care settings: cessation of use of mercury devices, prevention of blood-borne pathogen exposure, water and sanitation, indoor air quality, alternative technologies and health-care waste management policies; workplaces: elimination of asbestos-related diseases, chemical hazards, and psychosocial and healthy interventions; the home: household water treatment, public sanitation, radon, damp and mould, and solid fuel use in developing countries; rural areas: water safety plans; urban areas: water safety plans and healthy transport; and children’s health: environmental risks and conducting cohort studies on environmental and chemical impacts. In addition, the third WHO International Conference on Environmental Threats to the Health of Children was hosted by the Republic of Korea in Busan, 7–10 June 2009.</p> <p>The expected result was assessed as partly achieved even though the target was met, because the result was not fully achieved in one region.</p>
<p>8.3</p>	<p>Technical assistance and support provided to Member States for strengthening national occupational and environmental health risk management systems, functions and services.</p> <p><i>Partly achieved</i></p> <p>Technical support for the development of national policies and action plans on workers’ health was provided to 29 countries in all WHO regions within the framework of the Global Plan of Action on Workers’ Health (2008–2017). National environment and health action plans are being prepared in</p>

¹ Adams J et al., eds. *Essential environmental health standards in health care*. Geneva, World Health Organization, 2008.

² Adams J et al., eds. *Water, sanitation and hygiene standards for schools in low-cost settings*. Geneva, World Health Organization, 2009.

³ *UN-water global annual assessment of sanitation and drinking-water: 2008 pilot report – testing a new approach*. Geneva, World Health Organization, 2008.

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	<p>the South-East Asia and Western Pacific regions, and in 10 countries in the African Region in accordance with the strategic process set out in the Libreville Declaration. In response to the launching of a “mercury-free health care” global initiative, Argentina and the Philippines announced plans for phasing out mercury use in medical products. Technical assistance continues to be provided for the management of indoor air pollution and to build capacity in drinking-water and sanitation monitoring in the African Region, and for occupational health issues in the European and South-East Asia regions. Drinking-water quality management in the South-East Asia and Western Pacific regions is being addressed through multi-year implementation projects, and in other regions as part of ongoing workplans. Environmental and occupational health information systems have been strengthened and children’s environmental indicators piloted. Support was provided for chemical risk management, including toolkits for risk assessment and management, and to eliminate asbestos-related diseases in the workplace.</p> <p>The expected result was assessed as partly achieved even though the target was exceeded, because the result was not fully attained in one region.</p>
<p>8.4</p>	<p>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.</p> <p><i>Partly achieved</i></p> <p>Activities to promote the inclusion of health impact assessments in the development of sectoral policies were scaled up in five countries and a group of 26 African cities. An initiative to encourage development banks to include health criteria in loans policies was launched, and tools were developed to facilitate such a change in bank lending practices. Workshops to support countries in assessing vulnerability and establishing effective responses to protect people’s health from the effects of climate change were held in seven countries. In the European Region, support was given to countries through the Transport, Health and Environment Pan-European Programme and the WHO European Healthy Cities Network.</p> <p>The expected result was assessed as partly achieved even though the target was exceeded, because the results were not fully attained in three regions.</p>
<p>8.5</p>	<p>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.</p> <p><i>Partly achieved</i></p> <p>As part of a global plan of preventive action to address interlinked health and environment issues, the First Inter-Ministerial Conference on Health and Environment in Africa was convened in Libreville, Gabon, 26–29 August 2008. A roadmap for completion of situation analyses and needs assessments was drawn up as a basis for the development of national plans of joint health and environment action in African countries. In response to resolution WHA61.19 on climate change and health, a workplan for scaling up technical support to Member States for assessing and addressing the implications of climate change for health and health systems was endorsed by the Executive Board at its 124th session.¹ The theme of World Health Day 2008 triggered advocacy activities across the regions. Similar activities related to climate change and human health were also part of WHO’s contribution to the Fifteenth Conference of the Parties to the United Nations Framework Convention on Climate Change. A new WHO/UNEP project to reduce reliance on DDT</p>

¹ Resolution EB124.R5.

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for vector control also was formally launched in May 2009 with support from the Global Environment Facility. In accordance with resolution WHA60.26 (Workers' health: global plan of action), interagency collaboration to eliminate asbestos-related diseases was strengthened.

The expected result was assessed as partly achieved even though the target number of studies or reports published or co-published by WHO was met, because the result was not fully attained in one region.

SUMMARY OF FINANCIAL IMPLEMENTATION (US\$ thousand)

2008–2009	African Region	Region of the Americas	South-East Asia Region	European Region	Eastern Mediterranean Region	Western Pacific Region	WHO headquarters¹	Total
Approved budget	18 749	12 057	13 827	17 951	16 358	12 364	39 150	130 456
Funds available ²	11 096	6 628	8 956	22 748	7 006	8 305	44 697	109 738
<i>Funds available as a % of approved budget</i>	59%	55%	65%	127%	43%	67%	114%	84%
Expenditure	9 611	6 255	8 157	16 988	4 788	5 898	34 244	85 941
<i>Expenditure as a % of approved budget</i>	51%	52%	59%	95%	29%	48%	87%	66%
<i>Expenditure as % of funds available</i>	87%	94%	91%	75%	68%	71%	77%	78%

The total approved budget for the strategic objective was US\$ 130 million, of which US\$ 110 million (84% of approved budget) were made available through assessed and voluntary contributions. The lower than expected level of available funds compared with the approved budget was mainly attributable to the difficulty of raising resources for country support programmes in the African and Eastern Mediterranean regions.

Of the available funds, US\$ 86 million (78% of available funds) were implemented during the biennium. The lower than expected implementation rate was primarily a result of the fact that funding for the climate change and environmental impact assessment programmes was not received until late in the biennium. Implementation of both programmes will continue during 2010–2011.

¹ The figures for WHO headquarters include those for the Water Supply and Sanitation Collaborative Council, which separated from WHO during the biennium 2008–2009 (funds available: US\$ 7.7 million; expenditure: US\$ 6.9 million).

² Includes US\$ 0.3 million of undistributed funds.

LESSONS LEARNT AND KEY CHALLENGES

Persuading public-sector policy-makers to consider the benefits that would accrue from healthier environments remains a challenge for WHO. While multisectoral collaboration over climate change mitigation and health impact analysis at national and international level has been successful, the complexities of such collaborative exercises need to be recognized. Similar challenges also face efforts to engender national intersectoral ownership of projects undertaken to implement the Libreville Declaration in Africa.

Despite closer collaboration between WHO headquarters and regional offices, stronger commitment at country level and the availability of novel sources of funding, implementation of planned activities remains uneven across the regions.

Greater importance should be given to activities such as decreasing reliance on solid fuel use for heating and cooking, and strengthening the evidence base for the effectiveness of primary health and environmental interventions in urban settings, as well as to coordinating support for occupational health.

STRATEGIC OBJECTIVE 9

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

During 2008–2009, most Member States, through intersectoral action, took steps to better align national coordination mechanisms in order to strengthen the nutrition, food safety and food security components of poverty reduction strategies, as well as integrated nutrition, food safety and food security programmes connected with climate change and rising food prices. The Growth Standards were adopted in 109 countries and an additional 69 were considering doing so. The WHO Global Database on Child Growth and Malnutrition contains nearly 3000 surveys from 145 countries, with results presented in a standardized format that allows international comparisons. A total of 108 Member States analysed their food and nutrition policies and practices under the Nutrition Landscape Information System initiative; 173 Member States joined the WHO Global Foodborne Infections Network (previously Global Salm-Surv) in order to reinforce integrated foodborne and zoonotic disease surveillance and training in cross-sectoral monitoring of antimicrobial resistance. WHO launched an initiative to estimate the global burden of foodborne diseases. Collaborative efforts with international partners and the creation of networks, such as the International Food Safety Authorities Network and Asia FoodNet, improved WHO’s capacity to respond to emergencies, for example, the global food price crisis and melamine contamination of infant formula. Collaboration with entities of the United Nations system, the World Bank, nongovernmental organizations and donors, including through the revival of the United Nations System Standing Committee on Nutrition and the consolidation of the REACH initiative against child hunger and undernutrition, improved the coherence and effectiveness of the nutrition architecture.

ASSESSMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

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

		Fully Achieved (3)		Partly Achieved (3)	

9.1	<p>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.</p> <p><i>Partly achieved</i></p> <p>WHO’s partnerships with, inter alia, FAO, UNICEF, WFP, the World Bank and OIE, strengthened responses to emergencies, such as the global food price crisis and the contamination of infant formula with melamine. WHO now coordinates its food safety emergency actions with existing global systems for emergencies related to animals and primary production. WHO convened a meeting of the three other United Nations lead agencies on nutrition (FAO, UNICEF and WFP), to develop a joint reform proposal for the United Nations System Standing Committee on Nutrition. Technical cooperation was focused on reducing salt intake and protecting children from marketing pressure in the European Region; responding to food safety and nutrition problems in the African Region; expanding an integrated approach to planning and funding in the Western Pacific Region; promoting intersectoral action among food safety stakeholders in the Region of the Americas; mitigating the impact of climate change on nutrition in the South-East Asia Region; and developing</p>
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	<p>a regional nutrition strategy through the newly created Advisory Committee on Nutrition in the Eastern Mediterranean Region.</p>
9.2	<p>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.</p> <p><i>Fully achieved</i></p> <p>Within the framework of the FAO/WHO Codex Alimentarius Commission, new standards were developed for, inter alia, the assessment of genetically modified food and the prevention of antimicrobial resistance. FAO and WHO addressed the need to improve the quality of the scientific advice given to the Codex, and the convening of joint expert meetings on nutrition was proposed. Within WHO, the provision of food safety related advice has been centralized and risk assessments for all food-related hazards are now uniformly coordinated. A library of evidence of effective nutrition actions was designed to standardize, update and disseminate WHO advice on nutrition. Guidance was issued on nutrition and HIV. A new procedural manual was produced to simplify the development of food-based dietary guidelines that have been adopted by more than 100 countries.</p>
9.3	<p>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.</p> <p><i>Fully achieved</i></p> <p>Support continued to be provided to Member States to enable them to adopt and implement the WHO Child Growth Standards, including through training workshops conducted in 25 countries across five regions. The WHO Global Database on Child Growth and Malnutrition, which allows international comparisons to be made, now covers some 3000 surveys from 145 countries. The WHO Global Database on Body Mass Index was developed to provide adult overweight and obesity data in countries, and a WHO Global Databank on Infant and Young Child Feeding was created. The Nutrition Landscape Information System was established in order to generate country nutrition profiles by linking all the WHO nutrition databases and consolidating the nutrition, food security and development-related indicators of existing partner agency databases. Estimates of obesity prevalence and trends were published in the <i>World health statistics</i> reports. A review of indicators and methods for nutrition surveillance was initiated.</p>
9.4	<p>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.</p> <p><i>Partly achieved</i></p> <p>Within the framework of a global review of food and nutrition policies, 108 countries analysed their own policies in this regard. WHO, in collaboration with FAO, UNICEF, WFP and UNAIDS, promoted regional consultations on nutrition and HIV/AIDS in the African, South-East Asia and Western Pacific regions, which led to the drafting of national action plans on the integration in government programmes of nutritional care and support for people living with HIV. WHO reviewed the impact of the global food price crisis on diet and nutrition and supported 12 countries in four regions to develop practical responses to the food price crisis. The Communication for Behavioural Impact approach for increasing breastfeeding rates was further promoted and supported as part of the drive to implement the Infant and Young Child Nutrition Strategy. Capacity in treating severe malnutrition was also strengthened, including through the development of country-level guidelines.</p>

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<p>9.5</p>	<p>Systems for surveillance, prevention and control of zoonotic and non-zoonotic diseases strengthened; food-hazard monitoring and evaluation programmes established and integrated into existing national surveillance systems, and results disseminated to all key players.</p> <p><i>Partly achieved</i></p> <p>The WHO Global Foodborne Infections Network (formerly Global Salm-Surv), which now includes 173 Member States, promotes integrated foodborne and zoonotic disease surveillance among professionals in the veterinary, food production and public health fields and offers training in cross-sectoral monitoring of microbial resistance. Two additional training sites were established in the African and Western Pacific regions and at least 400 professionals from 106 countries received training. WHO launched an initiative to estimate the global burden of foodborne disease and established the Foodborne Disease Burden Epidemiology Reference Group. The level of contamination by persistent organic pollutants in human milk was measured in 26 countries and the results will be used as reference points for monitoring environmental pollution.</p> <p>The expected result was assessed as partly achieved even though the two indicator targets were met because the initiation of studies on the burden of foodborne diseases was postponed in some countries.</p>
<p>9.6</p>	<p>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.</p> <p><i>Fully achieved</i></p> <p>The joint WHO/FAO International Food Safety Authorities Network was further developed and linked to the OIE/FAO/WHO Global Early Warning and Response System for Major Animal Diseases, including Zoonoses to facilitate the sharing of information among food safety authorities and chief veterinary officers in Member States. Recent international food safety emergencies, such as contamination of infant formula with melamine and pork with dioxin, demonstrated the importance of an integrated network.</p>

SUMMARY OF FINANCIAL IMPLEMENTATION (US\$ thousand)

2008–2009	African Region	Region of the Americas	South-East Asia Region	European Region	Eastern Mediterranean Region	Western Pacific Region	WHO headquarters	Total
Approved budget	39 778	14 608	13 939	5 975	8 938	19 273	24 423	126 934
Funds available	7 964	3 432	4 046	3 761	3 146	5 445	27 579	55 372
<i>Funds available as a % of approved budget</i>	20%	23%	29%	63%	35%	28%	113%	44%
Expenditure	7 597	3 093	3 431	2 840	1 921	4 363	23 201	46 447

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<i>Expenditure as a % of approved budget</i>	19%	21%	25%	48%	21%	23%	95%	37%
<i>Expenditure as % of funds available</i>	95%	90%	85%	76%	61%	80%	84%	84%

The total approved budget for the strategic objective was US\$ 127 million, of which US\$ 55 million (44%) were made available through assessed and voluntary contributions. A total of US\$ 53 million were for Base programmes and US\$ 2.7 million were for Partnerships and collaborative arrangements, primarily the United Nations Standing Committee on Nutrition.

The difficulty of raising voluntary contributions for the strategic objective hampered WHO's ability to respond to requests for scientific advice on both nutrition and food safety. New activities connected with food consumption are increasingly focused on the interrelation between risks and benefits. The new funding mechanism, the Global Initiative for Food-related Scientific Advice, which covers both nutrition and food safety advice, has not yet attracted significant funds. Despite the recognition accorded by Member States to the WHO Global Foodborne Infections Network (formerly Global Salm-Surv), its activities are mainly supported through in-kind contributions of trainers, hence, additional fund-raising efforts are required.

There was a significant funding shortfall for developing the International Food Safety Authorities Network. The absence of national systems to assess zoonotic and foodborne risk is curtailing progress. Such systems need to be integrated in national food-control systems and have direct and efficient links to international emergency networks, such as International Food Safety Authorities Network and the OIE/FAO/WHO Global Early Warning and Response System for Major Animal Diseases, including Zoonoses. Nutrition surveillance and policy monitoring are currently underfunded, although the forthcoming publication of a global status report on scaling up nutrition action should facilitate advocacy and fund raising. Initiatives to estimate the global burden of foodborne disease, in particular the Foodborne Disease Burden Epidemiology Reference Group, have raised significant resources for the work of both the Secretariat and the Reference Group and its task force, through targeted and consistent efforts, demonstrating that Member States and donors recognize the value of this initiative. However, only 50% of the funds required for the six-year project have been raised.

Of the available funds, US\$ 46 million (84%) were implemented during the biennium.

LESSONS LEARNT AND KEY CHALLENGES

While WHO's normative work is recognized by all partners, a renewed focus on policy guidance, food-related disease surveillance and laboratory strengthening has presented an opportunity for further enhancing the Organization's role. Increased recognition by donors of WHO's work elicited support for initiatives, such as the Foodborne Disease Burden Epidemiology Reference Group. The creation of a coordinated, uniform system for consolidating scientific food safety advice should provide new opportunities for action and make work in the area more efficient. Actions and information sharing were being effectively integrated across the Organization and with partner organizations. Uptake of the Five Keys to Safer Food training materials demonstrated efficient regional promotion and support.

With regard to nutrition, greater efforts were needed to create synergies between the three organizational levels. An analysis of country cooperation strategies indicated that nutrition tended to be accorded lower priority or delegated to other agencies and the matter would, therefore, be discussed with WHO representatives. A global plan to strengthen the capacity of WHO staff has been developed and is awaiting funding.

STRATEGIC OBJECTIVE 10

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

The strong commitment indicated by Member States to the renewal of primary health care underpins the support that WHO is delivering in all regions. Following the adoption of the Paris Declaration, Member States have tailored their actions in accordance with different initiatives, for example, Sector-Wide Approaches, programme-based approaches, or the International Health Partnership, enabling progress to be made in aligning global interventions with national health plans. A total of 25 out of 57 countries with critical shortages in human resources for health prepared investment plans in order to improve the quality of health-professional education, but not all have the resources needed to support their plans. More countries have reliable ways of tracking health policies and spending in order to reduce out-of-pocket payments. A few countries are dedicating 2% of their health budget to research. The Intergovernmental Working Group on Public Health, Innovation and Intellectual Property established a link between implementation of the WHO strategy on research for health and the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property. More Member States now adhere to international standards for health information systems, 40% of low- and middle-income countries have generated reliable basic health statistics, and there is wider access to electronic archives and scientific journals in countries. A total of 115 countries completed the WHO Global Observatory for eHealth survey in 2009 and 53 indicated that they had eHealth policies.

ASSESSMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

Of the **twelve Organization-wide expected results** for this strategic objective, six were “fully achieved” and six “partly achieved”.

Fully achieved (6)						Partly achieved (6)					

10.1	<p>Management and organization of integrated, population-based health-service delivery through public and nonpublic providers and networks improved, reflecting the primary health care strategy, scaling up coverage, equity, quality and safety of personal and population-based health services, and enhancing health outcomes.</p> <p><i>Fully achieved</i></p> <p>Regional task forces and technical working groups provided oversight and guidance in translating the commitment of Member States to primary health care renewal into country cooperation strategy documents. Support was provided to transform national health-care delivery systems into people-centred primary care networks that reflect regional priorities: district health systems in the African, South-East Asia and Western Pacific regions; integrated health services delivery networks in the Region of the Americas and European Region; and improved quality in the Western Pacific Region. A site-based programme on people-centred primary care to raise awareness among key national public health experts, and tools for evaluating public health services were used in the health-care reform process in 10 countries. Country case studies were conducted to assess the impact of health-care delivery reforms, such as decentralization of health services, best practice in strengthening district and community-based health services, and hospital autonomy. Patient safety tools, in particular the WHO safe surgery guidelines and the surgical safety checklist, were updated; in the</p>
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	<p>Eastern Mediterranean Region, the Patient Safety Hospital Friendly Initiative was piloted in seven countries and the African Partnerships for Patient Safety initiative was launched. WHO completed its research on adverse events and devised a patient safety curriculum for medical schools in order to address safety gaps.</p>
10.2	<p>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.</p> <p><i>Fully achieved</i></p> <p>A framework for supporting health-sector strategies and health planning processes in countries, which responds to expectations for primary health care renewal, is being prepared. Technical cooperation was mainly focused on: building capacity in health planning and policy-making in more than 60 low-income countries; mobilizing resources from, for example, the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria; implementing health strategies and assessing the performance of health systems; and supporting policy dialogue on health strategies in 45 countries in the African Region and 14 in the Region of the Americas. WHO also developed planning and costing tools, which are being used to scale up health services. Work has begun on a country health intelligence platform to provide Member States with regularly updated situation analyses of their health systems.</p>
10.3	<p>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.</p> <p><i>Fully achieved</i></p> <p>Additional assistance was provided for the closer alignment of global interventions with national health plans and to support country initiatives involving, for example, national planning processes, round tables, donor coordination mechanisms and multi-stakeholder platforms. A reference document for the Paris Declaration process, including a quick-reference toolkit, was updated. Within the International Health Partnership, an interagency working group chaired by WHO developed a framework for joint assessment of national health plans, and guidance was provided to 18 countries on the use of common tools and frameworks for monitoring and evaluating health systems. WHO worked with the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance and the World Bank, facilitating their move towards more harmonized funding mechanisms, and with the OECD and World Bank in the preparation of a report¹ for submission to the Third High Level Forum on Aid Effectiveness. Country case studies on compliance with the aid effectiveness agenda were completed in Cambodia, the Lao People’s Democratic Republic, Philippines and Viet Nam, and WHO continues to monitor aid effectiveness in selected countries.</p>

¹ *Effective aid, better health: report prepared for the Accra High Level Forum on aid effectiveness, 2–4 September, 2008.* Geneva, World Health Organization, Organisation for Economic Co-operation and Development and The World Bank, 2008.

10.4	<p>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.</p> <p><i>Partly achieved</i></p> <p>In close collaboration with the Health Metrics Network, WHO supported the strengthening of health information systems. Assessments were carried out of: data quality in four countries in the European Region; health facilities in five countries in the African Region; the analytical component of health sector reviews and analyses in three regions; and health information systems in 65 countries. A global plan of action was prepared in 30 countries. Regional consultations were held on strengthening health information systems in the South-East Asia Region, and on improving vital statistics in the South-East Asia and Western Pacific regions.</p> <p>The expected result was assessed as partly achieved even though the indicator target was met because the result was not fully attained in all regions.</p>
10.5	<p>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.</p> <p><i>Partly achieved</i></p> <p>Headquarters and all regional offices produced annual summaries of key statistics, and progress was made in establishing regional observatories and databases, and improving operability between different databases. Special reports were published, inter alia, on women and health¹ and global health risks.² Many countries across all regions were supported in gathering and analysing data either through household surveys, such as on health examinations and ageing, facility assessments or censuses, including at district level. An electronic version of the International Statistical Classification of Diseases and Related Problems and a web-based eleventh revision were prepared and work began on classifications for both patient safety and traditional medicine. In 2009 a research policy was adopted in the Region of the Americas. The Regional Offices for Africa and the Eastern Mediterranean continued work on their regional strategies on the basis of the draft strategy on research for health.</p> <p>The expected result was assessed as partly achieved because certain aspects relating mainly to coordination and leadership in research for health were not fully attained in all regions.</p>

¹ *Women and health: today's evidence tomorrow's agenda*. Geneva, World Health Organization, 2009.

² *Global health risks: mortality and burden of disease attributable to selected major risks*. Geneva, World Health Organization, 2009.

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10.6	<p>National health research for development of health systems strengthened in the context of regional and international research and engagement of civil society.</p> <p><i>Partly achieved</i></p> <p>The draft WHO strategy on research for health was considered by the Executive Board at its 124th session and recommended for endorsement by the Sixty-second World Health Assembly.¹ Pending consideration by the Health Assembly,² several WHO departments are using its framework for updating specific strategies and plans, for example, in the areas of food safety, influenza and patient safety. Notably, the research strategy has been integrated in the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property. The EVIPNET portal enabled additional countries to strengthen their health research systems as evidenced by more robust local studies. A recently published casebook on ethical issues in health research would be used in future training courses.³</p>
10.7	<p>Knowledge management and eHealth policies and strategies developed and implemented in order to strengthen health systems.</p> <p><i>Fully achieved</i></p> <p>Strategies on knowledge management were prepared in four regional offices, and on eHealth in several countries. Knowledge management and eHealth, as well as the use of health information and communications technologies to strengthen health systems, are now components of more WHO country cooperation strategies. Partnerships were extended to include additional United Nations and other development agencies. Coverage of the Health InterNetwork Access to Research Initiative was expanded, associated training courses organized, and training materials made available in several languages.</p>
10.8	<p>Health-workforce information and knowledge base strengthened, and country capacities for policy analysis, planning, implementation, information-sharing and research built up.</p> <p><i>Fully achieved</i></p> <p>Further efforts were made to collate data and information for human resources for health planning, monitoring, research and advocacy at regional and global levels. The Global Atlas of the Health Workforce, which can be accessed on the Internet, is actively populated by WHO at all levels, but although coverage has increased, only 44% of Member States are reporting countries. A desk study was carried out on the existence of human resources for health units in health ministries as a proxy indicator for measuring their technical and institutional capacity to design and lead the implementation of related policies.</p>

¹ See EB124/2009/REC/2.

² Postponed to the Sixty-third World Health Assembly, see document WHA62/2009/REC/3, summary record of the first meeting of the General Committee.

³ Cash R. et al., eds. *Casebook on ethical issues in international health research*. Geneva, World Health Organization, 2009.

10.9	<p>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.</p> <p><i>Fully achieved</i></p> <p>The progress made in human resources for health development among the 57 countries with severe staff shortages continued to be monitored. According to a stock-taking exercise, 47 countries now have multi-year plans and 25 investment plans for improving the quality of health-professional education, although only six have the resources required to support their plans.</p>
10.10	<p>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.</p> <p><i>Partly achieved</i></p> <p>Faced with a growing demand from countries for technical support to expand or maintain access to services and social and financial risk protection, WHO was able to support more than 65 countries. Collaborative efforts across the Organization were focused on securing early intelligence from countries on the impact on health of the financial crisis and suggesting ways of maintaining or improving universal coverage while it lasted. WHO continued to collate and disseminate evidence on aspects of health financing policies that reflected different interests: improving efficiency and curtailing costs in higher-income countries, and raising additional resources in order to move away from out-of-pocket payments in lower-income countries. Member States in all regions sought support in developing either general health financing strategies, sometimes as part of overall health plans, or components of a health financing system, such as provider payment systems, hospital financing and health insurance.</p> <p>The expected result was assessed as partly achieved even though the indicator targets were met because the result was not fully attained in three regions.</p>
10.11	<p>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.</p> <p><i>Partly achieved</i></p> <p>Guidelines on estimating the economic impact of disease and injury,¹ and guidance on measuring expenditure on human resources for health as part of the national health accounts exercise² were finalized. More than 30 countries requested and received support in using tools, for example for identifying financial catastrophe linked to out-of-pocket payments and the financial implications and costs of health insurance. In response to the growing number of requests from countries for support in preparing applications to global health initiatives, the Regional Office for Africa supported the preparation of proposals to the Global Fund to Fight Aids, Tuberculosis and Malaria by 22 countries and to the GAVI Alliance by 9 countries.</p> <p>The expected result was assessed as partly achieved even though the target number of Member</p>

¹ WHO guide to identifying the economic consequences of disease and injury. Geneva, World Health Organization, 2009.

² Dal Poz, MR. et al. *Handbook on monitoring and evaluation of human resources for health: with special applications for low- and middle-income countries*. Geneva, World Health Organization, World Bank and United States Agency for International Development, 2009, Chapter 6.

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	States given technical support for using WHO financial tracking, evaluation and management tools was met because the result was not fully attained in two regions.
10.12	<p>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.</p> <p><i>Partly achieved</i></p> <p>WHO supported more than 50 countries to track their health expenditure in connection with policy-making. The Regional Office for the Western Pacific updated the framework for institutionalizing national health accounts, while the Regional Office for Europe worked with Kyrgyzstan and Tajikistan on implementing sector-wide approaches to finances. The Regional Offices for South-East Asia, the Eastern Mediterranean and the Western Pacific collaborated on preparing training modules in financing policy, and the Regional Office for the Americas supported countries in designing and monitoring Poverty Reduction Strategy Papers. The Regional Office for Africa supported countries in measuring efficiency and exploring the feasibility of results-based financing.</p> <p>The Organization-wide expected result was assessed as partly achieved even though the target numbers of partnerships in which WHO participated and countries that received long-term financing options were met, because four WHO offices reported that insufficient funding had compromised progress.</p>

SUMMARY OF FINANCIAL IMPLEMENTATION (US\$ thousand)

2008–2009	African Region	Region of the Americas	South-East Asia Region	European Region	Eastern Mediterranean Region	Western Pacific Region	WHO headquarters	Total
Approved budget	142 093	37 462	57 829	48 567	66 206	46 607	115 290	514 054
Funds available ¹	58 780	21 494	34 406	38 301	39 493	39 282	194 288	426 089
<i>Funds available as a % of approved budget</i>	<i>41%</i>	<i>57%</i>	<i>59%</i>	<i>79%</i>	<i>60%</i>	<i>84%</i>	<i>169%</i>	<i>83%</i>
Expenditure	51 785	20 818	30 553	29 533	34 680	28 838	122 417	318 625
<i>Expenditure as a % of approved budget</i>	<i>36%</i>	<i>56%</i>	<i>53%</i>	<i>61%</i>	<i>52%</i>	<i>62%</i>	<i>106%</i>	<i>62%</i>
<i>Expenditure as % of funds available</i>	<i>88%</i>	<i>97%</i>	<i>89%</i>	<i>77%</i>	<i>88%</i>	<i>73%</i>	<i>63%</i>	<i>75%</i>

¹ Includes US\$ 23 000 of undistributed funds.

The total approved budget for the strategic objective was US\$ 514 million, of which US\$ 495 million were for Base programmes and US\$ 19 million for Partnerships and collaborative arrangements, such as the World Alliance for Patient Safety, the Health Metrics Network and the Global Health Workforce Alliance.

Of the approved budget, US\$ 426 million (83%) were made available through assessed and voluntary contributions, of which US\$ 347 million (70% of approved budget) were for Base programmes and US\$ 79 million (407% of approved budget) for Partnerships and collaborative arrangements. In the African, South-East Asia and Eastern Mediterranean regions, the approved budget generally exceeded the amount of the funds that could be raised and implemented for health-system support at country level.

Of the available funds, US\$ 319 million (75%) were implemented during the biennium. A total of US\$ 273 million (79% of available funds) were for Base programmes and US\$ 46 million (58% of available funds) were for Partnerships and collaborative arrangements. The lower than average implementation rate for Partnerships and collaborative arrangements was mainly due to a higher level of funding than expected being received, of which a proportion was earmarked for activities in 2010–2011.

LESSONS LEARNT AND KEY CHALLENGES

The renewed interest in strengthening health systems and in primary health care was a positive development. The alignment of the health systems agenda, global health initiatives and various funding platforms with countries' own plans was a first step towards improving the functioning of national health systems. While internal and external partnerships have been strengthened, synergy and collaboration across the Organization are aspects that still need to be addressed. The lack of expertise, particularly at country level, represents a major challenge. Therefore, the number of health personnel needs to be increased and their skills enhanced in countries with the greatest need as part of the overall strengthening of health systems.

STRATEGIC OBJECTIVE 11

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

In 2008–2009, with the continued support of WHO, 29 countries formulated or updated their medicines policies and 10 developed transplantation policies; several countries in the African and Western Pacific regions formulated national policies on traditional medicine and 15 countries drew up safe blood policies. Regional medicines policy guidelines and strategies were updated in two regions. The Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property were adopted by Member States.

By late 2009, 46 national medicine regulatory agencies and 114 vaccine regulatory agencies had been formally assessed. Regulatory oversight for prequalification of vaccines against infection with pandemic influenza A (H1N1) 2009 virus was assessed in 13 countries. Many developing countries still lack adequate regulatory systems for medicines, vaccines, blood products, diagnostics and other health technologies.

Despite the potential of comprehensive supply strategies and the rational use of medical products to reduce medical and economic waste, progress in promoting them has been hampered by a lack of political interest at country level and of resources within WHO.

ASSESSMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

Of the **three Organization-wide expected results** for this strategic objective, one was “fully achieved” and two were “partly achieved”.

Fully achieved (1)	Partly achieved (2)
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<p>11.1</p>	<p>Formulation and monitoring of comprehensive national policies on access, quality and use of essential medical products and technologies advocated and supported.</p> <p><i>Partly achieved</i></p> <p>A total of 56 countries were supported to formulate, implement and monitor their national medicines policies; experts from another 60 countries participated in training sessions in related areas. Global indicators for monitoring access to essential medicines were refined and used in two United Nations reports on achieving Millennium Development Goal 8.^{1,2} The first global WHO Congress on Traditional Medicine, held in Beijing, 7–9 November 2008, adopted the Beijing Declaration on the integration of traditional medicine into national health systems. A new vaccine regulatory process was piloted in three countries, and a global training programme for reviewing clinical data for vaccine registration was developed. Technical support was provided to 22 priority countries for strengthening their blood transfusion services and to 39 priority countries for improving injection safety.</p>
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¹ *Delivering on the global partnership for achieving the Millennium Development Goals: Millennium Development Goals gap task force report 2008*. New York, United Nations, 2008.

² *Strengthening the global partnership for development in a time of crisis: Millennium Development Goals gap task force report 2009*. New York, United Nations, 2009.

	<p>The expected result was assessed as partly achieved because some planned support to countries in the areas of medicines supply management and safe blood and blood products was not implemented, largely due to gaps in voluntary contributions.</p>
11.2	<p>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.</p> <p><i>Fully achieved</i></p> <p>A total of 67 global monographs on medicine quality, seven reference standards, 30 reference spectra and 10 sets of medicine quality guidelines were published. The United Nations prequalification programme, managed by WHO, prequalified 84 medicines, including 14 paediatric formulations. A total of 19 global vaccine quality standards were issued or updated. By the end of 2009, 98 prequalified vaccines had been produced in 16 countries, catering for 53% of the world's birth cohort in 112 countries. Efforts to achieve regulatory harmonization were intensified in the African Region. A total of 12 global norms and related guidance were issued covering, inter alia, donated blood, human cell and tissue transplantation and investment planning. Participants from many countries took part in training programmes on blood safety, emergency surgical care and other health technologies. The prequalification processes for diagnostics for HIV/AIDS and malaria were begun.</p>
11.3	<p>Evidence-based policy guidance on promoting scientifically sound and cost-effective use of medical products and technologies by health workers and consumers developed and supported within the Secretariat and regional and national planning programmes.</p> <p><i>Partly achieved</i></p> <p>The seventeenth edition of the WHO Model List of Essential Medicines and second edition of the WHO Model List for Children were published in March 2009. Most countries across all income levels are adapting them and preparing national lists of essential medicines as the basis for medicines procurement and use in the public sector; some are also using the Lists as a guide for reimbursement and insurance systems. Regional training courses were held and several countries received support in connection with clinical guidelines, medicines pricing and reimbursement for essential medicines. A draft list of essential medical devices for 100 clinical practice protocols and five types of health facility was prepared. In response to resolution WHA60.16, on progress in the rational use of medicines, the global database of studies on the rational use of medicines was completed. Country support in promoting rational use among prescribers and consumers tends to be restricted to national normative activities, such as updating lists of essential medicines and treatment guidelines, and pilot projects, while fully scaled-up national implementation programmes remain rare in all regions.</p> <p>The expected result was assessed as partly achieved because of a lack of political interest at country level and of resources within WHO.</p>

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SUMMARY OF FINANCIAL IMPLEMENTATION (US\$ thousand)

2008–2009	African Region	Region of the Americas	South-East Asia Region	European Region	Eastern Mediterranean Region	Western Pacific Region	WHO headquarters	Total
Approved budget	22 592	8 940	14 290	6 971	16 763	9 989	54 488	134 033
Funds available ¹	20 968	5 573	5 917	3 465	7 852	13 609	103 038	160 497
<i>Funds available as a % of approved budget</i>	93%	62%	41%	50%	47%	136%	189%	120%
Expenditure	19 147	5 200	5 401	3 635	6 572	9 049	77 635	126 638
<i>Expenditure as a % of approved budget</i>	85%	58%	38%	52%	39%	91%	142%	94%
<i>Expenditure as % of funds available</i>	91%	93%	91%	105%	84%	66%	75%	79%

The total approved budget for the strategic objective was US\$ 134 million, of which US\$ 160 million (120%) were raised through assessed and voluntary contributions. The increase was due mainly to the additional funding needed for global normative activities, in particular, further expansion of the WHO/United Nations prequalification programme for priority vaccines, medicines and diagnostics, and the programme for better medicines for children. Of the available funds, US\$ 127 million (79%) were spent during the biennium. Not all the available funds were implemented as some of the contributions were received late and the recruitment of staff for these programmes was delayed.

Of the approved budget, 41% was planned for global normative functions and 59% for regional and country support activities. The difficulty of raising financing for country-based support activities, particularly in the Eastern Mediterranean and South-East Asia regions, meant that part of the regional and country budget remained unfunded. That, coupled with the increase in the global normative budget, resulted in an expenditure ratio of 61% for global normative activities and 39% for regional and country support. This ratio has been constant over past bienniums and does not apply to WHO as a whole, but it correctly reflects the large global normative component in the strategic objective.

LESSONS LEARNT AND KEY CHALLENGES

When technical subjects, such as counterfeit medicines or product prequalification, elicit strong political interest and controversy, certain conditions are required to ensure continued progress including wide global consultation, strictly applied rules and procedures, publication of a single global standard based on all the available scientific evidence, and complete transparency regarding progress and future developments.

¹ Includes US\$ 74 000 undistributed funds.

Regulatory authorities were well prepared and responded vigorously to the need to facilitate rapid development of vaccines against infection with pandemic influenza A (H1N1) 2009 virus, while retaining a proportionate degree of independent oversight of the quality, safety and efficacy of candidate products. Authorities in Member States also cooperated with WHO, and with each other, in exchanging information to build consensus.

Certain technical areas, such as the containment of antimicrobial resistance, promoting the rational use of medicines and medical devices, and injection safety, while supported by World Health Assembly resolutions and having potential medical and economic benefits, lack extrabudgetary funding, and, therefore, do not show significant progress.

Addressing gaps in capacity in low- and middle-income countries will enable better implementation of planned activities. For example, less than one third of Member States have a diagnostics regulatory system, and, where regulations exist, they are often not enforced. WHO should concentrate its support in those countries on facilitating institutional reform and building the capacity of professional staff in regulatory agencies.

STRATEGIC OBJECTIVE 12

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

The global economic crisis and pandemic (H1N1) 2009 required closer cooperation between technical staff throughout WHO, which improved the delivery of regular information on risks and responses adapted to national situations. The series of regional conferences on primary health care renewal gave a clear leading role to WHO and fostered collaboration with countries and partners. In addition to sessions of governing bodies, meetings of the Intergovernmental Working Groups on Public Health Innovation and Intellectual Property, and Pandemic Influenza Preparedness facilitated discussions among Member States on urgent public health matters. Progress was made on alignment of WHO country cooperation strategies with Member States’ priorities, and on harmonization among United Nations and other development partners. WHO strengthened its engagement in partnership mechanisms and initiatives, such as the United Nations Development Group “Delivering as One” pilot process and the International Health Partnership, particularly at country level.

ASSESSMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

Of the **four Organization-wide expected results** for this strategic objective, all were “fully achieved”.

Fully achieved (4)			

12.1	<p>Effective leadership and direction of the Organization exercised through enhancement of governance, and the coherence, accountability and synergy of WHO’s work.</p> <p><i>Fully achieved</i></p> <p>Leadership, synergy and performance throughout WHO were strengthened by regular meetings of the WHO Global Policy Group, as well as monthly retreats for Assistant Directors-General, regular meetings of executive management teams at regional level and the closer involvement of heads of WHO country offices, for example, through the Fifth Global Meeting of heads of Country Offices. The Director-General further demonstrated WHO’s leadership by conducting effective dialogue with different partners and coordinating the health agenda, and by actively supporting the United Nations Secretary-General on foreign policy and global health issues. Several intergovernmental working group meetings resulted in the adoption of global strategies and action plans.</p> <p>The expected result was assessed on the basis of a qualitative evaluation because the stakeholder survey was considered to be no longer appropriate.</p>
12.2	<p>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.</p> <p><i>Fully achieved</i></p> <p>The implementation in two regions thus far of the harmonization and alignment capacity development programme has improved the ability of WHO country teams to engage with partners and harmonize their work with other United Nations agencies and development partners. WHO</p>

	<p>regional offices have strengthened their collaboration with the United Nations Regional Directors' Team mechanism within the United Nations Development Assistance Framework. A total of 145 Member States have country cooperation strategies, which are regularly updated and are being used to reinforce the health component of the Framework and other health partnerships, and to mobilize additional resources. A competitive selection process for heads of country offices was initiated during the biennium.</p>
12.3	<p>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.</p> <p><i>Fully achieved</i></p> <p>Development of policy guidance for United Nations Reform processes, including “Delivering as One”, and on partnerships, has helped improve coherence between WHO and the United Nations, hosted partnerships and various collaborative arrangements. Engagement by regional offices with United Nations Regional Coordination Mechanisms and the Regional Directors of other United Nations agencies strengthened synergies and alignment in order to maximize contributions to the health development agenda at regional and country levels. WHO country teams have assumed leadership of the Health Cluster within the United Nations Development Assistance Framework. In support of primary-health-care renewal, WHO has also revitalized and expanded its efforts to engage with civil society. At least 250 possible collaborations with the private sector were reviewed. Memorandums of Understanding were issued or renewed with four hosted partnerships and several intergovernmental organizations.</p>
12.4	<p>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.</p> <p><i>Fully achieved</i></p> <p>WHO's achievements included the implementation of a WHO publishing policy, expansion of the master list of publications, adoption and implementation of resolution WHA61.12 on multilingualism, and improvement of access to technical and scientific literature through global library services. Key information products, including <i>The world health reports</i>, regional reports and technical and scientific publications, as well as multilingual versions of the <i>Bulletin of the World Health Organization</i> and <i>The world health report</i> were published and distributed on time. The role of the Internet in sharing and disseminating health information is increasing and multilingual web sites are now operational across different levels of the Organization. The web site of the Regional Office for Africa was revamped in English, French and Portuguese; that of the Regional Office for the Eastern Mediterranean now provides access to 40 portals in Arabic and English, and 12 country offices in the Region have launched web sites. Functioning WHO health information networks include, the Global Health Library, the Health, Literature, Library and Information Services network, the Virtual Health Library and the medical journals consortium.</p>

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SUMMARY OF FINANCIAL IMPLEMENTATION (US\$ thousand)

2008–2009	African Region	Region of the Americas	South-East Asia Region	European Region	Eastern Mediterranean Region	Western Pacific Region	WHO headquarters	Total
Approved budget	48 966	16 559	14 304	25 341	26 482	15 636	67 056	214 344
Funds available	45 088	13 187	13 109	25 358	22 834	15 147	100 184	234 908
<i>Funds available as a % of approved budget</i>	92%	80%	92%	100%	86%	97%	149%	110%
Expenditure	44 967	10 741	12 986	24 903	23 403	13 950	87 516	218 466
<i>Expenditure as a % of approved budget</i>	92%	65%	91%	98%	88%	89%	131%	102%
<i>Expenditure as % of funds available</i>	100%	81%	99%	98%	102%	92%	87%	93%

The total approved budget for the strategic objective was US\$ 214 million, of which US\$ 235 million (110%) were made available through assessed and voluntary contributions, mostly as programme support costs. Of the available funds, US\$ 218 million (93%) were implemented during the biennium. Higher-than-expected implementation of the approved budget in headquarters, and the resultant increase in the allocation of programme support costs to the strategic objective, were attributable largely to an unexpected rise in salary costs due to exchange rate fluctuations.

In past bienniums, total expenditure has exceeded income from programme support costs. A WHO working group has been established to review the situation and propose ways of improving harmonization between strategic objectives 12 and 13 in order to achieve savings and introduce working methods that would deliver full cost recovery.

At regional level, the regional development fund has remained under strategic objective 12 even though it is mainly used for health emergency response. This approach is being reconsidered and an emergency fund will be set up under strategic objective 5.

LESSONS LEARNT AND KEY CHALLENGES

Improving coherence and dialogue across the Organization as a whole and fostering WHO's leadership role, to which the Director-General and Regional Directors were fully committed, were the key focus of attention during the biennium. Country cooperation strategies were also widely implemented.

The financial crisis stimulated a debate on the need to define WHO's core functions more clearly. While pandemic (H1N1) 2009 represented an additional challenge, it also provided an opportunity for testing collaboration mechanisms, partnerships and communications systems and reinforcing them where necessary.

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Appropriate resourcing is required to improve efficiency and make savings, and to ensure the effectiveness of WHO's leadership, governance and partnership functions. The convening of additional unplanned intergovernmental working groups and consultations has had a negative impact on scheduled activities. Global health partnerships and initiatives also increased the demands made on WHO technical staff, particularly in support of countries' needs.

Country cooperation strategies are now recognized as an Organization-wide reference point for countries' activities and, therefore, need to be more closely monitored. The competitive and competency-based selection process for heads of WHO country offices should enhance WHO's leadership in countries, however, it needs to be strictly applied.

Efforts to align the budget with WHO's priorities, and the expected results with available resources will be pursued through dialogue with Member States. Monitoring of corporate performance on the basis of agreed indicators will be further strengthened.

STRATEGIC OBJECTIVE 13

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

WHO’s results-based management framework was reinforced through the stricter measurement and use of performance indicators, and greater alignment with the priorities defined in country cooperation strategies. The Global Management System was introduced in headquarters and the Western Pacific Region, and preparations and training were completed for its implementation in the Eastern Mediterranean, European and South-East Asia regions. The Global Management System provides the Organization with a fully integrated system encompassing planning and budgeting, technical and financial implementation, monitoring and reporting, and budget and finance management. The International Public Sector Accounting Standards were being introduced as part of the United Nations harmonization process, but their coverage will not be complete until the Global Management System becomes fully operational across all regions. The Global Service Centre provides managerial and administrative support services covering information technology, payroll, human resources, payments and procurement. Its performance is approaching the expected service level in all areas. Most elements of the Capital Master Plan for 2008–2009 were completed; however, many projects that were deferred remain unfunded. The first Global Human Resources Plan was prepared and a revised selection process for heads of WHO country office, using a global roster, was introduced. Cooperation was strengthened between headquarters and the regional offices to better track alignment between planned expenditures, donor resources, implementation and results. The Executive Board at its 125th session, in resolution EB125.R1, decided to establish an Independent Expert Oversight Advisory Committee, which will have a positive impact on risk management and control systems.

ASSESSMENT OF ORGANIZATION-WIDE EXPECTED RESULTS

Of the **six Organization-wide expected results** for this strategic objective, one was “fully achieved” and five were “partly achieved”.

Fully achieved (1)	Partly achieved (5)				

13.1	<p>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.</p> <p><i>Partly achieved</i></p> <p>WHO’s management system was further enhanced and greater emphasis placed on performance indicator data collection and analysis and planning for country-level work. The refining of the indicators in the amended Medium-term strategic plan means that the Organization-wide expected results indicators are clearer and easier to measure and report on. Greater expertise in results-based management, planning processes, including strategic planning, and programme monitoring and assessment have resulted in more consistent, harmonized planning processes and increased transparency in performance monitoring and reporting. The framework for programme development and management at country level has been made clearer and particular attention has been given to ensuring workplans are aligned with the priorities indicated in country cooperation strategies. More consistent peer review mechanisms have improved the quality of planning processes and performance management at all levels.</p>
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	<p>The Organization-wide expected result was assessed as partly achieved because agreed time frames for monitoring and reporting were not always complied with.</p>
13.2	<p>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.</p> <p><i>Partly achieved</i></p> <p>Through more detailed, real-time monitoring, the Global Management System enables funding gaps and risks to be identified and tracked, thereby providing a firmer basis for the allocation of funds, such as those in the core voluntary contributions account. Active engagement with donors to ensure predictable and flexible donations resulted in contributions from 14 donors and the signing of several multi-year framework agreements. Although some progress has been made in implementing the International Public Sector Accounting Standards (IPSAS), their coverage will not be complete until the Global Management System has been introduced in all WHO offices. Good management secured a modest overall positive return on investments despite the unprecedented challenges posed by the global banking crisis. Despite delays affecting financial reporting and income management caused by initial difficulties with the introduction of the Global Management System, which particularly affected human resources planning, all requirements have ultimately been met.</p> <p>The expected result was assessed as partly achieved because of the shortfall in the targeted amount of fully and highly flexible voluntary contributions.</p>
13.3	<p>Human resource policies and practices in place to attract and retain top talent, promote learning and professional development, manage performance, and foster ethical behaviour.</p> <p><i>Partly achieved</i></p> <p>The policy on contractual arrangements was amended in order to achieve equity between types of appointment. The updated <i>WHO e-Manual</i> consolidated human resources policy and procedures in a user-friendly tool accessible to all WHO staff. Numerous training and facilitation exercises were carried out to ensure the smooth integration of human resources in the Global Management System, and support continued to be provided at all organizational levels. Communication and dialogue have been improved, inter alia, through Global Staff Management Council and regional personnel officers meetings, and by the launching of the global web-based human resources community site. Completion of the first global human resources workplan, in 2009, clearly indicated WHO's priorities and should facilitate the allocation of roles and responsibilities. Initial assessments were completed for the first WHO heads of country offices global roster. A document on ethical principles and staff conduct was published and disseminated to all staff members.</p> <p>The expected result was assessed as partly achieved because the introduction of a formal mobility scheme was postponed until the biennium 2010–2011.</p>
13.4	<p>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.</p> <p><i>Partly achieved</i></p> <p>The deployment of the Global Management System from mid-2008 created opportunities for the sharing of a common architecture, reviewing the integration of systems and consolidating processes across WHO. The Global Private Network became operational across regional and country offices, allowing WHO to use global applications to leverage economies of scale in operational management. During 2009, efforts were made to integrate Information Technology Infrastructure Library based processes used by the Global Service Desk with regional service desks. Support</p>

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	<p>structures were developed and operational procedures continuously improved so as to work effectively for end-users across WHO. Other information communications technology achievements covered, implementation of a global identity management system, development of information security policies, and arranging support in emergencies.</p> <p>The expected result was assessed as partly achieved because of the limited introduction of the Global Management System as the primary platform for consistent real-time information management.</p>
13.5	<p>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.</p> <p><i>Fully achieved</i></p> <p>The delivery of management and administrative support services was initially hampered by the introduction of the Global Management System and the Global Service Centre. Service levels were affected during the first 12 months of operation (months six to 18 of the biennium) because the system was unstable and most of the staff in the Global Service Centre were new to WHO. Service delivery improved during 2009, and, for the last half of the year, the Centre was operating in accordance with the Service Level Agreement. Accounts Payable and Global Procurement and Logistics met all their performance targets, while Payroll and Global Human Resources partly achieved them. Issues relating to quality and controls were identified and are being resolved.</p>
13.6	<p>Working environment conducive to the well-being and safety of staff in all locations.</p> <p><i>Partly achieved</i></p> <p>Achievements in this area were the result of the careful management and implementation of critical repair and maintenance projects. In general, regional and country offices attempted to improve security through mandatory security training of staff members, provision of technical assistance and performance of fire and emergency evacuation drills. Compliance with Minimum Operating Safety Standards in country offices reached a global average of 70%; appropriate recommendations were made in the case of the Regional Offices for Africa and the Eastern Mediterranean.</p>

SUMMARY OF FINANCIAL IMPLEMENTATION (US\$ thousand)

2008–2009	African Region	Region of the Americas	South-East Asia Region	European Region	Eastern Mediterranean Region	Western Pacific Region	WHO headquarters	Total
Approved budget	125 526	29 823	49 551	36 932	38 040	33 214	229 286	542 372
Funds available	99 885	18 688	37 016	38 268	37 492	29 419	252 294	513 061
<i>Funds available as a % of approved budget</i>	<i>80%</i>	<i>63%</i>	<i>75%</i>	<i>104%</i>	<i>99%</i>	<i>89%</i>	<i>110%</i>	<i>95%</i>

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Expenditure	99 348	19 337	36 755	37 065	38 611	25 122	233 387	489 624 ¹
<i>Expenditure as a % of approved budget</i>	79%	65%	74%	100%	102%	76%	102%	90%
<i>Expenditure as % of funds available</i>	99%	103%	99%	97%	103%	85%	93%	95%

The total approved budget for the strategic objective was US\$ 542 million, of which US\$ 513 million (95%) was made available through assessed and voluntary contributions. Of the available funds, US\$ 490 million (95%) were implemented during the biennium.

A total of 55% of the funding was from assessed contributions, which represent only 25% of the Organization's funding, and was fully implemented. The growth in the Organization's operations over previous bienniums required increased managerial support for programmes, including through enhanced technological development and security costs.

Voluntary contributions and the income generated by programme support costs have been insufficient to cover the proportion of the total budget allocated for expenditure on general management and administration. The Programme budget 2010–2011 contains plans for participating in United Nations system consultations on cost recovery in order to develop ways of charging a portion of administration costs directly to technical work, where they can be accurately and reasonably attributed. The work on cost recovery is expected to improve support for the strategic objective in the next biennium.

LESSONS LEARNT AND KEY CHALLENGES

Much of the work associated with this strategic objective was influenced by the preparations for the introduction of the Global Management System in all locations. New procedures and disciplines have affected the way in which WHO plans its work and how the plans are linked to funding sources and programme implementation. The deployment of information technologies was also affected.

The introduction of the Global Management System resulted in operational difficulties, user frustration and time spent in remedying the flaws. To ensure effective management and accountability in the future, more attention should be given to the quality of system data, human resources planning, including financing, common standards and processes, and monitoring and analysing cost drivers.

Over-optimistic budgeting and a lower level of donor support than that set by the World Health Assembly meant that resources were not always aligned with programme implementation. The Secretariat is developing relevant strategies, including an action plan for better resource alignment, for discussion by the Programme, Budget and Administration Committee of the Executive Board.

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¹ Further expenditure of US\$ 52 million was financed through separate mechanisms.