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WHO Regional Office for Europe Performance assessment report 2012–2013

This document provides the Regional Committee for Europe with a final assessment of the implementation of the Regional Office's 2012–2013 programme budget as well as performance against objectives set in document EUR/RC61/Inf.Doc./10, using the programme budget as a strategic tool for accountability – a pilot trial for WHO reform in the European Region. The Standing Committee of the Regional Committee for Europe provided input as part of its oversight function.

The performance assessment has two parts.

(1) The main part is an analytical overview of the performance of the WHO Regional Office for Europe, with summary tables and annexes. It describes the background and context of technical achievements, the financial situation and technical and managerial challenges faced during the biennium. It identifies lessons learnt, which will inform programme budget implementation for 2014–2015 and planning for 2016–2017.

(2) The Appendix (available online and in English only) gives a detailed account of the WHO European Region's contribution to the indicators of WHO-wide expected results. It also provides detailed accounts of achievements for each key priority and other priority outcomes during 2012–2013. These include weblinks to the concrete outputs delivered by the Secretariat during the biennium.

WORLD HEALTH ORGANIZATION REGIONAL OFFICE FOR EUROPE
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark Telephone: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: governance@euro.who.int Web: http://www.euro.who.int/en/who-we-are/governance

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Executive summary

1. After several years of continued imbalance between the priorities endorsed by the governing bodies and the funding available to implement those priorities and with an unclear division of responsibilities between Member States and the Secretariat, the 60th session of the Regional Committee for Europe (RC60) in 2010 requested the Regional Director to submit for its 61st session a package of performance indicators and a list of key deliverables for the 2012–2013 biennium. The intention was to enhance transparency and accountability for implementation of the programme budget (PB) in the Region. For RC61 in 2011, the Regional Director provided an information document[1] with the requested performance indicators and the list of key deliverables. The document, entitled "The programme budget as a strategic tool for accountability – a proposed 2012–2013 pilot trial for WHO reform", proposed a package to be used in a pilot trial for WHO reform, which was starting at that time. This performance assessment document informs the Regional Committee of the results of the pilot trial and the performance of the Region in general in implementing the global PB 2012–2013.

2. Central to the pilot trial was the concept of a value chain in which, through a series of steps, inputs are transformed into health impacts; at each step (process, outputs, outcomes and health impact), further value is added. The value chain also indicates that the Secretariat can be held solely accountable only for the efficiency of the process and delivery of outputs, while achievement of the outcomes is the joint responsibility of Member States and the Secretariat. The value chain also illustrates how placing conditions on the inputs, in particular by the specification of voluntary contributions, has effects throughout the value chain, sometimes beyond the purpose of the individual contribution.

3. The Standing Committee of the Regional Committee for Europe (SCRC) played a key role in the pilot trial period. As part of its oversight function, it closely followed progress and provided feedback on performance and advice on formatting and presenting the information on performance. This report was shaped by an ongoing dialogue between the SCRC and the Secretariat.

4. The pilot trial covered 83 priorities for the Region, 27 of which were considered "priorities within priorities" and thus called "key priority outcomes" (KPOs), which were to be given managerial and funding preference. The trial also included six performance indicators in three groups: inputs, process and results.

- **Inputs**: "Proportion of specified contributions that can be used for funding salaries" and "Proportion of voluntary contributions that are flexible at the SO [strategic objective] level or above". For the first indicator, the baseline was 50% and the target 55%; however, achievement was only 46%, that is, even less than the baseline. For the second, the baseline was 7%, while the target and the achievement were 14% and 20%, respectively. Thus, the flexibility provided for some of the voluntary contributions was countered by increased inflexibility with respect to staff funding from other contributions.
- **Process**: "Proportion of total expenditures spent on staff in base programmes (SO1–SO11)". For this indicator, the baseline was 60%, while the target was 55% and the achievement 56%. The reduction in the share of overall expenditure on staff costs was a main challenge of the Regional Office in 2012–2013. This challenge was amplified by difficulties in funding staff costs from specified voluntary contributions. For the indicator

[1] The programme budget as a strategic tool for accountability: a proposed 2012–2013 pilot trial for WHO reform. Copenhagen: WHO Regional Office for Europe; 2011 (EUR/RC61/Inf.Doc/10; http://www.euro.who.int/__data/assets/pdf_file/0012/150033/RC61_eInfDoc10.pdf, accessed 16 April 2014).

"Proportion of corporate resources in SO1–SO11 allocated to KPOs, with the remainder allocated to other priorities within the SO", the target was 80%, while achievement was 51%. There are several explanations, including insufficient priority given by the Secretariat to allocation of resources to the KPOs and difficulty in funding salaries, which took resources from the KPOs.

- **Results** (outputs and outcomes): "Proportion of planned KPO outputs delivered" (target 95%, achieved 72%) and "Proportion of planned KPOs achieved" (target 85%, achieved 65%). The explanations for the low achievement of both these indicators may be sought in the factors affecting the earlier steps of the value chain, mentioned above. Equally important may be overplanning and over-optimism on the part of both the Member States and the Secretariat with respect to what could feasibly be achieved within the biennium.

5. All 83 priority outcomes have been reviewed in detail to account for the achievements for each outcome pursued during 2012–2013; the results of the review are given in the Appendix. The main highlights are summarized below by SO. Details and weblinks to the concrete outputs delivered by the Secretariat in the biennium are given in the Appendix,[2] which is available online and in English only.

6. ***Strategic objective 1****: To reduce the health, social and economic burden of communicable diseases*

- The 2002 polio-free status of the European Region was maintained.
- Laboratory capacity was increased, so that 33 countries can now detect two emerging respiratory viruses: Middle East respiratory syndrome coronavirus and avian influenza A(H7N9).
- Partnerships were established to address leishmaniasis, invasive mosquito species, re-emerging vector-borne diseases and soil-transmitted helminths at regional and country levels.

7. ***Strategic objective 2***: *To combat HIV/AIDS, tuberculosis and malaria*

- HIV treatment coverage is still low but improved from 23% in 2010 to 35% in 2012.
- The Region achieved 80% coverage for prevention of mother-to-child HIV transmission in 25 targeted low- and middle-income countries; only 1% of new HIV cases reported in 2012 in the Region were transmitted from mother to child.
- A new molecular diagnostic test to detect tuberculosis (TB) and rifampicin-resistant TB (as a proxy for multidrug-resistant tuberculosis (MDR-TB)) in less than 100 minutes was widely introduced in the Region.
- Treatment coverage for MDR-TB patients increased from 63% in 2011 to 97% in 2013.

8. ***Strategic objective 3***: *To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries and visual impairment*

- The noncommunicable diseases (NCDs) global monitoring framework was adopted regionally in May 2013.
- *The European Mental Health Action Plan* was adopted by the Regional Committee in 2013.

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[2] Performance assessment report 2012–2013. Appendix: OWER indicators and detailed outcome assessment sheets. Copenhagen: WHO Regional Office for Europe; 2014 (https://euro.sharefile.com/download.aspx?id=s8fba90cf8e94c6e8).

- To promote action on violence and injury prevention in the Region, a European fact sheet and global status report on road safety and a European report on preventing child maltreatment were published.

9. ***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*

- Good progress was made in decreasing child mortality and improving maternal health in eastern and central Europe (as per indicators for meeting the Millennium Development Goals (MDGs)).
- More Member States (18) have developed, with WHO support, policies for achieving universal access to sexual and reproductive health care.
- Awareness has increased on healthy ageing; evaluation of the WHO European Healthy Cities Network for 2012–2013 showed that 80% of cities now have initiatives or actions on healthy ageing.

10. ***Strategic objective 5****: To reduce the health consequences of emergencies, disasters, crises and conflicts and minimize their social and economic impacts*

- An all-hazards approach was adopted in order to strengthen health systems preparedness in European Member States.
- Partnerships for health response and close collaboration with the European Centre for Disease Prevention and Control and the European Commission were promoted to enhance health emergency preparedness, risk management and response capacity throughout Europe.
- In collaboration with partners, the Regional Office has established mechanisms to mobilize a network of experienced international experts to respond to emergencies; the geographically dispersed office for preparedness for humanitarian and health emergencies in Turkey is expected to consolidate this work.

11. ***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*

- More countries developed and adopted national alcohol policies after endorsement of the *European action plan to reduce the harmful use of alcohol 2012–2020*.
- A new political framework for obesity (*Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020*), based on the strategic dimensions of Health 2020 (equity and governance), was adopted by Member States.
- With technical support from the Regional Office, more countries in the Region became smoke-free, banned tobacco advertising, promotion and sponsorship, raised tobacco taxes and adopted pictorial health warnings; 50 countries in the Region have ratified the *WHO Framework Convention on Tobacco Control* (three in the 2012–2013 biennium).

12. ***Strategic objective 7***: *To address 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*

- 2012–2013 was a “watershed” biennium for significantly increased investment, research and technical assistance in identifying social determinants of health.

- For the first time, improving health by addressing social determinants and reducing health inequities was formally included as a key area and an indicator of economic growth, in the western Balkans.
- The issue of migration and public health was addressed by assessing national capacity to deal with large influxes of migrants to the Mediterranean subregion.
- Gender, human rights and equity have been integrated throughout the work of the Regional Office and in the Health 2020 process.

13. ***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*

- Good progress was made in reducing the exposure of the general population and of vulnerable and socioeconomically disadvantaged groups to risk factors.
- New and updated tools for assessing environmental and occupational health threats and guidelines were developed with WHO collaborating centres, partners and experts across the Region.
- Close collaboration was maintained with other United Nations programmes and specialized agencies in the area of environmental health.

14. ***Strategic objective 9***: *To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development*

- Awareness and understanding about food safety increased, in particular about the Codex Alimentarius and better detection of and response to food safety emergencies in countries.
- Member States have developed, implemented and evaluated strategies to address both under- and over-nutrition.
- Capacity-building for the health workforce and recommendations for breastfeeding, complementary feeding and infant nutrition were delivered, with a focus on central Asian countries.

15. ***Strategic objective 10****: To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research*

- Three high-level events were organized or supported by the Regional Office: "Impact on the crisis on health and health systems", "Health systems for health and wealth in the context of Health 2020" and the "International anniversary conference marking 35 years of the Declaration of Alma-Ata on primary health care".
- A roadmap was approved to implement the WHO European action plan to strengthen public health services and related capacity.
- *The European health report 2012* was launched with high media interest; it was the most frequently downloaded publication of the Regional Office in 2013.
- The first WHO autumn school on "Health information and evidence for policy-making" was held in Turkey, with representatives from 16 Member States.
- A new regional knowledge translation network, the Evidence-informed Policy Network (EVIPNet) Europe, was launched.

16. ***Strategic objective 11***: *To ensure improved access, quality and use of medical products and technologies*

- Twenty-five more countries improved their capacity for regulation and quality assurance of medical products.

- Eighteen Member States improved their capacity and set policies for rational use of medical products (medicines, vaccines, blood products) and technologies.
- Fourteen non-European Union countries have undertaken studies on the use of antibiotics and devised pilot systems for monitoring consumption of antibiotics.

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

- Significant progress was made in WHO reform in the Region, including in the areas of planning, programme management and accountability.
- The synergy and coherence of WHO's policies and strategies with those of other partners in health in the European Region was ensured by proactive engagement, implementation of joint initiatives and active participation in policy-setting meetings.
- The Regional Office's online visibility was increased: the average number of monthly visits to the website showed a 22% increase for the biennium 2012–2013 as compared with 2010–2012 and an increase of 18% between 2012 and 2013.

18. ***Strategic objective 13***: *To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively*

- The WHO Regional Office for Europe is the only WHO regional office with no long-standing open audit recommendations.
- The proportion of single-source contracts was reduced from 66% to 13%.
- Over 800 conferences and meetings were organized at the UN City (Copenhagen, Denmark) between April and December 2013, including two visits by the United Nations Secretary-General; the Regional Office also organized two Regional Committee meetings and four high-level ministerial conferences during the biennium.
- Management was strengthened, with regular, high-quality management reports and the establishment of a management group to follow up and implement executive management decisions.
- Recruitment lead time was considerably reduced.

19. The main determinants of success were: good collaboration (within WHO, with partners and with ministries of health); political commitment; and strong national counterparts. Good collaboration with ministries of health and with national counterparts and strong political commitment were more prevalent for KPOs than for other priorities, suggesting that senior policy-makers in Member States gave higher priority to KPOs, either by design or coincidence.

20. The greatest impediment to implementation was reported to be lack of resources, with no apparent difference between KPOs and other priorities. Lack of resources can be due to an absolute shortage of input due to restrictions imposed by contributors, combined with how the Secretariat manages the available resources, in particular flexible corporate resources.

21. The World Health Assembly-approved PB 2012–2013 was funded at 104% (across all budget segments), with implementation of available resources at 91–93%. While the Regional Office for Europe was well funded, "pockets of poverty" persisted: SO4, SO6 and SO9 were funded at only 74%, 63% and 52% of the approved levels, respectively.

22. A number of lessons can be used in preparing PB 2016–2017. The concept of "priorities within priorities" was well received by Member States and there was wide engagement for

KPOs. In order for the approach to be more effective, however, the commitments and the accountability of the three parties involved in the value chain should be examined:

- Member States should set priorities and be realistic about how many outcomes can be pursued and how many different outputs can be absorbed at the same time. Uptake in most cases requires allocation of considerable technical, financial and political resources at national level.
- The Secretariat must also be realistic and manage funds according to the agreed priorities, recalling that some outputs and outcomes are of lower priority than others. Adequate attention should be given to monitoring technical progress and to the funding situation of priorities, with allocation of flexible corporate resources to their outputs. In times of constraints on financial or technical capacity, preference should be given to approved priorities, even if work on others must be halted.
- Member States and donors should allow their specified contributions to cover all of the cost elements required to deliver the outputs they are funding, including salaries. The best, most effective approach is to reduce specification of funding, for example, not to specify below the outcome level.

Overview of the report

23. This performance assessment report for 2012–2013 provides an analytical overview of performance, with a number of summary tables and annexes, while the Appendix (available online and in English only) comprises a detailed account of the contribution of the European Region to the indicators of the Organization-wide expected results and detailed accounts of achievement for each outcome (KPO and other priorities) in 2012–2013. It includes weblinks to the concrete outputs delivered by the Secretariat during the biennium. Annex 1 lists the terms and abbreviations used in the report and Annex 2 presents achievements in Organization-wide expected results in tabular form.

24. The report begins with the background and context of the pilot trial and the lessons learnt. It continues with a summary of implementation in technical areas (SO1–SO11) and in governance and enabling functions (SO12 and SO13). Details are provided in Annex 3 and in the Appendix.

25. The next section provides an analysis of financial implementation, including a brief analysis of the financing of staff costs. Details of financial implementation are provided in Annexes 3 and 4. This is followed by an analysis of the resource situation, including a comparison of the major offices of WHO and an analysis of voluntary contributions that allow less than 20% funding for salaries. An overview of all available voluntary resources, their sources and destinations is given in Annex 5.

26. The report finishes with an analysis of the determinants of success and impediments experienced during implementation of the outcome portfolio in 2012–2013 and lessons learnt, with implications for 2014–2015 and 2016–2017. Annex 6 is a summary of determinants of success and impediments by KPO and other priorities by strategic objective. The Appendix contains outcome assessment sheets with detailed accounts of the challenges faced and lessons learnt for each outcome (KPO and other) and their implications for planning for 2014–2015 and beyond.

Background and context

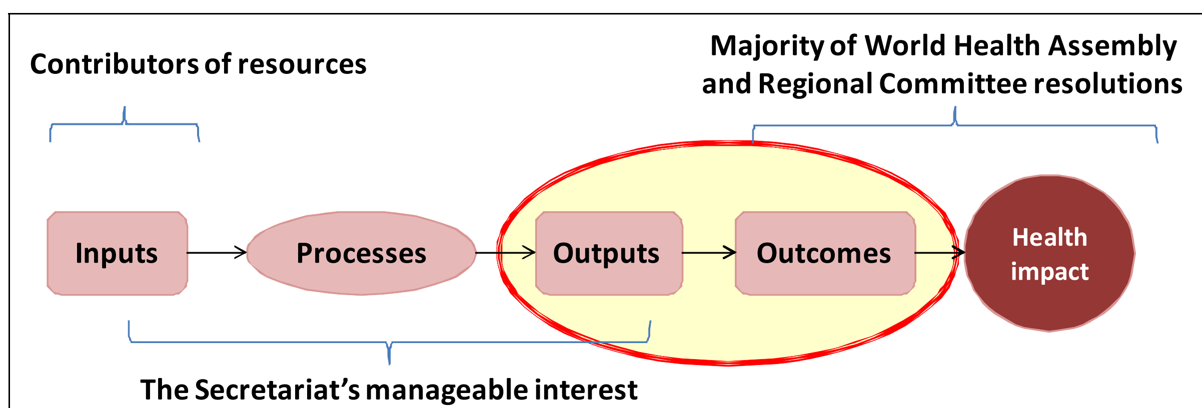
27. This report provides a review of a pilot trial in which the programme budget was used as a strategic tool for accountability and for assessing implementation of PB 2012–2013 in the WHO European Region.

28. The 60th session of the Regional Committee noted with concern the continuing imbalance between key health priorities endorsed by Member States and designated voluntary funding for such priorities. The Regional Committee requested the Regional Director, following the approval of PB 2012–2013 by the World Health Assembly in 2011 and in collaboration with the SCRC, to submit a package of performance indicators and a list of key deliverables to RC61 in order to strengthen the Regional Committee's governance and oversight functions. At the same time, the Regional Committee urged Member States to keep agreed priorities in mind when making voluntary contributions to the work of WHO.[3]

29. For RC61, the Regional Director provided an information document outlining a conceptual framework for accountability, a package of specific performance indicators and a list of key deliverables (document EUR/RC61/Inf.Doc/10). The document also proposed a pilot trial of the framework during 2012–2013 in the context of WHO reform. The Standing Committee was closely involved, with regular oversight reports, discussions and shaping the reporting requirements; the format of the report is a result of their input and feedback.

30. At the heart of the accountability concept is the Regional Office's value chain (Fig. 1), which involves transformation of inputs (money, staff, information) into public health impacts, with the overarching goal of improving the level and distribution of health in European populations.

Fig. 1. The Regional Office for Europe's value chain



31. Accountability for implementation of WHO's *Medium-term strategic plan 2008–2013* and PB 2012–2013 can be defined in at least two ways: for outcomes (that is, uptake by Member States) and for outputs and processes (that is, the deliverables and managerial performance of the Secretariat). For outcomes, accountability is measured by effectiveness in achieving results, which is the joint responsibility of public health authorities in individual

[3] Resolution EUR/RC60/R9. Proposed programme budget for 2012–2013. Copenhagen: WHO Regional Office for Europe; 2012 (http://www.euro.who.int/en/about-us/governance/regional-committee-for-europe/past-sessions/sixtieth-session/resolutions/eurrc60r9, accessed 22 April 2014).

Member States, the Secretariat and donors and contributors. Accountability for productive, efficient outputs and processes is the responsibility of the Secretariat.

32. The Secretariat can be evaluated not only with respect to the quality of the outputs (that is, policies, guidelines and manuals) but also the efficiency with which it has used financial, human and technical resources (that is, inputs) to produce outputs. The more conditions attached to inputs, the less managerial authority the Secretariat has. At one extreme, when inputs are tightly earmarked, the Secretariat can be held accountable only for using the resources as specified by the donor agreement and for carrying out the specified activities efficiently, not for whether the most important output has been produced. At the other extreme, when inputs are totally flexible, the Secretariat is accountable for the entire value chain, from inputs to outputs, and can have a major role in ensuring delivery of the joint outcomes.

33. The document also defined a new business model for the Regional Office, building on the skills and capacity that exist within European institutions and public services. These determine two main characteristics of the business model:

- When feasible, an intercountry mode will prevail, that is, one that addresses the common needs of countries through Region-wide approaches. It is expected that an increasing part of the Regional Office's work will be delivered in this way. When an output within an outcome is relevant for only a limited number of countries, a multicountry model may be used, making optimal use of the resources of the group. There are, however, and will continue to be outputs that are specific to the needs and circumstances of individual countries. Thus, a country-specific mode of operation will continue to be important and will be the chosen mode of delivery when appropriate.
- More systematic work with WHO collaborating centres across the Region will mean that a larger proportion of outputs are delivered in collaboration with these centres, with the Secretariat playing a lead role.

34. In the context of overall WHO reform, elements of the Regional Office's value chain have been incorporated into the results chain used in the Twelfth General Programme of Work 2014–2019 and PB 2014–2015. The most significant difference between the two "chains" is how the outputs are defined and measured and who is responsible for their delivery. This document focuses exclusively on implementation of the *Medium-term strategic plan 2008–201*3 in the WHO European Region for the 2012–2013 biennium.

Overview of lessons learnt

35. For 2012–2013, an outcome portfolio of 83 priority outcomes was defined. Of these, 27 outcomes were considered "priorities within priorities" or KPOs, which were to be given special attention in terms of monitoring and ensuring adequate resources and progress. The remaining 56 outcomes, also considered important, are known as "other priority outcomes". In situations of insufficient resources, preference in the allocation of flexible corporate resources would be given to KPOs. The portfolio of 83 outcomes formed the basis for operational planning, such as preparing biennial collaborative agreements with countries, which define the responsibilities of the Member States for uptake (outcomes) and the responsibility of the Secretariat for deliverables (outputs). The portfolio was also used to guide negotiations with potential contributors of voluntary resources. Implementation and achievement of the outcomes portfolio are described in Annex 3; details are given in the Appendix.

36. Six performance indicators were chosen, representing mutual accountability at the different stages of the value chain (Fig. 1). Baseline values were available for three of the

indicators and targets for 2012–2013 were set for all of them. Table 1 shows achievements in meeting each of the six performance indicators.

Table 1. Performance indicators*

	Indicator	Baseline	Target	Achieved	Accountable
Results	Proportion of planned KPOs achieved[a]	Not available	85%	65%	Member States and Secretariat
Results	Proportion of planned KPO outputs delivered	Not available	95%	72%	Secretariat
Process	Proportion of total expenditure spent on staff in base programmes (SO1–SO11)	60%	55%	56%	Secretariat
Process	Proportion of corporate resources in SO1–SO11 allocated to KPOs[b], with the remainder allocated to other priorities within the SO	Not available	80%	51%	Secretariat
Input	Proportion of voluntary contributions that are flexible at SO level or above	7%	14%	20%[c] 13%[d]	Member States and fund contributors
Input	Proportion of specified voluntary contributions that can be used for funding salaries	50%	55%	46%	Member States and fund contributors

KPO: key priority outcome; SO: strategic objective

**Source*: "Table 2. Performance indicators" in document EUR/RC61/Inf.Doc/10[1]

[a] A measure of the number of KPOs fully achieved as a percentage of all KPOs. The remaining 35% were partly achieved; no KPO was "not achieved" (for details, see Annex 3 and the Appendix).

[b] Assuming that the Director-General would allow the Regional Office to manage assessed contribution funds flexibly for SO1–SO11.

[c] Proportion of all voluntary resources (globally and locally mobilized) flexible at SO level or above.

[d] Proportion of Regional Office-mobilized voluntary contributions flexible at SO level or above.

37. The value chain transforms inputs through processes to results (outputs and outcomes). Therefore, non-optimal inputs and processes will appear as less-than-targeted results. If the performance indicators are well selected, they will tell a plausible, cohesive "story". Below, we attempt to tell a "story" based on Table 1 and with reference to Table 2. Further details are provided in subsequent sections of this document.

38. **Input**: While the proportion of voluntary contributions that are flexible at SO level or above was greater than that targeted, the proportion that could be used to fund salaries was less instead of more, as the 46% of specified voluntary contributions that could be used for this purpose is well below the overall average of the proportion of staff to total expenditures in SO1–SO11 of 56% (see section on "Implementation by staff cost and activities"). A considerable proportion of the other voluntary contributions include very little staff costs (see section on "Resource analysis"). The result was that flexible corporate resources had to be allocated to cover the gap in financing staff costs. Thus, the specified voluntary contributions to some extent drove the use of more flexible resources, as they did not allow adequate funding of the staff required to produce the outputs. Furthermore, specification of some large voluntary contributions skewed the funding, for example, towards specific countries, leaving others with similar needs underfunded (see section on "Resource analysis").

39. **Process**: The gap between the end-of-biennium cumulative budget and available resources for the 27 KPOs amounted to US$ 5 million; that for the 56 other priority outcomes

was US$ 5.8 million. A possible explanation for the similarity of the two gaps is that not enough priority was given to the KPOs in allocating flexible corporate resources: only 51% was allocated to the KPOs, despite the shortfall. This, in turn, is partly due to the fact that flexible corporate resources had to be used to finance staff costs to compensate for the inadequate resources for staff from the specified voluntary contributions and the realignment of staff capacity. The target for total expenditure on staff was almost met by efficiency savings (business model and administrative staff) and also by not filling posts that became vacant (see section on “Implementing by staff costs and activities”). This, in some cases, jeopardized the technical capacity to deliver.

40. **Results**: 65% of the KPOs were fully achieved, and 72% of the KPO outputs were delivered. These percentages fall short of the planned targets of 85% and 95%, respectively. In addition to the reasons given above under “Input” and “Process”, other explanations include: overplanning and over-optimism on the part of Member States and the Secretariat about what could feasibly be achieved within a biennium with the resources available; in-country factors that impeded uptake of the outputs (see section on “Success factors, impediments and lessons learnt”); longer than expected lead times for adjusting the technical capacity of the Secretariat to deliver the outputs for the KPOs; and insufficient priority given by the Secretariat to the country deliverables for the KPOs.

Table 2. Commitments*

	Member States	**Member States or donors**	**Secretariat**
Results	Uptake of outputs to accomplish the planned KPOs		Deliver planned outputs, including technical guidance and assistance
Resources	Allocate adequate *own* resources for *own* work on KPOs	Provide sufficient resources, flexibly or aligned with the KPO	Manage resources to ensure even financing for all KPOs
Productivity and efficiency			Achieve the two process and efficiency targets set for 2012–2013

**Source*: “Table 3. Commitments” in document EUR/RC61/Inf.Doc/10[1]

41. The concept of KPOs was well-received by Member States, as evidenced by the large number that engaged with most of the KPOs (see Annex 3) and the fact that the success factors “good collaboration with ministry of health”, “good collaboration with and strong national counterparts” and “strong political commitment” were more prevalent for the KPOs than for the other priority outcomes (see also Annex 6). In order for the approach to be more effective, however, a further look must be taken at the commitments and accountability of the three parties involved in the value chain (Fig. 1 and Table 2).

42. Member States must also set priorities and be realistic about how many outcomes can be pursued and how many different outputs can be absorbed at the same time. Uptake in most cases requires allocation of considerable technical and financial resources as well as political support.

43. Member States and donors must allow their specified contributions to cover all the cost elements required to deliver the outputs they are funding, for both KPOs and other priority outcomes. This also includes salaries. The best, most effective approach would be to make fewer specifications, such as not specifying below the outcome level.

44. The Secretariat must complete and consolidate realignment of technical capacity with the KPOs and the new business model, including ensuring the sustainability of workforce financing. Adequate executive attention should be given to monitoring technical progress and the funding situation of KPOs, with priority on the allocation of flexible corporate resources to their outputs.

Overview of implementation

45. This section provides a high-level summary of both technical implementation and implementation of governance and enabling functions. Of the 80 Organization-wide expected results of PB 2012–2013, 76 were relevant for the WHO European Region. Of these, 50 were fully achieved, while 26 were partly achieved (Table 3). Further details are provided in Annex 2.

Table 3. Overview of achievement of Organization-wide expected results for PB 2012–2013 by strategic objective in the European Region

SO	Fully achieved	Partly achieved	Not achieved	Not applicable for the European Region
01	5	2		2
02	1	4		1
03	3	3		
04	8			
05	2			
06	5	1		
07	2	3		
08	5	1		
09	6			
10	4	8		1
11	2	1		
12	4			
13	3	3		
Grand total	**50**	**26**	**0**	**4**

SO: strategic objective

46. The Appendix gives details of the achievement of these indicators, including which countries achieved them, when relevant. A table in Annex 3 shows each outcome (KPOs and other priority outcomes) with technical achievement compared with the budget, available resources and financial implementation. The Appendix provides detailed descriptions of each outcome, including the expected public health impact, the actual outputs delivered by the Secretariat, short examples, weblinks to relevant documentation of achievements, challenges and lessons learnt.

Technical implementation

Strategic objective 1: *To reduce the health, social and economic burden of communicable diseases*

47. Throughout the European Region, Member States have achieved greater population immunity through routine and supplemental vaccination. Sustainable, high-quality immunization and surveillance systems achieved the documented absence of endemic measles in 16 Member States and of rubella in 19 Member States, making them beacons for elimination in the Region. The 2002 polio-free status of the European Region has been maintained.

48. The Regional Office has established partnerships to address leishmaniasis, invasive mosquito species, re-emerging vector-borne diseases and soil-transmitted helminths at regional and country levels. Laboratory capacity to detect two emerging respiratory viruses that cause severe disease in humans – Middle East respiratory syndrome coronavirus and avian influenza A(H7N9) – is available in 33 countries. The Regional Office supports Member States in strengthening their surveillance of resistance to antibiotics and developing national multisectoral action plans against antimicrobial resistance.

49. With regard to implementation of the *International Health Regulations (2005)*, the capacity of Member States for early detection and response to public health events (including those of potential international concern) due to health hazards improved during the biennium, and information-sharing about events of public health importance has been strengthened. During the 2012–2013 biennium, over 700 public health events were managed by Member States, 90 of which were events of potentially international concern. In all the events, the affected Member States consulted WHO through the *International Health Regulations (2005)* or technical networks in order to manage them.

Strategic objective 2: *To combat HIV/AIDS, tuberculosis and malaria*

50. The major public health issues in SO2 in the WHO European Region include the prevention and control of HIV/AIDS, viral hepatitis and TB, particularly M/XDR forms, and the elimination of malaria. The HIV and TB epidemics have been growing in the eastern part of the Region in recent years.

51. HIV treatment coverage, although still poor, is improving – from 23% in 2010 to 35% in 2012 – and further scaling up of treatment is likely to be seen in data for 2013. The Region achieved 80% coverage for prevention of mother-to-child HIV transmission in 25 targeted low- and middle-income countries, and only 1% of new HIV cases reported in 2012 in the Region were transmitted by this route. In 2013, 13.3 million (1.8%) adults were estimated to have hepatitis B and 15.0 million (2.0%) to have hepatitis C. The distribution of HIV infection, sexually transmitted infections, viral hepatitis and TB is uneven, the burden falling disproportionately on vulnerable populations that are marginalized and whose behaviour is socially stigmatized or illegal.

52. Implementation of the regional action plan to prevent and combat M/XDR-TB has been accelerated, and most of the milestones have been met. A new molecular diagnostic test to detect TB and rifampicin-resistant TB (as a proxy for MDR-TB) in less than 100 minutes has been widely introduced and treatment coverage for MDR-TB patients has increased from 63% in 2011 to 97% in 2013. The success rate of treatment for MDR-TB patients is, however, only 48.5% (similar to the global rate) and below the target of 75% because of lack of efficient medicines, poor programme performance and inadequate patient-centred approaches.

53. There was a substantial decrease in the number of reported cases of autochthonous malaria during 2011–2013 in the Region. Elimination of malaria by 2015 remains feasible, but

importation of cases from endemic countries has increased the probability that malaria will become re-established in areas that are currently malaria-free. The action plans for HIV/AIDS, M/XDR-TB and malaria emphasize the role of the health sector at the centre of the response, working with other sectors to tackle the social determinants and social inequities, which require stronger intersectoral partnerships and meaningful engagement with civil society.

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

54. The NCD global monitoring framework was adopted in May 2013. It is aligned with Health 2020 targets and indicators and was prepared with maximum input from European Member States through consultations. Integrated WHO STEPwise approach to surveillance (STEPS) surveys and the package of essential NCD interventions for primary health care were used in a number of countries. Intercountry and subregional meetings contributed to strengthening primary care and public health services for the prevention and control of NCDs. The European Ministerial Conference on the Prevention and Control of Noncommunicable Diseases (December 2013) and its outcome, the Ashgabat Declaration, set further directions for addressing NCDs in the Region.

55. Drafting and subsequent adoption of *The European mental health action plan* by the Regional Committee in 2013 raised awareness in Member States about the importance of applying the principles and interventions proposed in the plan, as well as in other WHO documents, such as that on the mental health gap action programme: a number of countries made national assessments of challenges and their required activities, including drafting a national mental health policy. A regional policy consultation was held on a global action plan on mental health. WHO supported the development and implementation of expertise in identifying problems in the quality of service delivery, improving ability to evaluate outcomes and involving patients and families.

56. Two products contributed materially to promoting action on violence and injury prevention in the Region: a European fact sheet and global status report on road safety and a European report on preventing child maltreatment. Countries were given technical support for activities linked to the United Nations Decade of Action for Road Safety 2011–2020, such as developing a national road safety policy and advocating for higher priority for the issue. Policy workshops based on the results of the global status survey were held in a number of countries, with advocacy for "Pedestrian road safety week". Capacity-building workshops were held for European health ministry focal points, for injury surveillance, and for south-eastern Europe and Baltic countries, for the prevention of adverse childhood experiences and the association between alcohol and violence. Reports on improving trauma care and rehabilitation were disseminated. Advocacy for preventing disability accompanied the launch of the *World report on disability*,[4] and regional consultations were held for a global action plan on disability.

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*

57. Many countries of eastern and central Europe have made good progress in decreasing child mortality and improving maternal health, as seen by monitoring of indicators of MDG4

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[4] World report on disability. Geneva: World Health Organization; 2011 (http://www.who.int/disabilities/world_report/2011/en/, accessed 16 April 2014).

and MDG5. This acceleration in meeting the MDGs was achieved by implementing new or revised policies and tools to support improvement of access to and the quality of health care for mothers and children. A report on a survey of health behaviour in school-aged children, providing data on 11-, 13- and 15-year-olds in 43 countries and regions of the European Region and North America, is one of the 10 most successful WHO publications. Close collaboration with WHO collaborating centres and with the Special Programme of Research, Development and Research Training in Human Reproduction at WHO headquarters improved the quality of sexual education in a number of countries of the Region and included capacity-building in operational research in Kyrgyzstan, Russian Federation and Tajikistan. The Regional Office has been less involved in activities for decreasing unmet needs for family planning and the prevention of unsafe abortion because of limited human and financial resources.

58. The *Strategy and action plan for healthy ageing in Europe 2012–2020* raised attention about the health and well-being of older people. Evaluation of the WHO European Healthy Cities Network for 2012–2013 revealed that 80% of those cities now have initiatives or actions on healthy ageing; cooperation with the Regional Office on “age-friendly environments” was the topic most frequently reported as “having the most impact”.

Strategic objective 5: *To reduce the health consequences of emergencies, disasters, crises and conflicts and minimize their social and economic impacts*

59. In line with resolution WHA64.10 on “Strengthening national health emergency and disaster management capacities and resilience of health systems”, the Regional Office has adopted an all-hazards approach to strengthen health systems preparedness in European Member States, and a toolkit for assessing health systems capacity for crisis management was published. While building sustainable emergency risk management capacity is a priority in crisis-prone countries, the financial crisis and austerity measures are real challenges to ensuring adequate resources for emergency preparedness and response. Experience has shown that the poorest, most vulnerable populations tend to be affected the most by disasters and health crises.

60. An effective response system requires close collaboration of governments, international organizations, civil society, the private sector and other partners. The Regional Office promotes partnerships for health response and collaborates closely with the European Centre for Disease Prevention and Control and the European Commission to enhance health emergency preparedness, risk management and response capacity throughout Europe in order to strengthen WHO’s response capacity, as described in the *Emergency response framework*[5] adopted by Member States in resolution WHA65.20 on “WHO’s response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies”.

61. Other collaborative partners include the United Kingdom Health Protection Agency, which, as a WHO collaborating centre for mass gathering preparedness and extreme events, supports WHO in assisting countries in developing their public health capacity. Technical support is provided to enhance preparedness and conduct assessments; tools and international experts are provided to prevent or respond to the potential public health consequences of such events, also within the framework of the *International Health Regulations (2005).*

62. In collaboration with partners, the Regional Office has established mechanisms to mobilize a network of experienced international experts to respond to emergencies. The establishment of a joint regional platform to mobilize international expertise and resources will improve emergency preparedness and future crisis response operations. The actions will be

[5] Emergency response framework (ERF). Geneva: World Health Organization; 2013 (http://www.who.int/hac/about/erf/en/; accessed 16 April 2014).

consolidated by the establishment of a geographically dispersed office for preparedness in humanitarian and health emergencies in Turkey, as endorsed by RC63 in decision EUR/RC63(2) on the "Establishment of a new geographically dispersed office (GDO) for preparedness for humanitarian and health emergencies in Turkey".

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*

63. After endorsement of the *European action plan to reduce the harmful use of alcohol 2012–2020*,[6] an increasing number of countries are developing or reformulating a national alcohol policy. Of the 53 Member States that provided information to the Secretariat by December 2013, 37 have a written national policy on alcohol, and 20 are updating their national policy. Of the 16 Member States with no national policy on alcohol, 10 are developing a national policy. Since 2012, 10 Member States have adopted a new national alcohol policy in line with the European action plan.

64. Member States have adopted a new political framework for obesity (Vienna Declaration) based on the strategic dimensions of Health 2020 (equity and governance); 35 countries are involved in the WHO childhood obesity surveillance initiative; and 49 Member States have updated their data on diet, physical activity and obesity, including the epidemiology and policy developments, as part of the WHO European database on nutrition, obesity and physical activity (NOPA). With political and technical support from the Regional Office, the *WHO Framework Convention on Tobacco Control* was ratified by three additional countries in the Region – Czech Republic, Tajikistan and Uzbekistan – bringing the total number of Parties in the Region to 50. With technical support from the Regional Office, more countries in the Region became smoke-free, banned tobacco advertising, promotion and sponsorship, raised tobacco taxes and adopted pictorial health warnings. Several countries strengthened their tobacco legislation and policies substantially. An existing tobacco control database was re-launched, with new, up-to-date information, which will serve as a tool for policy-makers in the Region. The *European tobacco control status report 2013*[7] was launched during the ministerial conference on NCDs, leading the way to future work for a tobacco-free Europe. Guidance was provided for implementation of standards for sexuality education in Europe (2010; 2013), which triggered the establishment and revision of sexual education in schools in Estonia, Finland, Germany, Kyrgyzstan, Netherlands, Switzerland and Turkmenistan and closer collaboration between education and health sectors.

Strategic objective 7: *To address 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*

65. The 2012–2013 biennium was a watershed, when investment, research and technical assistance to reach this strategic objective began with the Verona Initiative, kept in step with the Commission on Macroeconomics and Health, followed by the WHO Commission on Social Determinants of Health, leading to the European study and *Review of social determinants and*

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[6] European action plan to reduce the harmful use of alcohol 2012–2020. Copenhagen: WHO Regional Office for Europe; 2012 (http://www.euro.who.int/en/health-topics/disease-prevention/alcohol-use/publications/2012/european-action-plan-to-reduce-the-harmful-use-of-alcohol-20122021, accessed 16 April 2014):

[7] European tobacco control status report 2013. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/en/health-topics/disease-prevention/tobacco/publications/2013/who-european-tobacco-control-status-report-2013, accessed 16 April 2014).

the health divide in the European Region[8] and *Health 2020: a European policy framework supporting action across government and society for health and well-being*,[9] which was endorsed by all 53 European Member States at RC62 in Malta. The objectives of Health 2020 are now integrated into all Regional Office programmes; country assistance within this framework was first delivered in 2013. Objectives and indicators to improve health as a way to achieve inclusive growth targets were formally adopted by ministers of health and of the economy in seven countries in the western Balkan growth strategy, South-east Europe 2020. This is the first time that improving health by addressing social determinants and reducing health inequities has been formally included as a key area and as an indicator of economic growth in the western Balkans.

66. A project on migration and public health began in 2013, with activities to assess the capacity of health sectors to deal with the large influx of migrants to the Mediterranean countries most affected. As a result of a joint WHO–ministerial assessment in Italy, the Sicily region has programmed creation of a contingency plan on health and migration, building on the recommendations of the assessment. A Roma health programme was established in 2012–2013, with fruitful collaboration with WHO collaborating centres and has achieved some significant milestones.

67. Gender, human rights and equity have been integrated throughout the work of the Regional Office and in the Health 2020 process and through capacity-building and by supporting an accountability mechanism, led by WHO headquarters (an office-wide action plan prepared with extensive contributions from the Regional Office). Health 2020 was endorsed by the WHO European Healthy Cities Network and the Regions for Health Network, thus enabling implementation at all levels of government.

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*

68. Member States in the European Region made progress in addressing environmental determinants of health through active engagement in governance of the environment and health process and participation in capacity-building to enhance knowledge about the interaction between environment and health risks. The achievements contribute to reducing the exposure of the general population and of vulnerable and socioeconomically disadvantaged groups to risk factors present in various settings, including the workplace, and in the environment (air, food, soil, water and physical agents such as noise and ionizing and non-ionizing radiation), including under emergency conditions (man-made or natural).

69. The increased capacity and competence of the Regional Office, due primarily to consolidation of the WHO European Centre for Environment and Health in Bonn, Germany, allowed it to provide intensive technical assistance to Member States, partners and stakeholders in meeting the commitments of the *Parma Declaration on Environment and Health*. Over 30 Member States received direct technical assistance from WHO, and all 53 Member States

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[8] Review of social determinants and the health divide in the WHO European Region: final report. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/publications/2013/review-of-social-determinants-and-the-health-divide-in-the-who-european-region.-final-report, accessed 16 April 2014).

[9] Health 2020: a European policy framework supporting action across government and society for health and well-being. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/publications/2013/health-2020-a-european-policy-framework-supporting-action-across-government-and-society-for-health-and-well-being; accessed 16 April 2014).

participated in intercountry activities. New and updated tools for assessing environmental and occupational health threats and guidelines have been developed with WHO collaborating centres, partners and experts across the Region to guide appropriate, effective policies and interventions on environmental determinants of health. In addition, new networks for chemical safety, the environment and health inequalities and the health effects of climate change have been launched to mobilize the scientific community to support WHO technical work more effectively and to provide Member States with new platforms for exchanging information, strengthening capacity and supporting implementation of commitments at national level.

70. WHO continued to actively support implementation of relevant multilateral environmental agreements and programmes (such as the *Protocol on Water and Health*, the Transport, Health and Environment Pan-European Programme (THE PEP) and the *Convention on Long-range Transboundary Air Pollution*), creating synergy with parallel and complementary mechanisms for pursuing the objectives of the Parma Declaration. Close collaboration has been maintained with other United Nations programmes and specialized agencies (Food and Agricultural Organization, United Nations Development Programme, United Nations Economic Commission for Europe, United Nations Environment Programme, World Meteorological Organization), institutions and agencies of the European Union (several European Commission Directorates-General, European Environment Agency, European Food Safety Authority, European Parliament) and other partners.

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

71. The Secretariat has supported capacity-building on food safety in South-eastern European countries and central Asian republics and has raised awareness and understanding about food safety, in particular in regard to the work of the Codex Alimentarius and how countries can better detect and respond efficiently to food safety emergencies. The systems for surveillance, prevention and control of foodborne diseases in Albania, Croatia, Kazakhstan, Kyrgyzstan, Romania, Serbia, Tajikistan, Turkmenistan and Uzbekistan have been strengthened, with a focus on mechanisms for intersectoral collaboration, cooperation and information-sharing and the importance of a whole-food-chain approach. Technical support was provided to countries during food safety emergencies and a four-year (2009–2013) food safety project in Albania was finalized. A major challenge for both WHO's delivery on food safety and Member States' uptake is ensuring good collaboration, cooperation and communication between the health and agriculture and veterinary sectors, which is crucial for cost-effective prevention and control of foodborne diseases.

72. Member States have developed, implemented and evaluated strategies to address both under- and overnutrition. In countries of the Region where malnutrition is significant, mechanisms to coordinate international organizations and national authorities have been established. Tools have been developed to facilitate implementation and evaluation of novel nutrition policies, such as healthy food baskets and e-health initiatives, to promote nutrition surveillance. Surveillance mechanisms for nutrition (Nut-PAT), particularly in children, were further developed and enlarged. Draft indicators to evaluate nutrition policies were developed. Support was provided to scientific and policy outputs for "nutrition action networks", notably the European Salt Action Network, and reducing the marketing of food to children. Capacity-building for the health workforce and recommendations for breastfeeding, complementary feeding and infant nutrition were delivered, particularly in central Asian countries.

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

73. Three high-level events were organized or supported by the Regional Office: “Impact of the crisis on health and health systems”, “Health systems for health and wealth in the context of Health 2020” on the fifth anniversary of the Tallinn Charter and the “International anniversary conference marking 35 years of the Declaration of Alma-Ata on primary health care”. The two cross-divisional programmes of corporate priority based on the health systems strengthening operational approach – for better M/XDR-TB prevention and control and for better NCD prevention and control – have delivered concrete outputs at interregional and country levels, with position papers, country assessment guides and country assessments.

74. New major policy initiatives started in line with the WHO reform are a European framework for action on people-centred, coordinated or integrated care and transformation and scaling up of health worker education and training (at the interface of health, education, science and civil society). A flagship course on health systems strengthening focused on universal health coverage for better NCD prevention and control and a course on health financing were held in Barcelona, Spain. A roadmap to implement the WHO *European action plan for strengthening public health capacities and services* was approved at an expanded advisory group meeting, which led to accelerated implementation at country and subregional levels, with a focus on the public health workforce.

75. Member States are increasingly using evidence as an important part of policy formulation and are proactively requesting evidence about their own and other health systems and about policy challenges (Health Systems in Transition (HiT) series, studies, evidence briefings). They use opportunities to draw comparisons and learn from experience, calling for policy dialogue, requesting policy summaries, joining and using the Health Systems and Policy Monitor. Challenges remain in packaging evidence so that it is accessible and timely and in helping ministries of health to bring evidence to bear on wider governmental debates, but the progress has been considerable.

76. The *European health report 2012*[10] was launched with high media interest; it subsequently became the most downloaded and requested publication of the Regional Office in 2013. Work on Health 2020 indicators and the monitoring framework was completed and adopted by the Regional Committee in 2013. The first “autumn school” on health information and evidence for policy-making, with representatives from 16 Member States, was held in October 2013 in Turkey and was extremely well received; Member States have requested that it be made an annual feature. Technical support for assessing and improving health information was provided to 15 countries, especially in central Asian and eastern Europe. Updating of the European Health for All database (HFA-DB) has continued: over 90% of countries have replied to data requests and joint data collection with Eurostat and the Organisation for Economic Co-operation and Development has been widened to include health care activities in order to develop health care indicators.

77. Support to countries on developing national e-health strategies and identifying information, communication and technological solutions for improving health management and preparation of interoperability standards has been extended. A new regional knowledge translation network, the Evidence-informed Policy Network (EVIPNet) Europe, was launched in

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[10] The European health report 2012: charting the way to well-being. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/en/data-and-evidence/european-health-report-2012, accessed 16 April 2014).

October 2012, currently with 13 member countries. Further, the health information initiative for Europe was established, to work towards a single, integrated health information system for Europe. Two meetings of the European Advisory Committee on Health Research, which advises the Regional Director, were held.

Strategic objective 11: *To ensure improved access, quality and use of medical products and technologies*

78. Key achievements include sharing evidence and promoting and training relevant country partners in the use of best practices for increasing and sustaining access to essential, good-quality medical products. Collaboration with authorities and relevant stakeholders has been instituted in most Member States in three main areas. Activities to improve the rational use of medicines, including antibiotics, comprise a network for prudent use of antibiotics; a pilot project on surveillance of antibiotic consumption in countries that are not members of the European Union; a training workshop on monitoring and evaluation, forecasting and quantifying anti-TB medicines; and country assessments in Hungary, Kyrgyzstan, Republic of Moldova and Tajikistan on access to medicines for treatment of NCDs as part of an overall assessment to identify challenges and progress in the management of NCDs. Secondly, regulation of medical products in countries in which the capacity of and collaboration with other countries have been strengthened, for example, where the prequalification collaborative procedure has been launched to facilitate and accelerate national registration of products that have already been assessed and prequalified in the WHO Prequalification of Medicines Programme, with three countries taking part (Georgia, Kyrgyzstan and Ukraine). Thirdly, support has continued to the pharmaceutical pricing and reimbursement policy network and the rational prescribing network.

Governance and enabling functions implementation

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

79. Significant progress was made in WHO reform in 2012–2013. Member States in the European Region made valuable contributions and interacted closely with the Secretariat in meetings of the global governing bodies. At its two sessions during the biennium, the Regional Committee adopted 19 resolutions and four decisions. Most of the resolutions addressed policies and tools for decision-makers and WHO support to Member States on issues of particular concern to Europe. The increasing interest of Member States and partners is evident in the large number of participants and especially in the participation of high-level officials at both sessions.

80. The first country cooperation strategy was signed, with Switzerland, and first drafts of strategies with Belgium, Cyprus and the Russian Federation have been written. The synergy and coherence of WHO's policies and strategies with those of other partners in health in the European Region was ensured by proactive engagement, implementation of joint initiatives and active participation in meetings of the United Nations Regional Coordination Mechanism and regional United Nations Development Groups (formerly called Regional Directors Team). New agreements were signed with the Organisation for Economic Co-operation and Development in 2012 and with the United Nations Population Fund and the United Nations Children's Fund in 2013. Collaboration with the European Union has been extended by active engagement with the European Commission and its agencies and by strengthening relations through the presidency of the European Union.

81. The presence of the Regional Office in traditional and social media has been strengthened, resulting in increased awareness of its work by Member States and better

understanding of WHO's role, priorities and main messages by stakeholders. Website users and audiences now have a richer interactive online experience, with a broader choice of communications products, more opportunity to engage with WHO experts and a more visually appealing, responsive website, with relevant, timely, accurate information. There has thus been a notable increase in the demand for web products and services by external audiences, partners and technical divisions. Examination of the average number of monthly visits to the website showed a 22% increase for the biennium 2012–2013 as compared with 2010–2012 and an increase of 18% between 2012 and 2013.

Strategic objective 13: *To develop and sustain WHO as a flexible, learning Organization, enabling it to carry out its mandate more efficiently and effectively*

82. There were several major achievements in 2012–2013. The Regional Office relocated to the UN City and the former premises were handed over to the Danish Government after more than 60 years of occupancy. The Regional Office remains the only WHO regional office with no long-standing open audit recommendation and the proportion of single-source contracts was reduced from 66% to 13%. Significant progress has been made in the management of fixed assets: approximately 65% of all fixed assets have been re-tagged, in full compliance with International Public Sector Accounting Standards. The electronic expenditure batch system was successfully deployed in the Regional Office and all country offices, thus eliminating cumbersome manual input and improving efficiency.

83. More than 800 conferences and meetings were organized at the UN City (Copenhagen, Denmark) between April and December 2013, including two visits by the United Nations Secretary-General; the Regional Office also organized two Regional Committee meetings and four high-level ministerial conferences during the biennium.

84. Management has been strengthened with regular, high-quality reports and the establishment of a group to follow up and implement executive management decisions. A leaner human resources plan for 2014–2015 was prepared, with a view to strengthening technical capacity while achieving financial sustainability in staffing. Eighteen general service staff positions were terminated and 12 professional positions were abolished. The reduction in general service staff was facilitated by offering separation by mutual agreement packages on a voluntary basis. Recruitment lead times have been considerably reduced.

Overview of financial implementation

Implementation by segment and strategic objective

85. Details of financial implementation are provided in visual format in Annex 4. Selected highlights are summarized here.

86. The overall financial situation of the Region in 2012–2013 was favourable. The World Health Assembly-approved budget (all segments) was funded at 104%, base programmes at 103%, special programmes and collaborative arrangements at 204% and outbreak and crisis response at 13% (Annex 4, Fig. 1). The apparent "overfunding" of special programmes and collaborative arrangements is due to an error in the original programme budget submitted to the Health Assembly, in which the budget for this segment was pegged at only half of what it should have been. The apparent "underfunding" of the outbreak and crisis response segment was due to the fortunate situation in which no major outbreaks or crises affected the Region during the biennium. Implementation of available resources was very high for all three segments, 91–93%.

87. The overall situation, however, masks variations in funding by SO, with, on the one hand, SO1 funded at 143% of the approved budget, SO7 at 138% and SO8 at 128%, and, on the other hand, SO4, SO6 and SO9 funded at only 74%, 63% and 52%, respectively (Annex 4, Fig. 3). Implementation of available resources exceeded 90% for all SOs except SO3, for which late arrival of funds caused some delay in implementation.

88. Overall, 61% was spent on staff costs and 39% on activities; 90% of the core voluntary contributions account and 80% of assessed contributions were spent on staff costs, with only 46% of other voluntary contribution funds (Annex 4, Fig. 10; see also the section on “Resource analysis”). Within activities, the largest expenditure was for “Contractual services, general”, followed by “Travel” and “General operational costs” (Annex 4, Fig. 11).

Implementation by mode of delivery

89. As noted in the section on “Background and context”, because of the high level of technical expertise in its Member States, the Regional Office implements programmes in three ways: intercountry, multicountry and country-specific.

90. The salaries of all staff in the Regional Office and the geographically dispersed offices are initially accounted for at intercountry level, irrespective of whether some of their time is planned to support specific countries. Only staff deployed directly in countries are accounted for in that country. This situation is reflected in Table 4 in the column “Implementation unadjusted”, which shows that 71% of financial implementation is at intercountry programme level. When the distribution of a staff member’s work is known, an adjustment is made outside the accounting system. The adjusted situation is shown in the last three columns of Table 3, which shows 64% implementation at intercountry programme level. The adjustment corresponds to a “billing” and is viewed as a more accurate reflection of the real situation than with the methods used previously.

Table 4. Implementation by mode of delivery, unadjusted and adjusted according to staff work (US$ 1000)

SO	Implementation unadjusted			Implementation adjusted		
	Country-specific	Intercountry programme	Total ICP	Country-specific	Intercountry programme	Total ICP
01	8 460	20 248	71%	10 645	18 063	63%
02	8 718	11 547	57%	10 457	9 808	48%
03	8 174	5 529	40%	9 619	4 084	30%
04	3 339	4 231	56%	4 067	3 503	46%
05	2 311	2 778	55%	2 706	2 383	47%
06	2 447	6 342	72%	3 647	5 143	59%
07	645	6 939	91%	1 913	5 671	75%
08	2 138	15 519	88%	2 710	14 947	85%
09	1 142	1 962	63%	1 451	1 654	53%
10	5 841	27 883	83%	9 334	24 389	72%
11	1 099	3 217	75%	2 078	2 239	52%
12	11 508	22 638	66%	11 508	22 638	66%
13	4 277	17 271	80%	4 274	17 274	80%
Total	**60 101**	**146 104**	**71%**	**74 410**	**131 795**	**64%**

ICP: intercountry programme

Implementation by staff costs and activities

91. Overall staff costs as a percentage of total expenditure were 56% for the technical SOs (SO1–SO11), although the percentage varied from 46% for SO1 to 70% for SO7 (Table 5). These variations reflect differences in the nature of the work, different applications of the Regional Office business model and differences in efficiency.

92. Throughout 2012–2013, financing staff costs was a challenge, requiring cumbersome, detailed management of financial and human resources; additional corporate resources were exceptionally requested to cover salary funding shortfalls and staff separations.

Table 5. Expenditure on staff and on activities by SO (US$ 1000)

SO	Activities		Staff		Total
	Implementation	% total	Implementation	% total	
1	15 610	54%	13 098	46%	28 708
2	8 925	44%	11 340	56%	20 265
3	7 360	54%	6 343	46%	13 703
4	3 408	45%	4 162	55%	7 570
5	1 955	38%	3 136	62%	5 090
6	4 338	49%	4 452	51%	8 790
7	2 238	30%	5 346	70%	7 584
8	5 836	33%	11 821	67%	17 656
9	1 020	33%	2 084	67%	3 105
10	12 910	38%	20 813	62%	33 723
11	1 980	46%	2 337	54%	4 317
SO1–SO11	**65 579**	**44%**	**84 932**	**56%**	**150 511**
12	4 809	14%	9 337	86%	34 146
13	9 014	42%	12 534	58%	21 548
Total	**79 401**	**39%**	**126 803**	**61%**	**206 205**

93. The number of continuing appointments increased as a consequence of the human resources policy of automatically granting this type of appointment after five years of fixed-term service (Table 6). With WHO reform, automatic granting of continuing appointments ceased and the number of continuing appointments will decrease as staff with continuing appointments leave the Organization. The number of fixed-term and temporary appointments was reduced considerably during the biennium by not replacing staff, offering separation by mutual agreement packages and delaying recruitment.

Table 6. Evolution in staff numbers and contract types, 2012–2013

Contract type	December 2011	December 2013	Difference
Continuing	242	296	54
Fixed-term	288	160	–128
Temporary	47	23	–24
Total number of staff	**577**	**479**	**–98**

94. While the reduction of nearly 100 in the overall number of staff was necessitated by financial constraints, it also reflects the new business model and the general drive to improve efficiency. Delayed recruitment for key positions nevertheless affects the capacity of the

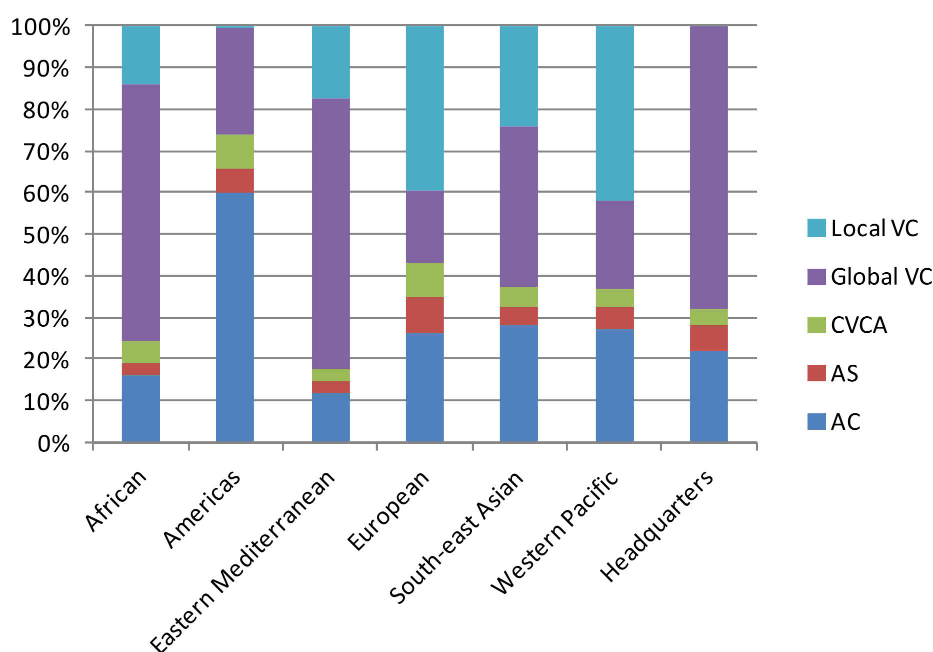
Regional Office to deliver. Unless the financial situation improves, further adjustments will be required to fully align capacity with priorities.

Resource analysis

95. The funding pattern varies considerably among WHO major offices (Fig. 2). The regional offices for Europe and for the Western Pacific rely on locally mobilized voluntary resources to a much greater extent – 39% and 42%, respectively – than the other major offices. A full list of sources of funding (local and global) is given in Annex 5. The Regional Office for the Americas is a special case, as almost all locally mobilized voluntary contributions are recorded in the budget of the Pan American Health Organization and thus do not appear in WHO records.

96. In the Regional Office for Europe, overall financing includes a larger proportion of funds from the core voluntary contributions account and administrative support costs than in other major offices. This is due partly to corporate funds received to cover salary shortfalls and the costs of separation of staff, as mentioned in the previous section.

Fig. 2. Funding patterns among major offices (relative composition of available resources for all budget segments)



VC: voluntary contributions; CVCA: core voluntary contributions account;
AS: administrative support; AC: assessed contributions

97. At least in the European Region, locally mobilized contributions tend to be more closely specified in terms of projects, the countries in which they can be used (see also Table 1) and the type of expenditure allowed, notably not allowing sufficient spending on staff.

98. Examples of large single contributions to base programmes earmarked for specific outcomes and countries, which constitute a substantial share of the overall funding available for individual SOs, include: SO1, nearly US$ 4 million (18% of total available for the SO) earmarked for Turkey; SO3, US$ 4.5 million (27%) earmarked for Turkey; SO8, US$ 8 million (42%) earmarked for the geographically dispersed office in Bonn (Germany) and US$ 1.5 million (8%) for high-risk areas in Sicily (Italy); SO9, US$ 850 000 (30%) for Albania; SO10,

US$ 1.9 million (7%) for the Republic of Moldova; and SO11, US$ 600 000 (17%) earmarked for Montenegro.

99. Overall staff costs for SO1–SO11 constituted 56% of all expenditure in these SOs (see Table 5). Overall voluntary contributions other than the core voluntary contributions account allowed only 46% of their total for staff costs (see section on "Implementation by staff costs and activities" and Annex 4, Fig. 10). There is also wide variation in other voluntary contributions and across SOs, with 61% of other voluntary contributions (US$ 24 million) and 23% of the total allowing less than 20% towards staff costs (Table 7).

Table 7. Voluntary contributions (other than the core voluntary contributions account) of which less than 20% were for salary expenditure, 2012–2013 (US$ 1000)

Strategic objective	Total awards		Awards with less than 20% for salaries			
	Number	Amount	Number	% of total	Amount	% of total
SO1	78	25 838	51	65%	7 645	30%
SO2	87	16 350	51	59%	4 358	27%
SO3	44	9 324	27	61%	1 693	18%
SO4	31	3 484	16	52%	1 907	55%
SO5	23	2 601	13	57%	889	34%
SO6	54	6 138	37	69%	3 380	55%
SO7	30	4 084	16	53%	1 003	25%
SO8	72	15 839	45	63%	1 171	7%
SO9	19	1 476	13	68%	191	13%
SO10	59	19 792	30	51%	1 371	7%
SO11	28	2 629	17	61%	1 371	52%
Total	**525**	**107 554**	**316**	**60%**	**24 981**	**23%**

100. For SO1, SO2, SO4, SO5, SO6, SO7 and SO11, 25% or more of the voluntary contributions come from awards that allow less than 20% for staff costs. Therefore, everything else being equal, it is a constant challenge to fund staff costs. The reason is probably a combination of contributors putting undue restrictions on the use of funds and inadequate explanations and negotiations on the part of the Secretariat.

Success factors, impediments and lessons learnt

101. The end-of-biennium report of the Global Management System on implementation of the nearly 800 Office-specific expected results (KPOs and other priority outcomes by country and intercountry) included assessment of factors for success and impediments. The latter represent the outcomes that were partly achieved or not achieved and may not be complete.

102. The main determinants of success are collaboration, including within WHO, with partners and with the ministries of health of Member States, political commitment and strong national counterparts (Fig. 3). Good collaboration with ministries of health, good collaboration with strong national counterparts and strong political commitment are relatively more frequently found for KPOs than for other priorities (see Annex 6), suggesting that senior policy-makers in Member States give higher priority to KPOs.

Fig. 3. Success factors (n = 494)

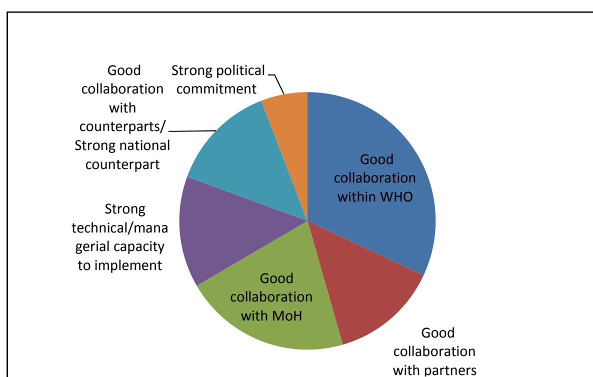
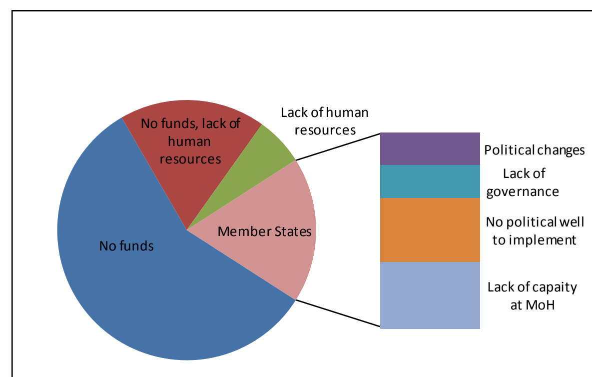


Fig. 4. Impediments (n = 33)



103. The largest impediment is lack of resources (Fig. 4), although there is no apparent difference between KPOs and other priority outcomes in this respect (Annex 6). The lack of resources may be due to an absolute shortage of input due to restrictions imposed by contributors combined with how the Secretariat manages the available resources, in particular, flexible corporate resources. About one fifth of the reported impediments were internal to Member States, comprising political changes, lack of governance, lack of political will and lack of capacity at the ministry of health.

104. For each of the outcomes, the challenges faced and the lessons learnt during implementation are recorded and analysed and their implications for plans for 2014–2015 are reflected in the individual outcome assessment sheets (see Appendix). Some common lessons can be drawn to guide planning for 2016–2017.

105. Some Member States lack physical and expert capacity in certain technical areas. For these, it will be important to continue providing country-specific technical support. This was found, however, to be more effective when support was provided to multiple technical areas or programmes at the same time and linked with support for health systems strengthening.

106. In addressing the challenges of “accepting politically and implementing technically”, the Secretariat should continue and further emphasize policy and strategic dialogue with all Member States, involving the highest political and policy levels, other sectors than health and local governments. Practically, this would mean increased support for evaluation and comparative analysis, more advocacy and communication, more opportunities for countries to learn from each other and working with national and international partners.

107. These lessons confirm the WHO Europe’s business model, while indicating that the model should be “fine-tuned” for 2016–2017. This will require a combination of further top-level technical staff expertise with strong convening and networking power. It will also require the Secretariat to further strengthen consistency among programme areas and systematically follow up the support provided.

108. Planning both internally within the Secretariat and with Member States should be realistic, avoiding “overplanning” and spreading political, policy, technical and financial resources too thinly.

109. Member States should set priorities and be realistic about how many outcomes can be pursued and how many different outputs can be absorbed at the same time. Uptake in most cases requires allocation of considerable technical, financial and political resources at the national level.

110. The Secretariat also must be realistic and manage according to the set priorities. As some outputs and outcomes are of lower priority than others, adequate attention should be given to monitoring technical progress and the funding situation of the prioritized outcomes, with respective allocation of flexible corporate resources to their outputs. In times of financial or technical capacity constraints, preference should be given to priority outcomes, even if this means stopping work on others.

111. Member States and donors should allow their specified contributions to fully cover all cost elements required to deliver the outputs they are funding, including salaries. The best, most effective approach would be to reduce specification of funding, for example, not specifying below the outcome level.

Annex 1. Glossary of terms and abbreviations

Administrative support costs: part of programme support costs; can be used to fund only category 6

Allocated budget: the budget as revised and approved by the WHO Director-General, subsequent to approval by the World Health Assembly

Assessed contributions: regular contributions made by all Member States, calculated on the basis of an assessment key determined by the United Nations. When the World Health Assembly adopts the appropriation resolution, it decides how assessed contributions should be used. For the current and past programme budgets, this was at the level of each strategic objective, that is, in 13 appropriation sections.

Base programmes: the part of the programme budget for which WHO has full, exclusive managerial control

Biennial collaborative agreements: agreements between WHO and Member States in the European Region that outline the focus of work during the coming biennium

Core voluntary contributions account: a mechanism to receive, allocate and manage resources that are provided to WHO from donors and which are flexible at the programme budget (across categories 1–5) or category level

Corporate resources: resources that can be managed by the Organization with a high degree of flexibility, including allocating, spending, according priority and filling budget financing gaps. They include assessed contributions, administrative support costs, the core voluntary contributions account and post occupancy charges.

Country-specific mode: used for outputs which are specifically tailored for individual countries

European Observatory on Health Systems and Policies: a collaborative arrangement within the programme budget's special programme and collaborative arrangements segment, located in Brussels, Belgium

Geographically dispersed offices: part of the Regional Office, with a specific technical focus and located outside Copenhagen, Denmark

Human resources: the human resources plan links results with staff and resources.

KPOs: key priority outcomes, which are specific "priorities within priorities" for additional managerial attention, including closer monitoring, during the 2012–2013 biennium

Output: an element in the value chain representing deliverables by the Secretariat, such as guidelines, norms and standards, policy options, capacity-building packages and technical advice; required by Member States to achieve a health impact

PB: the biennial WHO programme budget approved by the World Health Assembly before the start of the biennium. Budget envelopes are often adjusted during the biennium, resulting in the so-called "allocated budget".

Post occupancy charge: included in the staff costs charged to each project or workplan to recover any direct costs associated with project staff that are not otherwise covered. This is a WHO-wide charge that is applied to all salaries. In order to avoid double-counting, the post occupancy charge is applied outside the programme budget.

Priority outcome: element in the value chain deemed to be a priority by Member States. The measure of achievement of a priority outcome is "the number of Member States that have …"

Programme and Resource Management: a unit within the office of the Director, Programme Management

Secretariat: the staff and organizational, managerial and physical structures of WHO

Segment: one of three segments into which the programme budget is divided: base, outbreak and crisis response, and special programme and collaborative arrangements

SO: strategic objective, a high level in the results structure. The WHO *Medium-term strategic plan 2008–2013* is organized according to 13 SOs.

Special programme and collaborative arrangements: a segment of work in the programme budget that is decided on with partners; that is, WHO does not have the exclusive decision power in relation to, for example, budget levels. In the WHO Regional Office for Europe, this budget segment mainly comprises funds received from the GAVI Alliance, The Global Fund to Fight AIDS, Malaria and Tuberculosis and the European Observatory on Health Systems and Policies.

Specific outcome: generic, Region-wide priority outcome, for example, in country-specific workplans. The measure of achievement is "Member State A has taken up …" Under BCAs and workplans, outputs to be delivered by the Secretariat depend on the circumstances and needs of the country.

Voluntary contributions: "other voluntary contributions" are those other than administrative support costs, the core voluntary contributions account and the European Observatory on Health Systems and Policies.

WHO: World Health Organization; this term is used to cover Member States and the Secretariat

World Health Assembly: the highest governing body of WHO

Annex 2. Achievement of Organization-wide expected results in PB 2012–2013 in the WHO European Region

SO	Expected result	Description	Fully achieved	Partly achieved	Not achieved	Not applicable to EURO
01	01.001	Vaccines and immunization	1			
01	01.002	Poliomyelitis	1			
01	01.003	Tropical diseases, including zoonotic diseases	1			
01	01.004	Surveillance of communicable diseases		1		
01	01.005	Research on communicable diseases				1
01	01.006	*International Health Regulations (2005)* and response to epidemics		1		
01	01.007	Epidemic and pandemic diseases	1			
01	01.008	Coordination and assistance for outbreak containment				1
01	01.009	Operations and response to epidemics	1			
02	02.001	Prevention, treatment and care for HTM		1		
02	02.002	Delivery of services for HTM		1		
02	02.003	Medicines, diagnostic and technology for HTM		1		
02	02.004	Surveillance, evaluation and monitoring for HTM	1			
02	02.005	Resource mobilization for HTM		1		
02	02.006	Research for HTM				1
03	03.001	Commitment to address noncommunicable diseases	1			
03	03.002	Policies, strategies and regulations for noncommunicable diseases		1		
03	03.003	Data on noncommunicable diseases		1		
03	03.004	Evidence for interventions on noncommunicable diseases		1		
03	03.005	Implementation of programmes on noncommunicable diseases	1			
03	03.006	Health and social systems for noncommunicable diseases	1			
04	04.001	Universal access to CAMHAG services	1			
04	04.002	Research capacity on CAMHAG	1			
04	04.003	Maternal care	1			
04	04.004	Neonatal care	1			

SO	Expected result	Description	Fully achieved	Partly achieved	Not achieved	Not applicable to EURO
04	04.005	Guidance and support for child health and development	1			
04	04.006	Policies, strategies and interventions for adolescent health and development	1			
04	04.007	Guidance and support on reproductive health	1			
04	04.008	Guidance and support for healthy ageing	1			
05	05.001	Emergency preparedness	1			
05	05.007	Operations and response to emergencies and disasters	1			
06	06.001	Health promotion, and multisectoral collaboration on risks	1			
06	06.002	Surveillance of health risk factors	1			
06	06.003	Burden of diseases associated with tobacco	1			
06	06.004	Substance abuse		1		
06	06.005	Unhealthy diet and physical inactivity	1			
06	06.006	Unsafe sex	1			
07	07.001	Recognition of significance of determinants of health	1			
07	07.002	Intersectoral collaboration addressing determinants of health		1		
07	07.003	Data on determinants		1		
07	07.004	Ethics and rights-based approaches	1			
07	07.005	Gender-responsive policies and programmes		1		
08	08.001	Evidence-based assessment made and norms and standards formulated and updated on major environmental hazards to health (such as poor air quality, chemical substances, electromagnetic fields, radon, poor-quality drinking-water and waste-water reuse)	1			
08	08.002	Interventions to reduce environmental hazards	1			
08	08.003	Policy, planning and services for occupational and environmental health		1		
08	08.004	Environmental health policy and assessment	1			
08	08.005	Health sector leadership for a healthier environment	1			
08	08.006	Climate change	1			

SO	Expected result	Description	Fully achieved	Partly achieved	Not achieved	Not applicable to EURO
09	09.001	Partnership, leadership and coordination in nutrition and food safety	1			
09	09.002	Assessment of and response to malnutrition and foodborne diseases	1			
09	09.003	Monitoring, surveillance and nutrition assessment	1			
09	09.004	Plans, policies and programmes for nutrition	1			
09	09.005	Prevention and control of foodborne diseases and food hazards	1			
09	09.006	Risk assessment and control systems for foodborne diseases	1			
10	10.001	Health services management and organization		1		
10	10.002	National capacity for governance and leadership on health	1			
10	10.003	Coordination of mechanisms for aid effectiveness	1			
10	10.004	Country health information systems		1		
10	10.005	Evidence and knowledge generation		1		
10	10.006	Research for health system development				1
10	10.007	Management of and access to knowledge on health system development		1		
10	10.008	Policies, planning and implementation of human resources for health		1		
10	10.009	Production, distribution, and retention of human resources for health		1		
10	10.010	Health system financing and use of resources		1		
10	10.011	Economic impact, expenditure and cost–effectiveness analysis	1			
10	10.012	Advocacy for additional financing, generation and use of financial information	1			
10	10.013	Patient safety		1		
11	11.001	Policy on essential medical products and technologies		1		
11	11.002	Guidance on medical products and technologies	1			
11	11.003	Use of medical products and technologies	1			

SO	Expected result	Description	Fully achieved	Partly achieved	Not achieved	Not applicable to EURO
12	12.001	Leadership and direction of WHO	1			
12	12.002	WHO country presence	1			
12	12.003	Partnership mechanisms for health development	1			
12	12.004	Health knowledge and advocacy material	1			
13	13.001	Strategic and operational planning, performance monitoring and assessment		1		
13	13.002	WHO resources management		1		
13	13.003	WHO human resources development and management	1			
13	13.004	Information technology and systems for WHO		1		
13	13.005	Managerial and administrative support services	1			
13	13.006	Working environment at WHO	1			
Total			**50**	**26**	**0**	**4**

HTM: HIV/AIDS, TB, malaria and neglected tropical diseases; CAMHAG: child, adolescent and mother health, and ageing; SO: strategic objective

Annex 3. Outcomes portfolio monitoring (for a description of each outcome and output, see Appendix)

Serial #	KPO/ OPO	Cross-walking			# of countries	OSER (Outcomes in budget centres/ countries) Reporting					Budget and finances (US$ 000)			Adjusted implementation		
		PB 2012–2013	PB 2014–2015			Completeness	% of reported			# Accom's hed	Budget	Av. Resources	Impl'tion	FTE	Impl Staff	Impl Activities
		SO	Cat	Programme Area			Fully achieved	Partly achieved	Not achieved						US$ 000	US$ 000
01	KPO	1	I	Vaccine-preventable Diseases	13	100%	100%	0%	0%	17	5 242	5 171	4 536	2.3	656	2 508
02	KPO	1	V	Epidemic - and Pandemic-prone Diseases	18	100%	95%	5%	0%	20	1 937	1 895	1 706	2.7	977	829
03	KPO	1	V	Alert and response Capacities	23	96%	88%	12%	0%	22	7 350	7 152	7 021	12.1	3 426	4 078
04	KPO	2	I	HIV/AIDS	9	100%	60%	0%	40%	6	2 334	2 223	2 084	2.6	1 252	950
05	KPO	2	I	Tuberculosis	20	100%	95%	5%	0%	21	7 347	6 393	5 914	11.0	2 226	4 153
06	KPO	2	I	Malaria	5	100%	100%	0%	0%	6	1 584	1 530	1 427	0.8	288	915
07	KPO	3	II	Mental Health	18	100%	100%	0%	0%	20	4 256	3 622	3 611	7.5	2 041	2 474
08	KPO	3	II	Violence and Injuries	18	100%	85%	15%	0%	17	3 475	3 406	3 236	5.6	1 336	2 946
09	KPO	3	II	Noncommunicable Diseases	21	100%	77%	4%	19%	20	3 474	3 137	2 903	4.0	929	1 948
10	KPO	4	III	Healthy Ageing	5	100%	100%	0%	0%	5	1 302	1 256	1 221	1.8	765	393
11	KPO	4	III	Reproductive, Maternal, Newborn, Child and Adolescent Health	15	100%	100%	0%	0%	19	5 603	5 405	5 167	9.0	1 649	2 420
12	KPO	5	V	Alert and response Capacities	11	100%	100%	0%	0%	15	848	848	781	4.3	1 072	777
13	KPO	6	II	Noncommunicable Diseases	12	100%	100%	0%	0%	14	1 522	1 411	1 377	1.6	457	692
14	KPO	6	II	Noncommunicable Diseases	17	100%	100%	0%	0%	17	2 088	1 946	1 886	3.1	662	924
15	KPO	6	II	Noncommunicable Diseases	16	94%	100%	0%	0%	17	3 330	3 118	2 925	4.9	1 389	799
16	KPO	7	III	Social Determinants of Health	7	100%	100%	0%	0%	10	2 118	1 985	1 979	3.0	1 200	472
17	KPO	7	IV	National Health Policies, Strategies and Plans	10	100%	100%	0%	0%	11	1 824	1 649	1 665	5.2	1 900	992
18	KPO	8	III	Health and the Environment	2	100%	100%	0%	0%	3	4 369	3 615	3 457	11.4	3 405	1 650
19	KPO	9	II	Nutrition	5	100%	100%	0%	0%	9	1 232	1 192	1 186	3.2	416	424
20	KPO	9	V	Food Safety	0	100%	100%	0%	0%	1	846	687	687	0.4	176	104
21	KPO	10	IV	Integrated People-centred Health Services	19	100%	100%	0%	0%	20	3 086	2 949	2 136	3.8	1 197	793
22	KPO	10	IV	Integrated People-centred Health Services	24	100%	88%	0%	12%	22	2 458	2 287	2 192	4.1	1 139	1 069
23	KPO	10	IV	Health Systems Information and Evidence	11	100%	100%	0%	0%	15	1 217	1 205	1 170	1.7	502	303
24	KPO	10	IV	Health Systems Information and Evidence	11	100%	93%	0%	7%	13	1 523	1 500	1 495	2.1	690	607
25	KPO	10	IV	National Health Policies, Strategies and Plans	14	100%	69%	25%	6%	11	2 615	2 450	2 476	4.7	1 314	832

Serial #	KPO/ OPO	Cross-walking: PB 2012–2013 SO	Cross-walking: PB 2014–2015 Cat	Cross-walking: PB 2014–2015 Programme Area	# of countries	OSER (Outcomes in budget centres/ countries) Reporting: Completeness	% of reported: Fully achieved	% of reported: Partly achieved	% of reported: Not achieved	# Accom's hed	Budget and finances (US$ 000): Budget	Av. Resources	Impl'tion	Adjusted implementation: FTE	Impl Staff US$ 000	Impl Activities US$ 000
26	KPO	10	IV	Health Systems Information and Evidence	13	100%	100%	0%	0%	16	1 069	1 048	917	1.5	468	279
27	KPO	11	IV	Access to Medical Products and Strengthening Regulatory Capacity	12	100%	93%	7%	0%	13	1 552	1 517	1 494	2.3	616	502
28	OPO	1	I	Vaccine-preventable Diseases	15	100%	100%	0%	0%	17	7 594	7 624	7 545	4.8	1 153	4 560
29	OPO	1	V	Polio Eradication	13	100%	100%	0%	0%	19	4 357	4 173	3 752	2.2	589	2 505
30	OPO	1	V	Alert and response Capacities	11	100%	87%	13%	0%	13	1 709	1 663	1 629	2.7	760	663
31	OPO	1	V	Epidemic - and Pandemic-prone Diseases	1	100%	100%	0%	0%	2	1 773	1 738	1 718	1.2	336	670
32	OPO	1	V	Outbreak and Crisis Response	0	100%	100%	0%	0%	1	160	8	7	1.4	489	7
33	OPO	1	I	Neglected Tropical Disease	3	100%	100%	0%	0%	4	564	517	430	1.1	406	398
34	OPO	2	I	HIV/AIDS	16	100%	83%	0%	17%	15	4 705	3 998	3 729	11.9	2 431	1 200
35	OPO	2	I	HIV/AIDS	2	100%	67%	0%	33%	2	805	701	763	2.4	670	228
36	OPO	2	I	Tuberculosis	10	100%	100%	0%	0%	13	2 232	1 941	1 860	4.0	962	564
37	OPO	2	I	Tuberculosis	5	100%	86%	0%	14%	6	2 062	1 785	1 773	2.6	636	623
38	OPO	2	I	Tuberculosis	6	100%	100%	0%	0%	7	1 085	953	928	2.6	734	325
39	OPO	2	I	Malaria	1	100%	100%	0%	0%	2	607	607	575	0.5	172	193
40	OPO	3	II	Mental Health	2	100%	100%	0%	0%	3	54	22	20	0.3	116	20
41	OPO	3	II	Mental Health	3	100%	75%	25%	0%	3	1 127	1 097	1 078	0.3	136	10
42	OPO	3	II	Violence and Injuries	4	100%	100%	0%	0%	5	2 016	1 963	1 866	0.9	412	51
43	OPO	3	II	Violence and Injuries	0	100%	100%	0%	0%	1	24	0	0	0.3	98	0
44	OPO	3	II	Noncommunicable Diseases	3	100%	100%	0%	0%	6	22	20	20	0.6	97	20
45	OPO	3	II	Noncommunicable Diseases	3	100%	75%	0%	25%	3	63	13	13	0.5	100	13
46	OPO	3	II	Noncommunicable Diseases	10	100%	58%	0%	42%	7	105	89	89	0.8	146	89
47	OPO	4	III	Reproductive, Maternal, Newborn, Child and Adolescent Health	6	100%	71%	14%	14%	5	375	353	341	2.5	405	341
48	OPO	4	III	Reproductive, Maternal, Newborn, Child and Adolescent Health	1	100%	100%	0%	0%	4	127	124	84	0.4	155	84
49	OPO	4	III	Reproductive, Maternal, Newborn, Child and Adolescent Health	1	100%	100%	0%	0%	2	35	0	0	0.3	58	0
50	OPO	4	III	Reproductive, Maternal, Newborn, Child and Adolescent Health	4	100%	100%	0%	0%	5	376	319	274	2.6	640	274
51	OPO	5	V	Outbreak and Crisis Response	3	100%	100%	0%	0%	4	1 566	1 305	1 194	3.9	470	884
52	OPO	5	V	Outbreak and Crisis Response	5	100%	100%	0%	0%	9	2 559	2 520	2 517	1.9	707	221
53	OPO	6	III	Reproductive, Maternal, Newborn, Child and Adolescent Health	0	100%	100%	0%	0%	1	90	0	-0	0.1	34	0
55	OPO	6	II	Mental Health	6	100%	86%	0%	14%	6	60	15	12	0.3	99	12

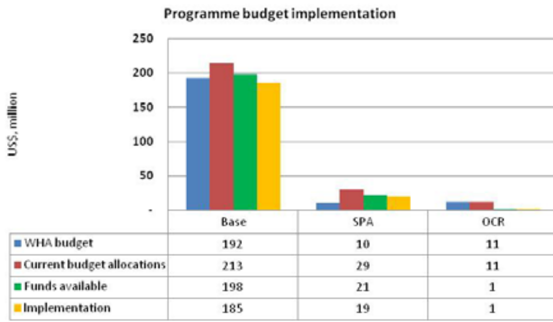
Serial #	KPO/ OPO	Cross-walking			# of countries	OSER (Outcomes in budget centres/ countries) Reporting					Budget and finances (US$ 000)			Adjusted implementation		
		PB 2012–2013		PB 2014–2015		Completeness	% of reported			# Accom's hed	Budget	Av. Resources	Impl'tion	FTE	Impl Staff	Impl Activities
		SO	Cat	Programme Area			Fully achieved	Partly achieved	Not achieved						US$ 000	US$ 000
56	OPO	6	II	Mental Health	3	100%	100%	0%	0%	4	109	86	75	1.8	460	75
57	OPO	6	II	Mental Health	4	100%	100%	0%	0%	5	147	69	63	0.5	100	63
58	OPO	6	II	Noncommunicable Diseases	1	100%	100%	0%	0%	2	137	105	86	0.8	289	86
59	OPO	6	II	Noncommunicable Diseases	21	100%	100%	0%	0%	25	573	358	344	2.1	480	344
60	OPO	6	II	Noncommunicable Diseases	1	100%	100%	0%	0%	1	11	5	5	0.0	9	5
61	OPO	6	III	Social Determinants of Health	0	100%	100%	0%	0%	2	790	790	777	0.7	237	777
62	OPO	7	III	Social Determinants of Health	24	100%	90%	3%	6%	28	1 850	1 739	1 667	5.2	1 702	773
63	OPO	7	III	Gender, Equity and Human Rights Mainstreaming	11	100%	50%	0%	50%	7	1 131	960	897	2.1	480	189
64	OPO	7	III	Gender, Equity and Human Rights Mainstreaming	6	100%	57%	0%	43%	4	160	113	110	0.6	234	52
65	OPO	7	III	Gender, Equity and Human Rights Mainstreaming	2	100%	100%	0%	0%	4	33	32	18	0.5	165	18
66	OPO	8	III	Health and the Environment	8	100%	88%	0%	13%	7	6 035	5 616	5 551	5.6	1 543	1 016
67	OPO	8	III	Health and the Environment	1	100%	100%	0%	0%	2	279	260	243	1.7	589	209
68	OPO	8	III	Health and the Environment	10	100%	92%	0%	8%	11	1 225	1 171	1 174	4.6	1 320	367
69	OPO	8	III	Health and the Environment	5	100%	88%	13%	0%	7	3 116	2 984	2 730	4.3	1 353	1 092
70	OPO	8	III	Health and the Environment	11	100%	100%	0%	0%	13	3 800	3 668	3 483	5.6	1 047	1 388
71	OPO	9	V	Food Safety	8	100%	100%	0%	0%	10	841	760	757	2.7	396	450
72	OPO	9	II	Nutrition	0	100%	100%	0%	0%	1	42	25	24	0.7	115	24
73	OPO	10	IV	Integrated People-centred Health Services	0	100%	100%	0%	0%	4	1 278	1 209	1 207	2.2	829	370
74	OPO	10	IV	Integrated People-centred Health Services	3	100%	83%	8%	8%	10	1 546	1 613	1 497	2.5	824	851
75	OPO	10	IV	National Health Policies, Strategies and Plans	10	100%	100%	0%	0%	4	1 081	954	927	1.8	456	436
76	OPO	10	IV	National Health Policies, Strategies and Plans	3	100%	100%	0%	0%	7	2 170	2 159	2 132	2.6	740	1 399
77	OPO	10	IV	Integrated People-centred Health Services	6	100%	100%	0%	0%	18	1 353	1 396	1 238	4.4	767	616
78	OPO	10	IV	Integrated People-centred Health Services	17	100%	94%	6%	0%	16	1 253	1 192	1 192	4.5	922	253
79	OPO	10	IV	Integrated People-centred Health Services	13	100%	90%	10%	0%	9	605	598	598	0.9	318	152
80	OPO	10	IV	Health Systems Information and Evidence	9	100%	100%	0%	0%	7	1 168	1 162	1 106	3.9	1 242	467
81	OPO	10	IV	Health Systems Information and	4	100%	50%	50%	0%	1	124	122	122	0.5	137	122

Serial #	KPO/ OPO	Cross-walking			# of countries	OSER (Outcomes in budget centres/ countries) Reporting					Budget and finances (US$ 000)			Adjusted implementation		
		PB 2012–2013	PB 2014–2015			Completeness	% of reported			# Accom's hed	Budget	Av. Resources	Impl'tion	FTE	Impl Staff	Impl Activities
		SO	Cat	Programme Area			Fully achieved	Partly achieved	Not achieved						US$ 000	US$ 000
				Evidence												
82	OPO	10	IV	Health Systems Information and Evidence	16	100%	95%	0%	5%	18	11 837	10 497	9 812	30.8	8 682	3 381
86	OPO	11	IV	Access to Medical Products and Strengthening Regulatory Capacity	8	100%	100%	0%	0%	11	2 096	2 015	1 916	2.3	674	981
87	OPO	11	IV	Access to Medical Products and Strengthening Regulatory Capacity	11	100%	100%	0%	0%	14	830	803	778	1.4	645	407
99	OPO	Vari ous			0	82%	100%	0%	0%	18	9 931	9 651	9 589	20.1	6 665	1 852

KPO: key priority outcome; OPO: other priority outcome; OSER: Office-specific expected result

Annex 4. Financial management report

Fig. 1



	Base	SPA	OCR
WHA budget	192	10	11
Current budget allocations	213	29	11
Funds available	198	21	1
Implementation	185	19	1

Fig. 2

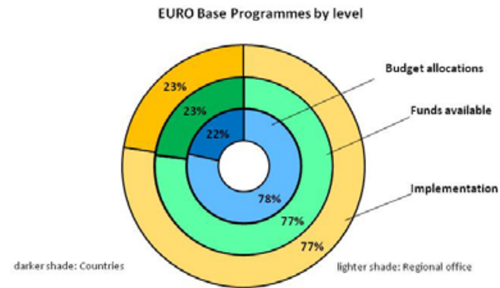
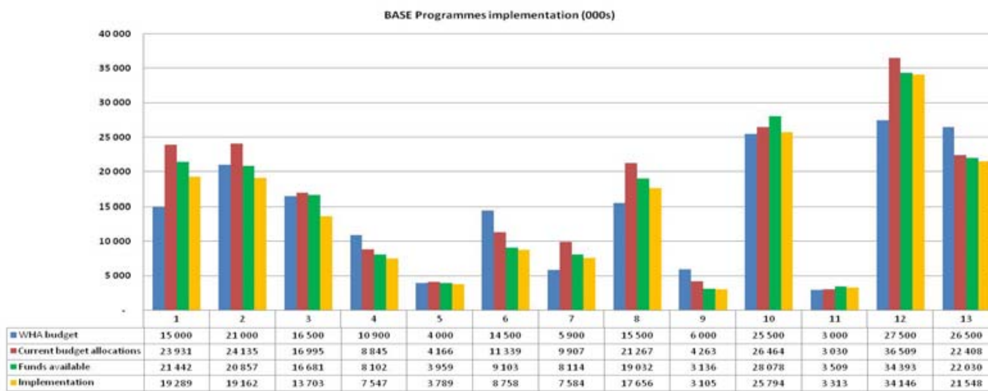
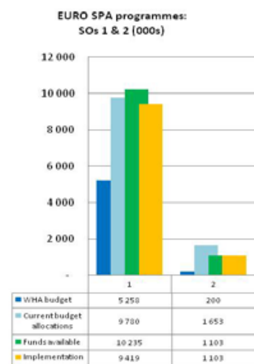


Fig. 3



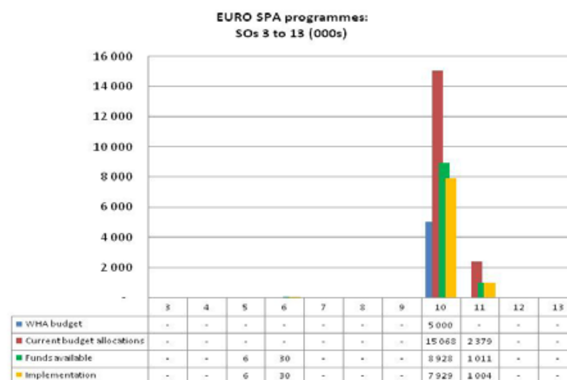
	1	2	3	4	5	6	7	8	9	10	11	12	13
WHA budget	15 000	21 000	16 500	10 900	4 000	14 500	5 900	15 500	6 000	25 500	3 000	27 500	26 500
Current budget allocations	23 931	24 135	16 995	8 845	4 166	11 339	9 907	21 267	4 263	26 464	3 030	36 509	22 408
Funds available	21 442	20 857	16 681	8 102	3 959	9 103	8 114	19 032	3 136	28 078	3 509	34 393	22 030
Implementation	19 289	19 162	13 703	7 547	3 789	8 758	7 584	17 656	3 105	25 794	3 313	34 146	21 548

Fig. 4



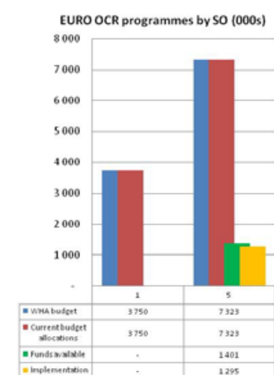
	1	2
WHA budget	5 258	200
Current budget allocations	9 780	1 653
Funds available	10 235	1 103
Implementation	9 419	1 103

Fig. 5



	3	4	5	6	7	8	9	10	11	12	13
WHA budget	-	-	-	-	-	-	-	5 000	-	-	-
Current budget allocations	-	-	-	-	-	-	-	15 068	2 379	-	-
Funds available	-	-	6	30	-	-	-	8 928	1 011	-	-
Implementation	-	-	6	30	-	-	-	7 929	1 004	-	-

Fig. 6



	1	5
WHA budget	3 750	7 323
Current budget allocations	3 750	7 323
Funds available	-	1 401
Implementation	-	1 295

Fig. 7

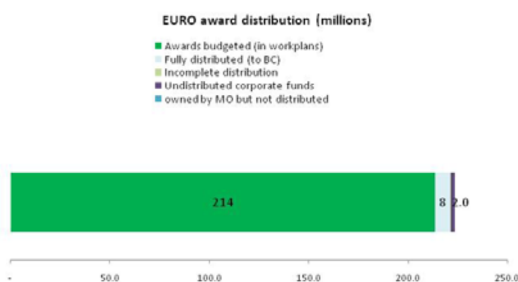


Fig. 8

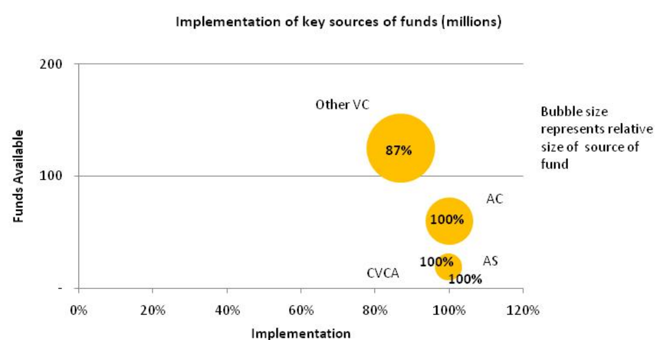


Fig. 9

Fig. 10

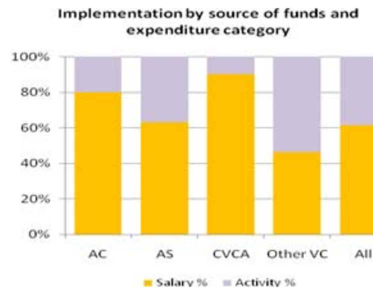
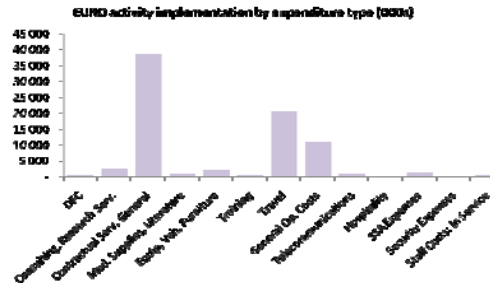


Fig. 11



Annex 5. Available resources by Regional Office contributor, type and strategic objective

	DONOR	SO 01	SO 02	SO 03	SO 04	SO 05	SO 06	SO 07	SO 08	SO 09	SO 10	SO 11	SO 12	SO 13	SO 93	TOTAL
Globally raised voluntary contributions	UNITED STATES OF AMERICA	8 635 602	2 654 961	-	-	-	599 086	-	-	115 500	-	278 353	-	14 600	-	12 298 102
	GAVI	5 329 110	-	-	-	-	-	-	-	-	669 786	668 053	-	-	-	6 666 949
	UN	1 412 812	2 816 038	119 047	24 000	158 530	-	-	499 236	-	50 000	-	-	-	-	5 079 663
	BLOOMBERG	-	-	3 884 500	-	-	-	-	-	-	-	-	-	-	-	3 884 500
	RUSSIAN FEDERATION	820 331	516 305	-	875 000	115 950	-	-	-	-	-	-	-	-	-	2 327 586
	WORLD LUNG FOUNDATION	-	-	-	-	-	1 347 778	-	-	-	-	-	-	-	-	1 347 778
	UNITED KINGDOM	142 942	-	-	-	342 508	-	-	50 000	-	557 159	125 398	-	-	-	1 218 007
	GATES FOUNDATION	392 050	581 693	-	25 000	-	-	-	-	22 000	-	-	-	-	-	1 020 743
	KNCV TUBERCULOSIS FOUNDATION	-	765 147	-	-	-	-	-	-	-	-	-	-	-	-	765 147
	WHO - MISCELLANEOUS	-	759	10 000	435 905	-	5 000	-	-	-	198 570	-	68 967	-	-	719 201
	JAPAN	-	-	-	-	488 825	30 000	-	-	-	50 000	-	-	-	-	568 825
	LUXEMBOURG	-	-	-	22 500	422 946	-	-	-	-	-	-	-	-	-	445 446
	UNITAID	-	-	-	-	-	-	-	-	-	-	387 000	-	-	-	387 000
	GERMANY	-	247 771	-	125 000	-	-	-	-	-	-	7 372	-	-	-	380 143
	EC	56 825	-	-	-	-	-	-	-	-	322 918	-	-	-	-	379 743
	KUWAIT	-	-	-	-	330 250	-	-	-	-	-	-	-	-	-	330 250
	SPAIN	148 261	-	-	-	-	-	76 065	-	-	-	-	-	-	-	224 326
	SANOFI ESPOIR	193 900	-	-	-	-	-	-	-	-	-	-	-	-	-	193 900
	ELI LILLY AND COMPANY FOUNDATION	-	179 640	-	-	-	-	-	-	-	-	-	-	-	-	179 640
	PROGRAM FOR APPROPRIATE TECHNOLOGY IN HEALTH (PATH)	139 515	-	-	2 271	-	-	-	-	-	-	-	-	-	-	141 786
	NORWAY	-	-	-	-	-	140 000	-	-	-	-	-	-	-	-	140 000
	SABIN VACCINE INSTITUTE	57 200	-	-	-	-	-	-	-	-	-	-	-	-	-	57 200
	UBS OPTIMUS FOUNDATION	-	-	49 721	-	-	-	-	-	-	-	-	-	-	-	49 721
	CANADA	45 000	-	-	-	-	-	-	-	-	-	-	-	-	-	45 000
	SWEDEN	-	-	-	-	-	-	-	-	-	-	34 829	-	-	-	34 829
	FRANCE	-	-	-	-	-	9 000	-	-	17 000	-	-	-	-	-	26 000
	NETHERLANDS	-	-	25 279	-	-	-	-	-	-	-	-	-	-	-	25 279
	GFATM	-	20 000	-	-	-	-	-	-	-	-	2 968	-	-	-	22 968
	ROCKEFELLER FOUNDATION	-	-	-	-	-	-	-	-	-	16 090	-	-	-	-	16 090
	REPUBLIC OF KOREA	6 000	-	-	-	-	-	-	-	-	-	-	-	-	-	6 000
	AUSTRALIA	-	-	600	-	-	-	-	-	-	-	-	-	-	-	600
	TOTAL Globally raised	**17 379 548**	**7 782 314**	**4 089 147**	**1 509 676**	**1 859 009**	**2 130 864**	**76 065**	**549 236**	**154 500**	**1 864 523**	**1 503 973**	**68 967**	**14 600**	**-**	**38 982 422**

	DONOR	SO 01	SO 02	SO 03	SO 04	SO 05	SO 06	SO 07	SO 08	SO 09	SO 10	SO 11	SO 12	SO 13	SO 93	TOTAL
Locally raised voluntary contributions	WHO - MISCELLANEOUS	167 032	812 147	2 434	50 000	10 000	767 818	460 834	641 202	-	8 080 875	-	45 000	556 041	-	11 593 383
	GERMANY	276 337	91 651	-	-	76 407	63 298	-	10 384 229	61 603	228 671	-	-	-	148 251	11 330 447
	UNITED STATES OF AMERICA	4 406 085	5 858 627	328 779	55 131	157 715	198 115	-	-	-	79 995	-	-	-	-	11 084 447
	EC	6 079	32 065	290 029	113 271	666 360	1 529 924	62 254	1 326 009	341 266	5 240 064	700 468	100 000	6 300	-	10 414 089
	TURKEY	3 948 141	-	4 569 854	-	-	-	-	13 167	-	-	-	170 163	-	-	8 701 325
	ITALY	8 954	-	-	-	1 177	-	2 909 301	2 880 527	568 505	-	-	66 854	-	256 954	6 692 272
	NETHERLANDS	1 278 598	840 158	428 602	524 558	-	302 974	-	44 864	-	2 036 102	524 558	-	-	-	5 980 414
	UN	423 844	1 556 852	152 717	669 603	-	79 000	129 953	707 889	381 472	273 116	79 454	-	-	-	4 453 900
	SPAIN	-	-	-	355 991	-	-	-	-	-	2 690 992	45 724	-	-	325 000	3 417 707
	DENMARK	-	-	-	-	-	-	-	-	-	-	-	-	-	3 005 124	3 005 124
	RUSSIAN FEDERATION	-	-	846 517	506 000	-	-	165 000	-	-	-	-	221 239	-	-	1 738 756
	SWITZERLAND	-	-	59 605	182 147	-	325 733	-	361 717	-	622 623	1 810	59 719	2 100	-	1 615 454
	GREECE	-	-	546 458	-	-	39 606	-	-	-	1 000 000	-	-	-	-	1 586 064
	UNITED KINGDOM	-	-	113 916	-	-	-	642 578	211 768	-	176 463	-	-	-	-	1 144 725
	BELGIUM	98 580	38 760	-	-	99 110	-	14 082	-	-	1	-	-	-	822 231	1 072 764
	FINLAND	-	-	75 412	-	-	713 743	-	5 810	-	127 855	-	-	-	-	922 820
	NORWAY	-	-	291 840	-	-	68 712	75 482	98 038	-	212 150	-	-	-	-	746 222
	UKRAINE	-	636 623	-	-	-	-	-	-	-	-	-	-	-	-	636 623
	FRANCE	255 889	835	-	-	-	-	-	134 567	-	-	-	-	-	-	391 291
	TURKMENISTAN	-	-	337 550	-	-	-	-	-	-	-	-	-	-	-	337 550
	MALTA	-	-	-	-	-	-	-	-	-	-	-	326 708	-	-	326 708
	AUSTRIA	-	-	-	-	-	151 664	-	80 985	-	-	-	-	-	-	232 649
	CANADA	-	-	119 132	38 410	-	-	-	17 699	-	-	-	-	-	-	175 241
	PORTUGAL	-	-	30 000	-	-	40 000	27 290	-	-	46 114	27 910	-	-	-	171 314
	AZERBAIJAN	-	142 403	-	-	-	-	-	-	-	-	-	-	-	-	142 403
	MOLDOVA	-	135 475	-	-	-	-	-	-	-	-	-	-	-	-	135 475
	WHO - EHMA	-	-	-	-	-	-	-	-	-	78 939	-	-	-	-	78 939
	ANDORRA	-	-	-	-	-	-	-	-	-	66 372	-	-	-	-	66 372
	TFYR MACEDONIA	-	62 074	-	-	-	-	-	-	-	-	-	-	-	-	62 074
	SAN MARINO	-	-	-	-	-	-	50 000	-	-	-	-	-	-	-	50 000
	AUSTRIA	-	-	-	-	-	-	-	49 463	-	-	-	-	-	-	49 463
	ISRAEL	-	-	-	-	-	46 018	-	-	-	-	-	-	-	-	46 018
	BULGARIA	-	-	9 345	28 013	-	-	-	-	-	-	-	-	-	-	37 358
	SERBIA	-	35 179	-	-	-	-	-	-	-	-	-	-	-	-	35 179
	HUNGARY	-	-	-	-	-	-	-	29 344	-	-	-	-	-	-	29 344
	WHO - MDTF MULTI DONOR TRUST FUND	-	-	21 018	-	-	-	-	-	-	-	-	-	-	-	21 018
	WHO - ICRC	-	-	-	-	-	19 731	-	-	-	-	-	-	-	-	19 731
	GFATM	-	13 746	-	-	-	-	-	-	-	-	-	-	-	-	13 746
	SWEDEN	-	3 010	-	-	-	-	-	-	-	-	-	-	-	-	3 010
	TOTAL Locally raised	**10 869 539**	**10 259 605**	**8 223 208**	**2 523 124**	**1 010 769**	**4 346 336**	**4 536 774**	**16 987 278**	**1 352 846**	**20 960 332**	**1 379 924**	**989 683**	**564 441**	**4 557 560**	**88 561 419**
Corporate funds	WHO - CVCA	965 461	2 242 882	1 655 607	1 615 893	934 232	1 467 109	1 760 480	491 544	869 526	5 584 496	867 873	4 382	593 641	-	19 053 126
	WHO - ASSESSED CONTRIBUTION	1 925 866	1 752 748	2 719 817	2 476 747	1 609 667	1 193 501	1 741 096	1 322 819	773 394	8 190 724	792 814	22 090 001	13 550 476	-	60 139 670
	WHO - AS PROXY	-	-	-	-	-	-	-	-	-	-	-	11 247 504	7 073 143	-	18 320 647

DONOR	SO 01	SO 02	SO 03	SO 04	SO 05	SO 06	SO 07	SO 08	SO 09	SO 10	SO 11	SO 12	SO 13	SO 93	TOTAL
DONOR															
WHO - POC	-	-	-	-	-	-	-	-	-	-	-	-	-	7 930 000	7 930 000
TOTAL Corporate resources	**2 891 327**	**3 995 630**	**4 375 424**	**4 092 640**	**2 543 899**	**2 660 610**	**3 501 576**	**1 814 363**	**1 642 920**	**13 775 220**	**1 660 687**	**33 341 887**	**21 217 260**	**7 930 000**	**105 443 443**
GRAND TOTAL ALL RESOURCES	**31 140 414**	**22 037 549**	**16 687 779**	**8 125 440**	**5 413 677**	**9 137 810**	**8 114 415**	**19 350 877**	**3 150 266**	**36 600 075**	**4 544 584**	**34 400 537**	**21 796 301**	**12 487 560**	**232 987 284**

CVCA: core voluntary contributions account; POC: post occupancy charge; SO: strategic objective

Annex 6. Summary of success factors and impediments by strategic objective, for SO1–SO11

Strategic objective	Success factors						Impediments						
	Good collaboration within WHO	Good collaboration with partners	Good collaboration with ministry of health	Strong technical or managerial capacity	Good collaboration with and strong national counterparts	Strong political commitment	No funds	No funds, lack of human resource capacity	Lack of human resources	Political changes	Lack of governance	No political will to implement	Lack of capacity at ministry of health
1	41	2	20	13	12		1	1					
2	18	9	7	6	3		9				1		
3	14	1	20	5	3	1	1		1			1	
4	9	9	11	1	4			2					
5		2	6	7	3	1							
6	6	2	7	2	5	1	1						
7	9	4	7	2	2	1	2						
8	5	7	5	10	10		2						1
9	1	2	3	3	1								
10	35	21	12	19	16	25	3	2	1	1		1	1
11	20	8	6	1	8			1					
Total	**158**	**67**	**104**	**69**	**67**	**29**	**19**	**6**	**2**	**1**	**1**	**2**	**2**
27 KPOs and 56 OPOs							8 KPOs and 13 OPOs						
KPOs	**62**	**29**	**50**	**21**	**36**	**22**	**6**	**4**		**1**	**1**	**2**	**1**
OPOs	**96**	**38**	**54**	**48**	**31**	**7**	**13**	**2**	**2**				**1**

KPO: key priority outcome; OPO: other priority outcome; SO: strategic objective

= = =