A70/40
SEVENTIETH WORLD HEALTH ASSEMBLY
Provisional agenda item 20.1








WHO MID-TERM PROGRAMMATIC AND FINANCIAL REPORT FOR 2016-2017

including audited financial statements for 2016

World Health Organization

CONTENTS

[1] Including the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases.

[2] Including the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction.

Information on voluntary contributions by fund and by contributor for the year ended 31 December 2016 is available on the WHO Programme Budget Web Portal (http://extranet.who.int/programmebudget/) and details of voluntary contributions by fund and by contributor, 2016 in document A70/INF./4 (available on the WHO website at: http://www.who.int/about/finances-accountability/reports/en/).

“The momentum for WHO reform has been strong and I trust this trend will continue.”

DIRECTOR-GENERAL’s FOREWORD

I am pleased to submit this WHO mid-term programmatic and financial report for 2016–2017 for consideration by the Seventieth World Health Assembly. Audited financial statements for 2016 are also included.

This is the last unified programmatic and financial report under my term of office as chief technical and administrative officer at WHO. In its reporting on the financing of technical programmes and its review of programme results, the report reflects my commitment to transparency, accountability, budgetary discipline, and financing for results. The momentum for WHO reform has been strong and I trust this trend will continue.

After the Programme budget 2016–2017 was approved by the World Health Assembly in 2015, the budget was further increased in 2016 to implement the newly established WHO Health Emergencies Programme, set up on the recommendation of several formal assessments of the WHO response during the Ebola outbreak in West Africa. This increased amount raised the Programme budget 2016–2017, which was already larger than that for the previous biennium, even higher.

I interpreted this willingness to increase funding for WHO as an expression of confidence in the Organization’s long-standing role in upgrading the quality of health care worldwide through its normative and standard-setting functions. The establishment of the new WHO Health Emergencies Programme expanded that traditional portfolio to include operational emergency work within countries.

Some Member States sought a better understanding of how the new programme would actually perform in practice. That evidence came in the period 2015–2016.

Many of the Programme’s early reforms were put to the test in 2015, when the Zika virus made its first appearance in the Region of the Americas and raised the alarming possibility that a mosquito bite during pregnancy could cause severe neurological abnormalities in newborns. Innovations, such as the introduction of an event management system and a clear pathway for command-and-control, coupled with the early declaration of a public health emergency of international concern, supported a level of WHO performance that has been praised for its speed and strategic focus.

A second major test came in 2016, when Angola and the Democratic Republic of the Congo confirmed outbreaks of yellow fever in their capital cities, marking the largest and most ominous African outbreaks experienced in four decades. These outbreaks of urban yellow fever demonstrated what can happen when migrants from rural areas and workers from mining and construction sites carry the virus into cities where powder-keg conditions prevail: dense populations of non-immune people, heavy infestations with mosquitoes that are perfectly adapted to urban life, and flimsy infrastructures that make mosquito control nearly impossible. The response was initially faced with a crippling shortage of vaccines – a problem that WHO and the experts who advise us were able to address through an innovative dosing strategy. The result was the largest emergency vaccination campaign against yellow fever ever undertaken in sub-Saharan Africa. A crisis was averted.

Unfortunately, the funding required to support rollout of the WHO Health Emergencies Programme failed to materialize in full. Compared with the previous biennium, flexible funds decreased, further adding to the overall shortfall. As 2017 progresses, WHO may be forced to downsize the expected results from programmes that fail to attract sufficient funding. These trends and needs are expected to spill over into the Proposed programme budget for 2018–2019.

INTRODUCTION

In an ambitious new era for health development under the 2030 Agenda for Sustainable Development, WHO and its partners have a solid foundation of success on which to build. Health plays a fundamental role in development and is the central focus of Sustainable Development Goal 3, "Ensure healthy lives and promote well-being for all at all ages". It is also relevant to all the Sustainable Development Goals. Understanding the significance of the role of health is a prerequisite for successful collective action on the social, economic and environmental determinants of health.

In 2016, WHO worked on a range of initiatives that impact the lives of people, especially vulnerable groups, as part of the collective effort to leave no one behind. WHO advanced its contribution to the achievement of health outcomes in line with the priorities set in the Twelfth General Programme of Work, 2014–2019. Substantial progress was achieved through WHO's core normative, standard-setting and convening roles, and by stepping up operational support and response at the country level.

The following selective examples highlight some of WHO's key achievements in 2016 and also provide insights into how investments have led to results also at the country level.

Sustainable Development Goals

The 2030 Agenda presents a major opportunity to place health in all sectors of policy-making. As its implementation is predominantly country-driven, WHO has initiated changes in working practices to support Member States in their efforts to achieve the Sustainable Development Goals. One such example concerns the specific capacity-building initiatives that have been undertaken to better prepare WHO country representatives to incorporate the health-related Sustainable Development Goal targets into national health plans and strategies, and to engage partners and stakeholders within and beyond the health sector, including non-State actors.

> WHO is committed to working with its Member States and partners to attain the highest possible standard of health for all people by achieving the Sustainable Development Goals and universal health coverage.

WHO regional offices and headquarters have established coordination mechanisms for the Sustainable Development Goals, to support efforts to implement the 2030 Agenda at the country level, including through the development of roadmaps, action plans and other specific initiatives. Within these mechanisms, region-specific priorities have been identified, through the assessment of national health needs. Such priorities include: innovative financing in the African Region, as part of the Organization's transformation agenda in the Region; ensuring health equity in the Region of the Americas; providing coverage of front-line health services in the South-East Asia Region; including health in national development plans in the European Region in line with the Health 2020 policy framework; addressing acute emergencies and protracted health crises with emphasis on universal health coverage and stronger health information systems in the Eastern Mediterranean Region; and setting country-specific health targets with robust methods for monitoring and review in the Western Pacific Region. In addition to the work on health being done by WHO regional offices, United Nations regional commissions provide a platform to support Member States in their efforts to achieve all the Sustainable Development Goals.

Yellow fever

Following a yellow fever outbreak in Angola in early 2016, WHO and partner organizations including the United Nations Children's Fund (UNICEF), Centers for Disease Control and Prevention, Médecins Sans Frontières, the GAVI Alliance, International Coordination Group for Vaccine Provision, International Federation of Red Cross and Red Crescent Societies, International Organization for Migration, and many nongovernmental organizations, supported the implementation of the biggest emergency yellow fever vaccination campaign ever held in Africa. In the Democratic Republic of the Congo, more than 7 million people were vaccinated in two weeks, and coverage was extended to 15 health zones in remote areas bordering Angola; in total, some 30 million people were vaccinated across the two countries. Staff from all three levels of WHO – country offices, the Regional Office for Africa and headquarters – came together under one integrated incident management system to stop the outbreak. Each level played an important role, from the country level where the outbreak occurred, to the Regional Office's oversight, command and control, to coordination support provided at the global level. The last

confirmed cases were reported in Angola on 23 June 2016 and in the Democratic Republic of the Congo on 12 July 2016.

Rollout of the new WHO Health Emergencies Programme

Sustainable Development Goal 3, target 3.d underlines the importance of strengthening the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks. More than 100 outbreaks of infectious disease are reported to WHO each year, and more than 200 million people are affected annually by natural and manmade disasters. One of the key developments in 2016 was the establishment and development of the new WHO Health Emergencies Programme. The Programme strengthens and focuses the Organization's role in emergency responses, adding stronger operational capabilities to the traditional technical and normative roles.

WHO responded to 47 emergencies in 2016

In 2016, WHO responded to 47 emergencies, of which five – in Iraq, Nigeria, South Sudan, Syrian Arab Republic, and Yemen – are designated grade 3 acute emergencies, denoting the highest level of response from the Organization. WHO also responded to 26 acute grade 1 and grade 2 emergencies, as well as 16 countries in protracted crisis. In 2016, for the first time in several years, WHO was able to reach all 18 besieged areas in the Syrian Arab Republic. In June, as part of an interagency convoy, WHO delivered more than 5 tonnes of life-saving treatments, enough for over 95 000 treatment courses, to the Syrian Arab Republic. The medical supplies included medicines for urgent care, such as insulin and emergency health kits, as well as for noncommunicable diseases and their risk factors, such as high blood pressure. Antibiotics, pain medications, nutrition supplies and medical instruments and equipment for use in small clinics and hospitals were also included. Some 811 patients were successfully transported to hospitals in western Aleppo, Idleb and across the border to Turkey.

Zika outbreak

On 1 February 2016, the Director-General declared the Zika virus disease outbreak, which spread through the Americas but also reached Africa, Asia, and the western Pacific, as a public health emergency of international concern. This declaration led to an urgent and coordinated response by WHO, Member States and more than 60 partners including United Nations entities, other international humanitarian organizations, partners from the Global Outbreak and Response Network, and technical research and development partners.

Making history, saving lives: from 80 new polio cases recorded every two hours in 1988 to fewer than 80 cases per year today

The global effort to eradicate polio has saved more than US$ 27 billion since 1988. If, as projected, the virus is eradicated in 2019 a further US$ 20–25 billion will be saved in health costs and productivity losses by 2035.

In total, 76 countries and territories now report evidence of mosquito-borne Zika virus disease, 13 countries have evidence of person-to-person transmission of the Zika virus, and 29 countries have reported microcephaly and other malformations. The WHO Secretariat is providing technical support to Member States on all aspects of Zika surveillance and control, with a special focus on clinical management, laboratory services and controlling the mosquito vectors of Zika virus, which also transmit dengue, chikungunya and urban yellow fever. In line with WHO's advice, some innovative approaches to mosquito control are being piloted in several countries, with promising results. Some 40 candidate vaccines are in the pipeline.

Development of the new Ebola vaccine

2016 also saw the end of the largest ever Ebola virus disease outbreak, which claimed at least 11 310 lives in the three most affected countries. WHO published final trial results demonstrating that the new Ebola vaccine, rVSV-ZEBOV, protected 100% of vaccinated volunteers. The trial, which involved 11 841 people in Guinea, was led by

WHO, together with Ministry of Health of Guinea, Médecins sans Frontières and the Norwegian Institute of Public Health, in collaboration with other international partners.

The rapid development of the vaccine contributed to the elaboration of WHO's R&D Blueprint, a global strategy to fast-track the development of effective tests, vaccines and medicines during epidemics.

Attainment of universal health coverage

In pursuing the Sustainable Development Goals, a core part of which requires the attainment of universal health coverage, WHO has been working with countries to support their efforts to safeguard health for all. In June 2016, Thailand became the first country in Asia to be certified as having eliminated mother-to-child transmission of HIV and syphilis. In Thailand today, more than 95% of all pregnant women living with HIV receive antiretroviral therapy. Essential health services are available to rich and poor alike, making the country's health system a model to emulate the world over. Though limited budgets for HIV/AIDS are often unable to sustain the costs of essential screening and treatment programmes, Thailand has demonstrated that with a sound, well-designed health system that includes the participation of diverse sectors, public health goals can be achieved.

Eliminating measles in the Americas

In 2016, WHO also celebrated the achievement of several other important milestones. In September, the WHO Region of the Americas was declared the first in the world to have eliminated measles, a viral disease that can cause severe health problems, including pneumonia, brain swelling and even death. This achievement culminates a 22-year effort involving mass vaccination against measles, mumps and rubella throughout the Americas.

"End malaria for good" in Europe

In April 2016, WHO announced that the European Region had reached its target to wipe out malaria, thus contributing to the global goal to "End malaria for good". Key partners had funded malaria elimination efforts in European countries, in a demonstration of strong political commitment from European leaders with WHO support.

Reduce health inequalities

While strengthening its support to countries, WHO has continued to seek innovative approaches to reduce health inequalities. Health inequalities are often aggravated by the high price of medical products. In 2016, WHO and industry groups announced new financing arrangements, in line with industry practices, that will sustainably finance the WHO Prequalification of Medicines Programme. The programme has transformed the market for public health vaccines and other medical products, making supplies more abundant and predictable and prices more affordable. In line with this positive trend, WHO released a report documenting dramatic price reductions for a revolutionary cure for hepatitis C infections. Strategies used include price negotiations, local production and licensing agreements that promote competition among generic manufacturers. Price reductions have made treatment possible for more than 1 million people living with chronic hepatitis C infection in the developing world. In Mongolia, for example, more than 6000 people have been treated with new hepatitis C drugs. Generic curative hepatitis C medicines now cost less than US$ 500 per treatment course in Mongolia and have proven nearly 100% effective, while in Egypt the price of a three-month treatment dropped from US$ 900 in 2014 to less than US$ 200 in 2016.

Provide evidence for decision-making

WHO continues to build evidence for decision-making. In that regard, in 2016, research was published documenting a steep rise in risk factors for noncommunicable diseases in the African Region; it showed that the prevalence of hypertension in the Region is now the highest in the world, and that 35% of the adult population is overweight. Hypertension is the main risk factor for cardiovascular disease, the world's number one killer.

WHO has also supported partnerships to counter noncommunicable disease risk factors. In Barbados, a project was implemented through two polyclinics to further improve treatment for hypertensive patients. The implementation of a new treatment protocol for hypertension, provision of counselling for patients on lifestyle changes, such as improving exercise and diet and reducing tobacco use, and the use of an electronic registry, allowed care providers to ensure appropriate patient follow-up and to monitor blood pressure control. The lessons learned and positive outcomes of this project will be expanded to scale up prevention and control of cardiovascular diseases, especially in low- and middle-income countries. This initiative is initially being rolled out in Barbados, Benin, Colombia, Ethiopia, India, the Islamic Republic of Iran, Jordan, Nepal, Nigeria, Philippines, Sri Lanka, Tajikistan, Thailand and Uganda, and will be open to all countries wishing to participate.

Improve equity and sustainable development

In 2016, WHO advanced its work on breaking down another set of barriers to equity and sustainable development. In March, a new pan-European WHO study revealed that despite progress in some areas – the number of 15 year-olds who reported first smoking a cigarette at age 13 or younger has fallen significantly since 2010, for example – young people's health and well-being continue to be undermined by gender and social inequalities. The study feeds into a growing body of evidence calling for more effective and targeted interventions by governments and policy-makers to tackle the effects of social, health and gender inequalities on young people in Europe.

Adolescent health

Further addressing the health of young people, under the umbrella of the Global Strategy for Women's, Children's and Adolescents' Health, WHO has supported countries in implementing and monitoring integrated policies and strategies for promoting adolescent health and development, and reducing adolescent risk behaviours. The Global Accelerated Action for Adolescent Health Implementation Guidance document supports this process. In the Western Pacific Region, school environment standards have been developed to promote healthy and safe physical, psychological, and social transitions from adolescence to adulthood, while in the South-East Asia Region, countries were supported in scaling-up the provision of adolescent-friendly health services, as well as extending those services to include HPV vaccine and prevention of health risk behaviours for sexual and reproductive health and noncommunicable diseases.

Refugee and migrant health

Among the most vulnerable of those left behind are refugees and migrants. With that in mind, the WHO Regional Office for Europe developed the Strategy and action plan for refugee and migrant health in the WHO European Region, which was adopted by the Regional Committee for Europe in September 2016. The Strategy focuses on strategic areas and priority actions to address the public health and health system challenges related to migration, in the spirit of the recently adopted 2030 Agenda for Sustainable Development, the European policy framework for health and well-being – Health 2020, and Health Assembly resolution WHA61.17 (2008) on health of migrants.

Antimicrobial resistance

2016 was also a year of intense awareness-raising among political leaders. In September, Heads of State and heads of delegation met at the United Nations General Assembly in New York to commit to working together to fight antimicrobial resistance. This was only the fourth time in the history of the United Nations that a health topic was discussed at the General Assembly (HIV, noncommunicable diseases, and the Ebola virus disease have also been discussed at previous sessions). The discussions emphasized the important role and responsibilities of governments, as well as the role of relevant intergovernmental organizations, particularly WHO within its mandate and in coordination with the FAO and the World Organisation for Animal Health (OIE) in responding to the challenges of antimicrobial resistance taking a broad, coordinated approach to address the root causes across multiple sectors, especially human health, animal health and agriculture.

These are only a few examples of WHO's numerous achievements in 2016. Some 85% of contributions to the programme budget outputs were reported as "on track" in 2016, which is in line with previous biennia. The areas of work reported as being "at risk" or "in trouble" are facing specific challenges, described below:

- emergency and crisis situations in fragile and vulnerable countries are slowing progress in some areas, while simultaneously resulting in increased costs for WHO's operations;
- weak monitoring and surveillance systems in countries are making the work of WHO challenging, especially with regard to identifying gaps and their causes, but also for supplying the evidence required to define priorities at the country level and attract domestic sources of funding;
- fragile health systems are put under strain by outbreaks such as Ebola virus disease and Zika virus, and outbreaks of vaccine-preventable diseases, such as measles, yellow fever, and cholera;
- flexible resources that can fill the gaps in underfunded areas in base programmes have reduced; and
- WHO faces major financial alignment issues owing to persistent gaps in the base programme component, with only 83% of base programmes currently financed, compared with 96% in 2014 (equivalent base programme financing). Several of the substantially underfinanced programme areas are those identified as catalysts for the achievement of the Sustainable Development Goals.

In order to move forward despite those challenges, WHO continues to seek innovative ways to implement its programmes, including by:

- reprioritizing activities focusing on the Organization's comparative advantage and leveraging partnerships and collaborations;
- mainstreaming activities that are key to advancing the 2030 Agenda into other programme areas;
- implementing further cost efficiency measures and savings;
- strengthening the Organization's control framework;
- investing in achieving value for money; and
- enhancing resource mobilization efforts.

The commitments undertaken in the 2030 Agenda for Sustainable Development and other international agreements place an ever greater responsibility on WHO and its partners to turn theory into results on the ground for all. The programmatic section of this report and the updated WHO programme budget web portal showcase the efforts being made at the three levels of the Organization, while highlighting results at the country level.

Financial stewardship and accountability

WHO is committed to maximizing the impact of every dollar invested on improving world health. This section gives on an overview of WHO's financing during the first year of the Programme budget 2016–2017, including a review of funds available and expenses.

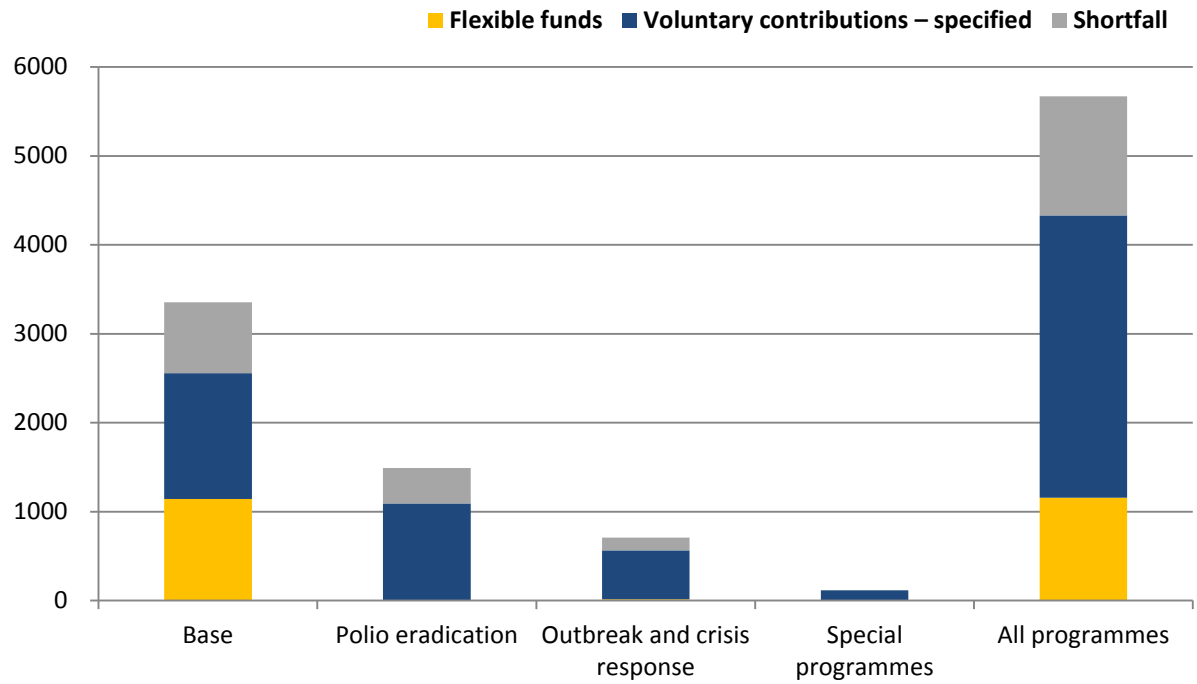
(a) Financing overview

The Programme budget 2016–2017 was originally approved by the Health Assembly in May 2015 at US$ 4385 million. In May 2016, the Health Assembly adopted a revision to the budget, bringing it to US$ 4545 million, which reflected an increase of US$ 160 million for the WHO Health Emergencies Programme. Base programmes – communicable diseases, noncommunicable diseases, promoting health through the life-course, health systems, emergencies and corporate services/enabling functions – represent 74% of the approved programme budget, or US$ 3354 million. The remaining programme budget is for polio, outbreak and crisis response and special programmes (research and training in tropical diseases – TDR; and research, development and research training in human reproduction – HRP), the budget for which has increased – due to the event-driven nature and financing of these programmes – from the Health Assembly-approved amount of US$ 1191 million, to US$ 2317 million as per the Director-General's delegated authority under resolution WHA68.1 (2015). The total budget reflected below is US$ 5671 million.

There are two major sources of financing for the programme budget: specified voluntary contributions and flexible funds, comprising assessed contributions, programme support costs and core voluntary contributions.

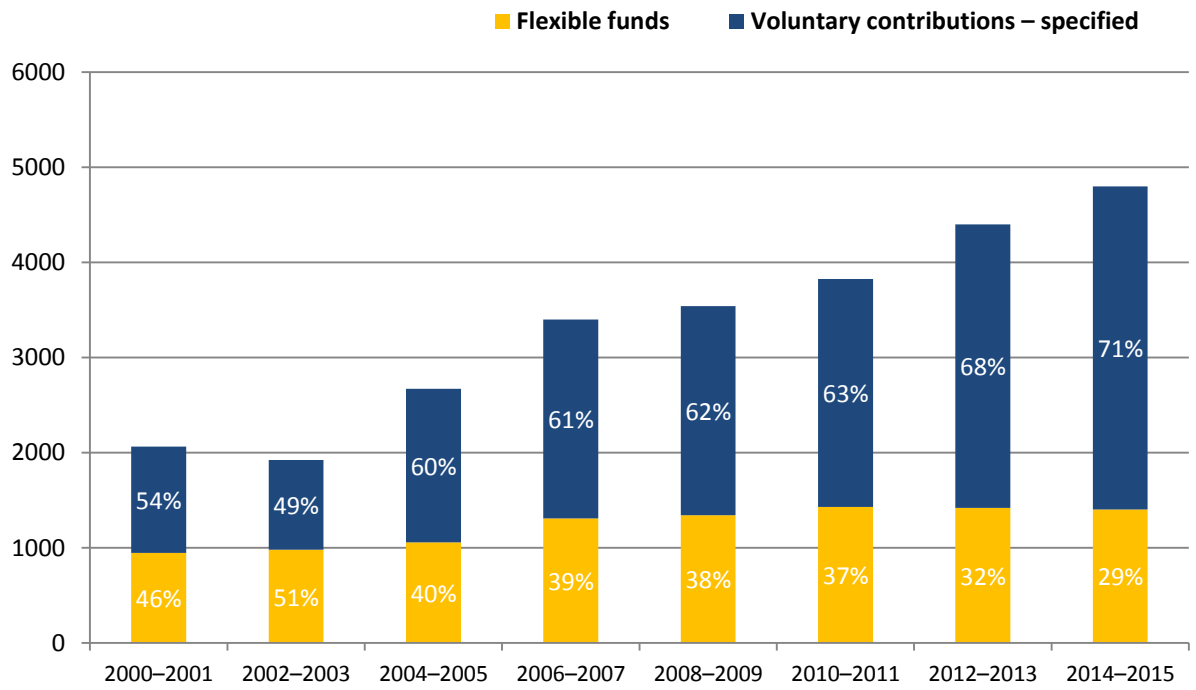
Funds available as at the end of December 2016 were US$ 4552 million for the total programme budget. Of this total, the amount available for base programmes was US$ 2777 million, representing 83% of the total base programme budget (US$ 3354 million). The equivalent base programme financing at the end of 2014 was 96%. The reduction in the level of financing is due to three factors: the increase in the base programme budget from 2014–2015 of US$ 396 million; the drop in core voluntary contributions; and the reduction in specified voluntary contributions. The graph below shows the overall split of the budget segments and related financing, up to 31 December 2016.

Financing of the Programme budget 2016–2017 (US$ millions)



The graph below shows the evolution of flexible funding and voluntary contributions specified since 2000.

Level of flexible funding and specified voluntary contributions from 2000 to 2015 (US$ millions)



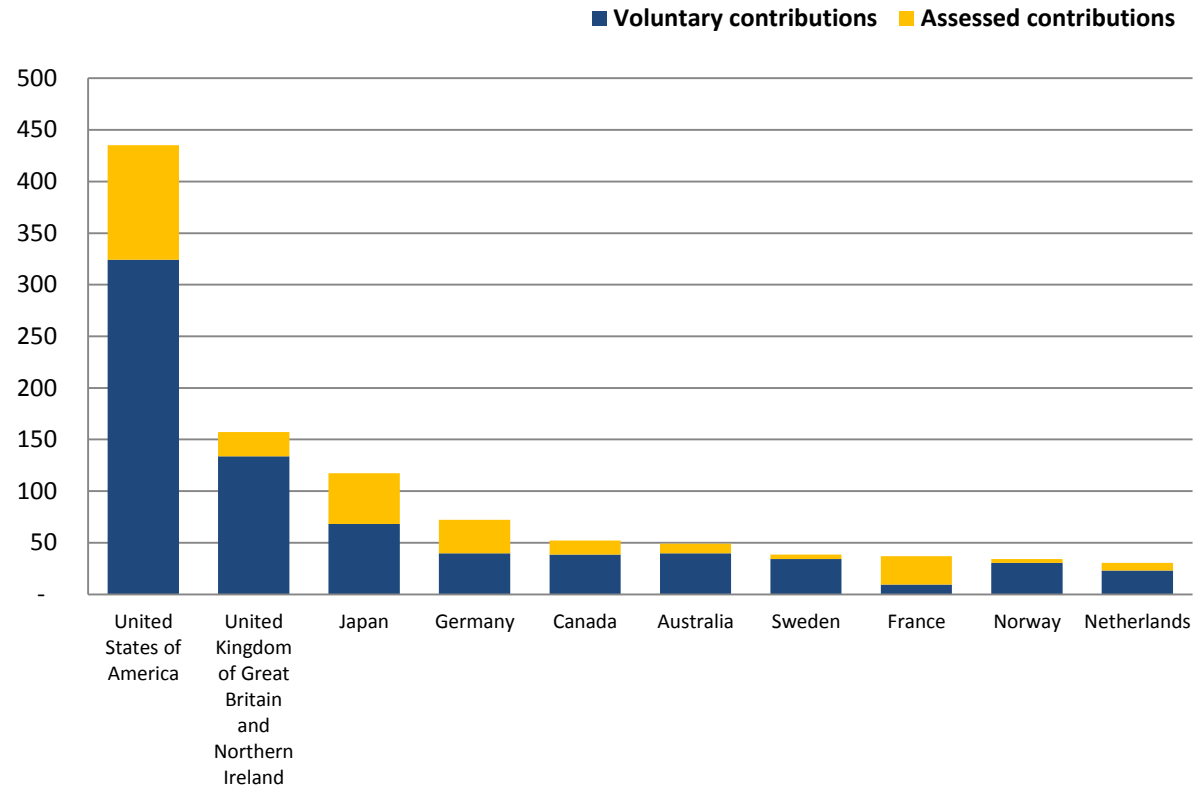
Assessed contributions are the largest component of flexible funding and have remained at a stable nominal level since 2000. Flexible funds from 2000 to 2004 were at US$ 1000 million, but increased to US$ 1300 million in 2006 with the creation of the core voluntary contributions account.

While the financing of the Health Assembly-approved programme budget more than doubled from 2000 to 2015, flexible funds have been unable to keep pace with the increase in specified voluntary contributions. This has caused an over-reliance on specified voluntary contributions, which has skewed the financing compared with the prioritization of the programme budget. This trend is continuing into 2016–2017 and the split is predicted to be the same as in 2014–2015.

Furthermore, the fall in the level of flexible funding for the base programme budget makes it more difficult to finance programme areas that do not attract specified voluntary funds. Flexible funds currently make up only 29% of the overall financing of the programme budget and are therefore insufficient to be strategically used for areas that do not attract funding.

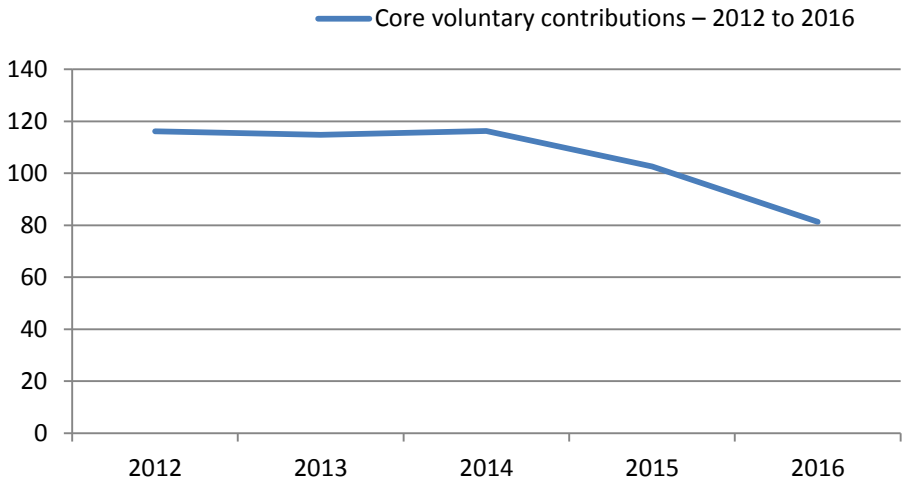
The 10 Member States that contribute the most to the programme budget are shown below and account for a combined total of US$ 1024 million, which is equivalent to 75% of the total contributions from Member States, or 47% of the total contributions from all sources.

Top 10 Member State contributors to the programme budget in 2016, combining assessed and voluntary contributions (US$ million)



Contributions to the core voluntary contributions account were US$ 81 million in 2016, representing close to a 40% reduction compared with the period 2012–2014. This is a matter of concern as certain important donors are no longer contributing at the same level as in previous years, while at the same time flexible funding needs are increasing across the Organization. As a result, it is increasingly difficult for the Organization to implement those priority areas which are deemed important by Member States, but which do not receive sufficient voluntary contributions.

Core voluntary contributions, 2012–2016



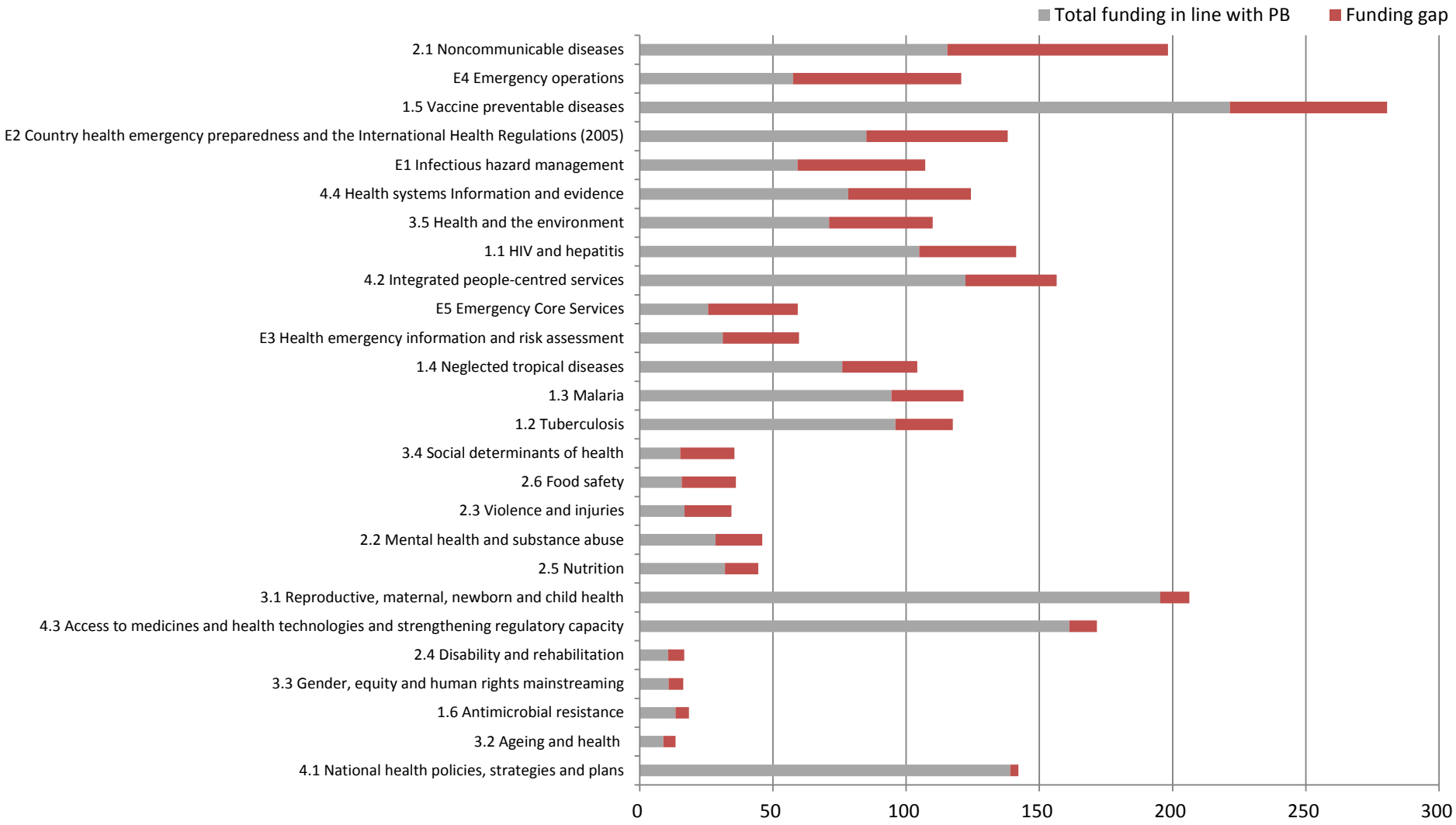
The below table summarizes the contributions to the core voluntary contributions account, by contributor for 2015 and 2016.

Contributors of core voluntary contributions (US$ million)

	Total 2015	Total 2016
Australia	15.67	9.52
Belgium	9.92	6.69
Denmark	5.12	3.65
Finland	5.96	
France	1.91	0.32
Ireland	1.09	0.34
Kuwait		0.50
Luxembourg	1.94	1.87
Monaco	0.03	0.03
Netherlands	5.98	5.98
Norway	5.59	5.89
Sweden	23.93	25.88
Switzerland	3.59	2.55
United Kingdom of Great Britain and Northern Ireland	21.90	18.13
Total core voluntary contributions	**102.62**	**81.35**

The alignment of funds available to the base programmes continues to present a challenge. Of the 26 technical programmes, seven have funding of 60% or less, which at this stage of the biennium is insufficient to meet the targets set for the approved programme budget. The majority of specified voluntary contributions goes to programmes outside the base programme budget (polio, outbreak and crisis response, and special programmes). As a result, there continue to be shortfalls as demonstrated in the graph below. The programme area with the largest funding gap is noncommunicable diseases, followed by emergency operations.

Base technical programme areas, funding and gap (US$ millions)



The underfinanced base programme areas can be categorized into three types:

(a) programme areas where the budget was increased because of emerging or increased needs, most notably the WHO Health Emergencies Programme and antimicrobial resistance;

(b) chronically underfinanced programme areas, including noncommunicable diseases, social determinants of health and food safety; and

(c) programme areas with a significant decrease in financing due to contributors being unable to maintain their existing financing levels (most notably HIV, as a result of the reduced contribution by UNAIDS).

WHO will be monitoring the situation throughout 2017 and will take appropriate actions to adjust programme implementation as required. Actions to mitigate the risks of not fully delivering planned activities in 2017, and to tackle the longer term impact of this financing gap include:

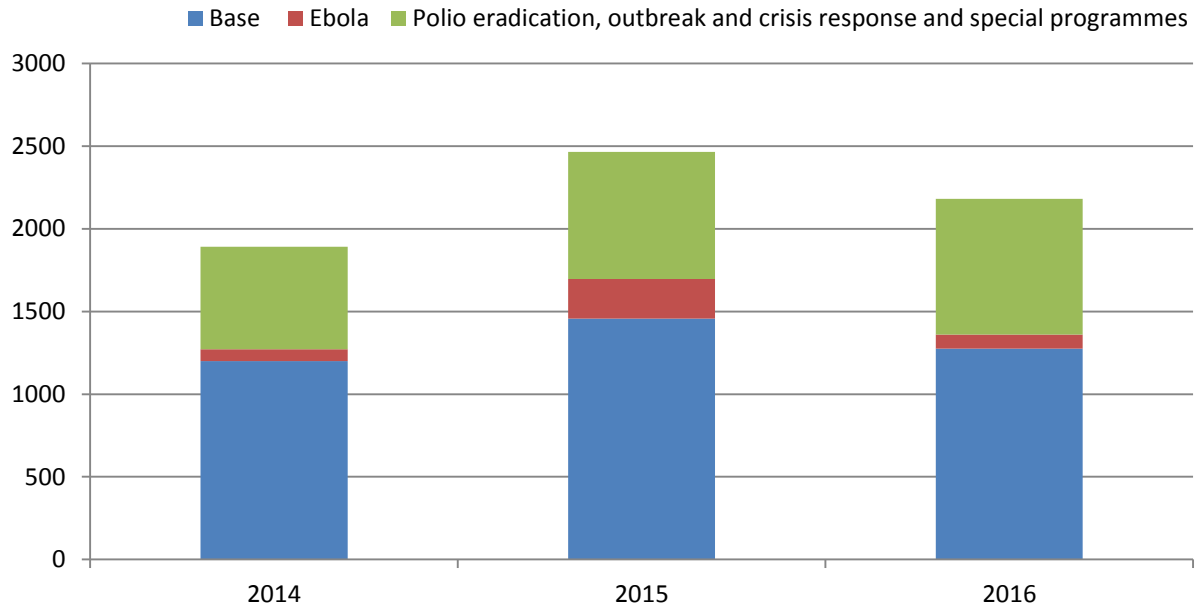
- reprioritizing activities under these areas in 2017, focusing on WHO's comparative advantage and strengthening work with partners;
- advancing the reform work to strengthen the resource mobilization function in WHO; and
- adjusting the Proposed programme budget 2018–2019 for some of the chronically underfunded programme areas ensuring that it is aligned to more realistic resource expectations.

(b) Expenses

Total expenses[1] for 2016 for the implementation of the programme budget were US$ 2182 million, representing a decrease of 11%, from 2015 and an increase of 15% from 2014.

The breakdown of total expenses for 2014, 2015 and 2016 by base programmes and polio, outbreak crisis response, and special programmes is shown below.

Programme budget expenses by segment: 2014, 2015 and 2016 (US$ million)



The higher expenses in 2015 were mainly due to increased emergency-related activities, including the Ebola virus disease outbreak emergency (US$ 312 million in 2014–15) and the expanded activities of the Global Polio

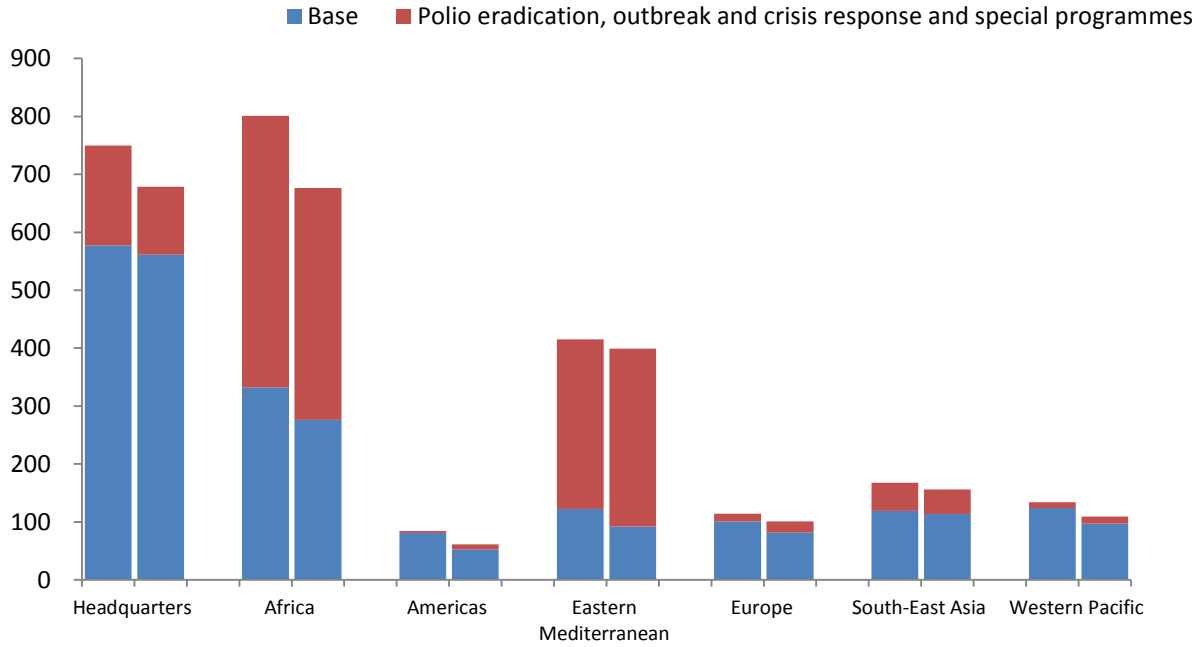
[1] Expenses are recognized when goods and services are received and not when commitments or payments are made.

Eradication Initiative. The percentage of total expenses relating to the base programmes segment was 58% in 2016, slightly down from 59% in 2015 and 63% in 2014.

The chart below shows 2016 expenses compared with 2015, by major office. In 2016, headquarters accounted for 31% of programme budget expenses, and regional offices and country offices accounted for the remaining 69%. Expenses have decreased for all regions, with the most significant decreases for headquarters and the African Region due to the reduction in outbreak and crisis response-related expenses.

In the Eastern Mediterranean Region, emergency and polio expenses increased due to the emergencies in Afghanistan, Iraq, Sudan, the Syrian Arab Republic and Yemen. The table below summarizes the largest expenses, by office, including a breakdown between base and polio, outbreak and crisis response, and special programmes.

Programme budget expenses by major office in 2016, compared with 2015 (US$ million)

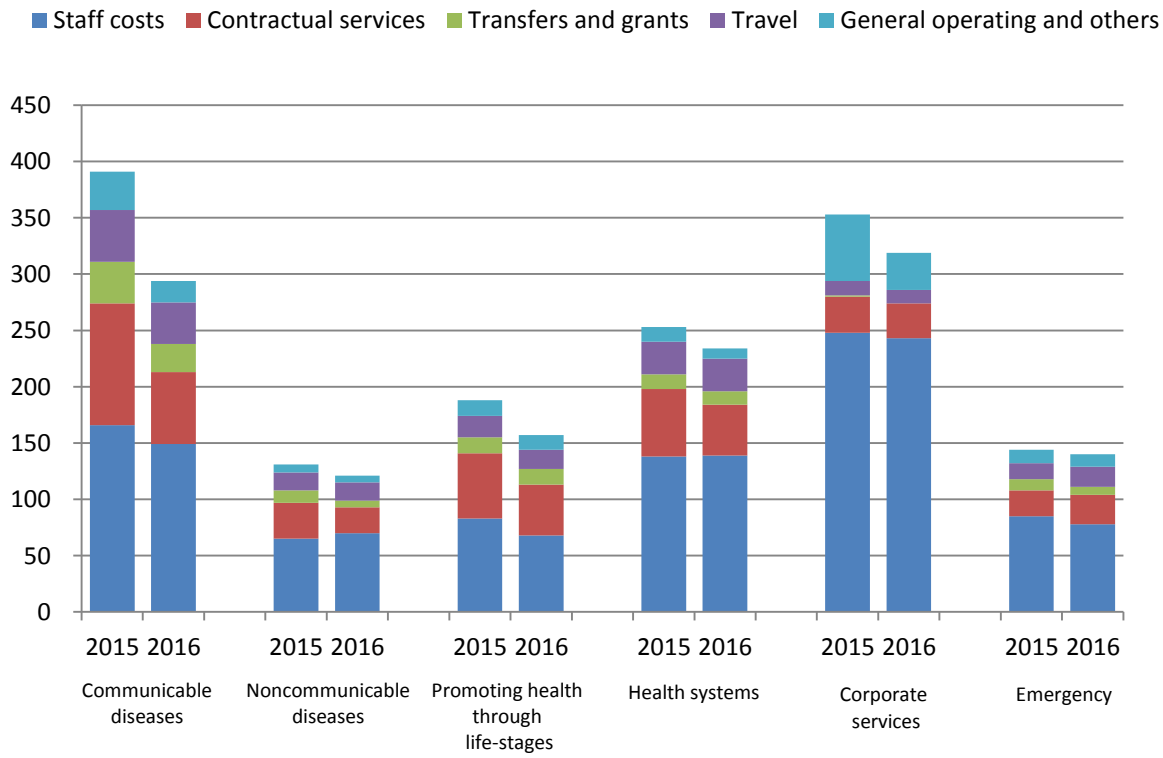


Expenditure by major office, 2015/2016

Programme budget expenses under the base segment, by category and expense type for 2016 and 2015, are shown below. Polio, outbreak and crisis response and special programmes accounted for just over 40% of programme budget expenses in 2016 and 2015. Most expenses under the polio, outbreak and crisis response and special programme segment (57% of total expenses under this segment) were for contractual services and transfers, and grants given for the use of external third parties to undertake activities.

This general trend of reduction in expenses is a result of the reduced funding received so far this biennium. In particular, category 1, communicable diseases, has had the biggest fall, which reflects reduced funding to the programme areas on vaccine preventable diseases and HIV and hepatitis.

Programme budget expenses under the base segment, by category and expense type for 2015 and 2016 (US$ million)



(c) Strengthening transparency and accountability, achieving value for money

Managerial accountability, transparency and risk management are key aspects of the WHO reform agenda and WHO continues to make progress in this regard. This year, for the first time, WHO has issued a statement of internal control in the mid-term programmatic and financial report for 2016–2017. The statement is a public accountability document, which describes the effectiveness of internal controls and is signed by the Director-General. The statement can be found in Section II of this document.

In order to strengthen implementation of the internal control and accountability frameworks, the internal control framework self-assessment checklist tool was developed and disseminated. Annual accountability compacts between the Director-General and the Assistant Directors-General, and the letters of representation of the Regional Directors are now available.

The corporate risk management policy, which complements the bottom-up phase of risk identification and prioritization with a top-down phase of validation and escalation, was finalized when the first full risk-management cycle was completed in June 2016.

Strengthening evaluation and organizational learning is another critical component of the ongoing WHO reform process. Four high-impact corporate evaluations/assessments were completed in 2016, including the evaluation of WHO's country presence, the evaluation of the impact of WHO publications, and the comprehensive evaluation of the implementation of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property, all of which provided useful recommendations and proposed actions for the improvement of the Organization's performance.

In 2016, eight internal audit reports were finalize and a further nine were either issued in draft, awaiting auditee feedback, or were still in progress. Furthermore, two special reviews audits were conducted (polio in Afghanistan and Pakistan, and recruitment at the International Computing Centre) and five reports were issued on UNAIDS audits.

Following the deployment of the WHO policy on whistleblowing and protection against retaliation in 2015, the Integrity Hotline, a confidential, externally managed service for the reporting of allegations of suspected wrongdoing, available to WHO staff and non-staff, was launched in June 2016. Awareness-raising and outreach activities included posters and brochures for display in all WHO offices, as well as Intranet-posted messages.

Strengthening WHO's transparency and accountability – direct financial cooperation

Transfers and grants to counterparts are mainly for contracts signed with national counterparts, primarily health ministries (direct financial cooperation) and, to a lesser degree, for contracts with other implementing partners, such as other United Nations organizations and nongovernmental organizations. In 2016, expenses under the programme budget for transfers and grants were 16% lower than in 2015. This reduction was due to stricter policies on the use of direct financial cooperation; these new policies have also significantly improved transparency and accountability for the use of the these funds. Of the total direct financial cooperation expenses in 2016, 63% were related to the Global Polio Eradication Initiative, compared with 48% in 2015. These expenses were highest in the African Region, followed by the Eastern Mediterranean Region.

Over the past few years, in furthering its efforts to ensure value for money, WHO has undertaken several important actions. The introduction of the Global Management System has brought significant and increasing transparency, better monitoring of the use of resources, an improved managerial culture and more efficient administrative processes.

In addition, WHO reviewed functions across offices, consolidated processing functions at low-cost duty stations and outsourced others to ensure both that expenses are sustainable in line with the available resources and the increased requirements on compliance, accountability and transparency, and that Member States and donors receive the best possible value for their contributions. The centralization of functions results in operational efficiency due to specialization using centres of excellence.

Examples of this are the relocation of payroll, accounts payable, procurement, and various human resources and information technology functions to the service centre in Kuala Lumpur, and the outsourcing of other functions such as printing, building maintenance and security. In 2016, as part of the WHO reform agenda, the Global Management System is undergoing various enhancements designed to increase value for money, administrative efficiency, and operational effectiveness. In addition, certain supplementary human resources and procurement policy functions have recently been relocated from Geneva to Budapest. As with Kuala Lumpur, this was done to leverage the fact that the United Nations salary scale for this location is much cheaper than for Geneva, both for general service and professional staff.

Achieving value for money is, however, more than simply a question of reducing the costs of administrative functions. WHO intends to improve how it demonstrates value for money in its programme delivery, through better measurement of the value of its health outputs and outcomes, and through effective prioritization. Further work is under way to improve indicators, and provide a more objective measurement of progress and performance against results expected. The integration of financial and performance reporting in the annual unified programmatic and financial report is also an important step towards demonstrating how these programme investments link with the results achieved.

STRENGTHENING ACCOUNTABILITY IN FOCUS

WHO African Region

In the African Region, the Accountability and Internal Control Strengthening project was launched to support the Regional Director's Transformation Agenda. The project aims to holistically address systemic weaknesses in the control environment, for example through a results measurement framework that includes managerial and technical key performance indicators. In recognition of the shared responsibility of the Secretariat and Member States regarding controls around the management of funds advanced to governments for implementing activities (direct financial cooperation), a handbook to familiarize health ministries with the relevant WHO rules and procedures has been developed and disseminated.

WHO Eastern Mediterranean Region

The Eastern Mediterranean Region maintained its strong focus on improving accountability and controls in the Region. Compliance dashboards, strengthened corporate risk management and evaluation at budget centre level are ongoing. The number of direct financial cooperation reports outstanding was reduced from 84 at the end of December 2015 to 60 at the end of October 2016; audit recommendations are being addressed expeditiously and financial control activities have been strengthened and streamlined.

WHO European Region

Oversight, compliance and accountability constitute a standing item on the agenda of the Regional Committee for Europe and the Standing Committee of the Regional Committee, under which Member States in the European Region receive regular reports and updates on the issues, challenges and progress made. For internal use and decision-making, detailed management reports and compliance dashboards are generated and reviewed through regular monthly managerial meetings. The dashboards are published on the Regional Office's intranet and are accessible to all WHO offices.

WHO Region of the Americas

In the Region of the Americas, the Enterprise Risk Management Standing Committee reviewed the risk profile of the eight top corporate risks for the Regional Office and identified mitigation actions. The corporate risk portfolio was presented to the Audit Committee in 2016. Eleven of 22 planned internal audit assignments were completed in 2016, including seven at the country level.

WHO South-East Asia Region

In the South-East Asia Region, significant progress has been made in transparency, accountability and risk management, which have been woven into the agendas of high-level regional meetings. The Independent Expert Oversight Advisory Committee commended the positive trends in several compliance areas and commended the Region on having no outstanding internal or external audit recommendations at the time of presentation to the Committee. Moreover, there has been noticeable progress in the achievement of governance reform objectives, with a reduction in the number of agenda items, pre-session documents and resolutions of governance meetings, and the sunset or conditional sunset of over 60% of past Regional Committee resolutions (78 resolutions were reviewed, 29 were sunset, 19 conditionally sunset and 30 remain active).

WHO Western Pacific Region

The Western Pacific Region continued to maintain zero overdue direct financial contributions, and random assurance activities were carried out in all country offices. The Regional Administration Network and the Programme Management Network continued to be strong forums for ensuring that compliance, risk, and accountability were discussed and reinforced. Key performance indicators (for example, PMDS compliance) are closely monitored and reviewed by senior management on a regular basis.

SECTION 1. ACHIEVEMENTS BY CATEGORY

Category 1

COMMUNICABLE DISEASES

Key achievements in 2016

Leaving no one behind, the concept on which the Sustainable Development Goals are founded, has long been a guiding principle of the communicable diseases programmes under category 1, which aim to treat or prevent every case, or vaccinate every child. Measures to address “diseases of poverty”, reach out to marginalized and neglected populations, and provide all children with the protection of immunization all serve to advance equity, which is a cross-cutting theme of all the Goals, while contributing directly to several of them specifically.

The year 2016 yielded tangible results in moving towards the attainment of Sustainable Development Goal 3, targets 3.3 on ending epidemics and 3.2 on ending preventable deaths of newborns and children under 5 years of age.

Congruent with the concept of leaving no one behind, WHO has coordinated the expansion of access to diagnostic testing, treatment and vaccination through strong multisectoral efforts. More than 1.3 billion treatments for neglected tropical diseases were distributed in 79 countries, more than 18 million people – around 50% of people living with HIV – are now on antiretroviral therapy, and all 11 countries of the South-East Asia Region were verified to have achieved maternal and neonatal tetanus elimination in 2016, making it the second WHO region to have achieved this historic milestone.

In response to a request by Member States for an integrated response to the threat posed by the world’s most significant vector-borne diseases, WHO has developed a draft global vector control response. Once given due consideration by the Health Assembly, this strategic framework will help Member States to improve their response to infections that are present in cities and rural settings alike and that claim more than 700 000 lives each year (including malaria, dengue, Chagas disease, chikungunya, Zika virus disease and yellow fever, among others).

2016 also witnessed increased or renewed political momentum in support of the objectives pursued under category 1.

In 2016, the European Region was announced as the first in the world to have achieved interruption of indigenous transmission of malaria, thus contributing to the global goal to "End malaria for good". The number of indigenous cases of malaria dropped from 90 712 in 1995 to zero in 2015.

Bidding farewell to malaria: The case of Sri Lanka

In a remarkable public health achievement, Sri Lanka was certified by WHO as having eliminated malaria, a life-threatening disease which had long affected the island country.

Sri Lanka is the second country in the WHO South-East Asia Region, after the Maldives, to eliminate malaria. The announcement that Sri Lanka had beaten malaria was made at the Sixty-ninth session of the WHO Regional Committee for South-East Asia in the presence of health ministers and senior health officials from all 11 Member States.

Sri Lanka's success in becoming and remaining malaria-free, the last local malaria case having been recorded in October 2012, has been achieved against many odds, thanks to years of concerted efforts by health workers and communities, unwavering political will, and the support of partners such as WHO and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

WHO contributed to high-level discussions at the United Nations General Assembly, including the Special Session on the World Drug Problem (New York, United States of America, 19–21 April 2016), the High-level Meeting on HIV/AIDS (New York, 8–10 June 2016), and the High-level Meeting on Antimicrobial Resistance (New York, 21 September 2016). Preparations are now under way for the High-level Meeting on Tuberculosis, planned for 2018.

The first Ministerial Conference on Immunization in Africa (Addis Ababa, 24 and 25 February 2016) culminated in the signing of a Ministerial Declaration for the Region, which acknowledged universal access to immunization as a cornerstone for health and development in Africa.

The adoption by the Sixty-ninth World Health Assembly of the global health sector strategy on HIV, 2016–2021 and the first global health sector strategy on viral hepatitis (resolution WHA69.22) represented a critical step forward in guiding and accelerating global efforts to tackle those diseases.

WHO recommended the use of several new tools, including a shorter standardized treatment regimen for the majority of patients with multidrug-resistant tuberculosis (MDR-TB), and the first rapid diagnostic test for hepatitis C virus.

In November 2016, WHO announced that the world's first malaria vaccine would be piloted in 2018 in three countries in sub-Saharan Africa. The pilot programme will evaluate the feasibility of delivering the required four doses, the impact of the vaccine on lives saved, and the safety of the vaccine in the context of routine use.

Crucial new evidence and practical guidance were issued, including a set of dedicated guidance documents on hepatitis, including guidelines on hepatitis B and C testing, on screening, care and treatment of persons with chronic hepatitis C infection, and on disease surveillance. The first global report on access to hepatitis C treatment was published, revealing encouraging progress in developing countries, where more than a million people had been treated for hepatitis C with a revolutionary new cure.

Evidence provided in WHO's Global Tuberculosis Report 2016, released in October 2016, showed that tuberculosis is now the world's leading infectious killer. The report also revealed that the pace of progress to tackle tuberculosis would not be sufficient to achieve the Sustainable Development Goal 3, target 3.3 to end the tuberculosis epidemic by 2030. The Secretariat worked with Member States and partners to build momentum around tuberculosis, and will co-host a global ministerial conference on tuberculosis in Moscow in November 2017. Building on critical new evidence, WHO has also provided guidelines to enable countries to roll-out additional molecular diagnostics and a shorter treatment regimen for MDR-TB.

The Special Programme for Research and Training in Tropical Diseases has delivered significant results both in researching evidence to enhance public health policy and practice, and strengthening institutional and individual capacities to conduct health research in low- and middle-income countries. Some main achievements of 2016 include enhancing country research capacity to support the End TB Strategy (and build the WARN-TB network),

informing policy to reach the visceral leishmaniasis elimination target in Nepal and Bangladesh, and developing a model contingency plan supported by a "how-to guide" for an early warning system for dengue outbreaks. The Worldwide Insecticide Resistance Network, initiated by the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, is growing rapidly. It addresses pressing epidemics, and supports some 110 MSc and PhD students in low- and middle-income countries to strengthen local capacity to conduct implementation research.

Following the United Nations General Assembly in New York in September 2016, during which Heads of State had committed to taking a broad, coordinated approach to addressing the root causes of antimicrobial resistance across multiple sectors, especially human health, animal health and agriculture, action to combat antimicrobial resistance was scaled up across departments in headquarters and at the regional and country levels. Collaboration with FAO and OIE was strengthened. Significant progress has been made towards implementing the Global Action Plan on Antimicrobial Resistance. In May 2015, all Member States committed to developing national action plans on antimicrobial resistance, and by March 2016, 65 Member States had set up multisectoral plans and 62 were in the process of developing plans. More than 90% of people in the world live in a country that either already has or will have a plan to address antimicrobial resistance. By December 2016, some 30 Member States had enrolled in the WHO Global Antimicrobial Resistance Surveillance System.

Challenges and lessons learned

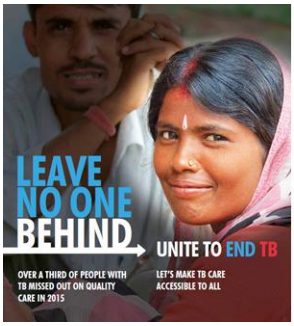
Ensuring sustainable levels of financing remains a challenge, which affects the implementation of regional and national strategies and activities for the programmes under this category. This has implications for WHO's ability to provide high quality technical support to countries and maintain sufficient human resources at the regional and country levels.

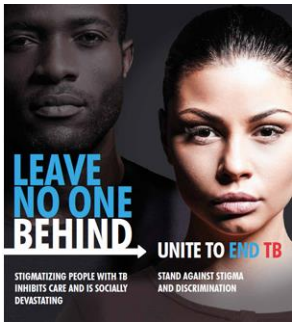
Regional and country offices were hit hard by the sudden announcement at the end of 2015 of the reduction in funding of the UNAIDS Unified Budget, Results and Accountability Framework. As a result, activities and staffing had to be reduced, particularly in non-priority countries. This has had an adverse effect on the delivery of technical support to Member States.

WHO country offices play an important coordination role in supporting the finalization of national neglected tropical diseases programmes and mobilizing resources from partners on neglected tropical diseases. However, the mobilization of funds in countries, in particular to sustain staff, has been particularly challenging in some priority countries. Specified contributions are adding constraints to the purpose of expenditures.

The deterioration of the security situation in some countries – particularly Afghanistan, Somalia and Yemen – and in certain areas in Pakistan and Sudan, together with political instability has hampered implementation and the ongoing monitoring of interventions.

In order to reach the targets of the Sustainable Development Goals, harder to reach populations must be able to access and adhere to services. This remains a challenge. The main stumbling blocks in health systems need to be tackled in order to further scale up prevention, treatment and care in disease-specific programmes. This is also the case for middle-income countries, which are adversely affected as a result of insufficient funding and attention despite hosting the majority of the vulnerable population. Several Member States have started using tools developed by WHO (such as the guide to tailoring immunization programmes) to identify barriers to reaching populations that are unvaccinated or undervaccinated, for example.





Changes in global policy settings may decrease the attention paid to communicable diseases and consequently lead to reductions in funding. This is the main impediment to the full implementation of activities under this area of work in Member States; however, constant monitoring, assistance and discussion between the three levels of the Organization are already mitigating some of these issues. Intensifying collaboration with partners for efficiency and effectiveness gains will be crucial to support Member States.

Sustained change will be required in the prevention and management of infection across sectors in all parts of the world in order to deal with antimicrobial resistance. Building consensus and understanding across multiple sectors regarding the urgent need for action is paramount to success. At a political level, understanding has increased through sustained political advocacy, and the generation of compelling evidence by the WHO Secretariat, external partners and Member States. This collaboration has been critical to securing high-level political commitment in a very short time frame.

At the operational level, more work is needed to clarify priority actions and incorporate them into existing plans and strategies, both inside and outside WHO. Data on the scope and scale of resistance, and on antibiotic consumption are lacking in much of the world, which makes managing the problem and sustaining political attention a challenge. The Secretariat is supporting Member States in their efforts to collect these data in a systematic and coherent fashion. Strengthening health systems to address antimicrobial resistance requires coordinated action across multiple programmatic areas, the capacity for which remains very limited. Although funds for antimicrobial resistance have been shared across regional and headquarters teams, the majority of WHO regional and country offices need more support. However, this capacity is not available and the lack of sustainable financing and a relevant budget ceiling does not permit the engagement of new capacity in a structured or strategic manner.

Priorities for 2017

In view of the challenges mentioned above, WHO has adjusted its work for 2017. The HIV programme, for example, is further focusing its remaining available resources on priority interventions and priority countries (“fast-track countries”) based on the disease burden. Activities related to WHO’s work in the research agendas tend to receive fewer resources. Most cost savings have been made through restructuring human resources. In the European Region, human resources are being redirected from the Regional Office to two priority fast track countries in 2017. In the Eastern Mediterranean Region, the Regional Action Plan for the Implementation of the Global HIV Health Sector Strategy 2016–2020 will be replaced by the development of country-specific collaboration plans for HIV focus countries in the Region: Islamic Republic of Iran, Libya, Pakistan and Sudan. The Western Pacific Region will reduce international support to countries with low incidence and prevalence of HIV and overall low HIV disease burden.

The switch from the use of trivalent to bivalent oral polio vaccine has been completed successfully and no more activities will be implemented in 2017. A WHO–UNICEF hub was established to jointly manage supply chain activities including Effective Vaccine Management assessments, which result in less time being spent on related support to countries. Consideration is being given to the possibility of outsourcing some of the capacity building and activities related to the supply chain to external partners (in particular in the South-East Asia Region), which help to further reduce dependency on WHO support in this area.

In seeking to improve efficiency, WHO has continued to work with partners and donors including the KNCV Tuberculosis Foundation, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States Agency for International Development, and the International Union against Tuberculosis and Lung Disease. This collaboration has included various activities, such as programme reviews and capacity building, including training. Cost-sharing arrangements are being explored for implementing critical activities. For example, at the regional and country levels, joint planning has been encouraged between disease programmes including those for HIV, tuberculosis and reproductive, maternal, newborn and child health. In the Regional Office for Europe, the tuberculosis, HIV and hepatitis programmes were merged to form one joint programme, following a strategic decision to address the disease burden in a coherent and integrated way, creating synergies in providing joint support to countries, and also leading to efficiencies.

WHO collaborating centres can provide various contributions such as technical expertise at a reduced consultancy fee or free of charge. Organizing a regional meeting in conjunction with other international

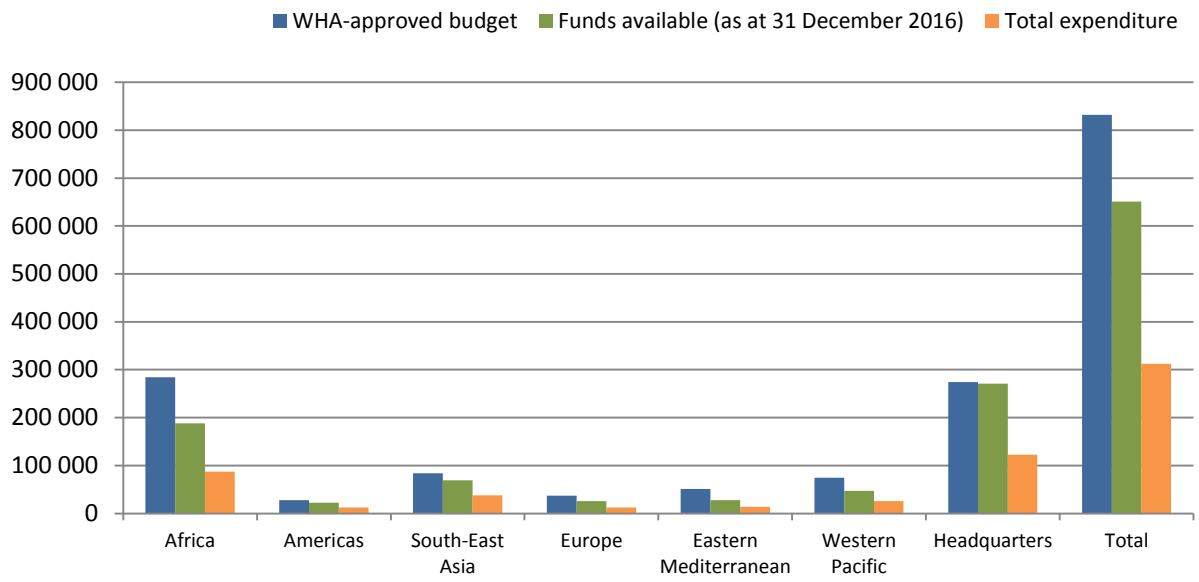
conferences can save the cost of travel for temporary advisors and members of the Secretariat. For example, WHO is planning to organize the Eleventh National Tuberculosis Programme Managers Meeting in the Western Pacific Region in conjunction with The Union Asia-Pacific Conference on Lung Health in March 2017 in Tokyo.

For antimicrobial resistance, the focus in 2017 will be to raise sustainable funding for this top priority.

Key figures for category 1

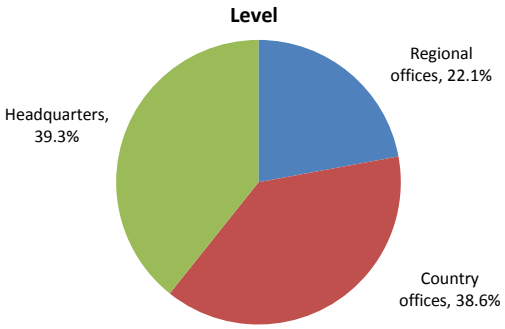
The total approved programme budget for category 1 was US$ 832 million[1] (see Figure 1). Available resources as at the end of 2016 were US$ 651 million or 78% of the approved figure. Expenditure was US$ 312 million or 38% of the approved programme budget and 48% of the funds available. Although overall the level of funding can be considered adequate at this stage of the biennium, it is important to note that regions and country offices were hit hard by the sudden announcement at the end of 2015 of the reduction of the UNAIDS Unified Budget, Results and Accountability Framework funding. Funds available at headquarters include resources for the Special Programme for Research and Training in Tropical Diseases, which are highly specified and cannot be used for other activities under category 1. Low implementation (38%) against the programme budget can be explained by the lower availability of funds in some regions including the African Region (31%) and the Eastern Mediterranean Region (27%) whereas the overall expenditure of 48% shows that major offices are on track with implementing resources currently available.

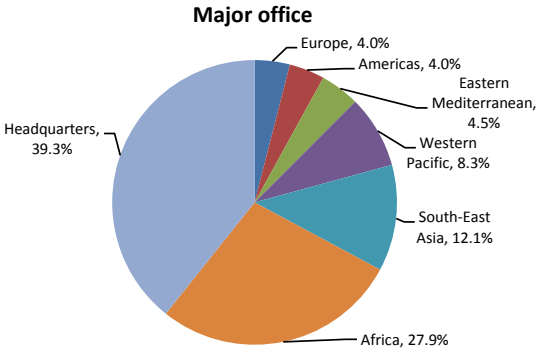
Budget and expenditure by major office

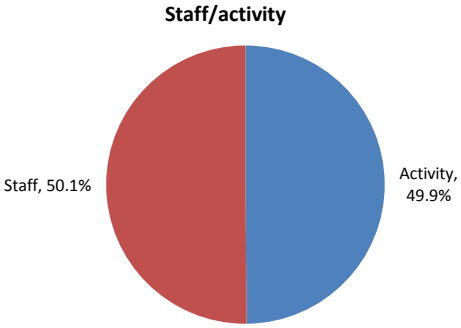


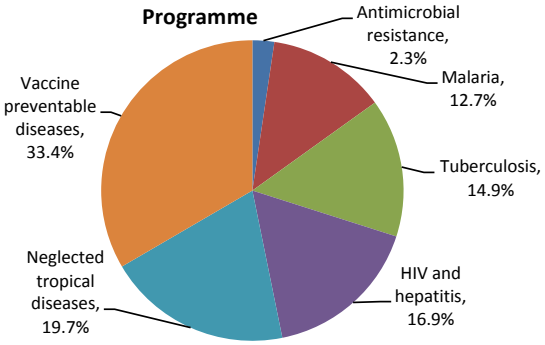
[1] This includes the approved programme budget allocation for antimicrobial resistance.

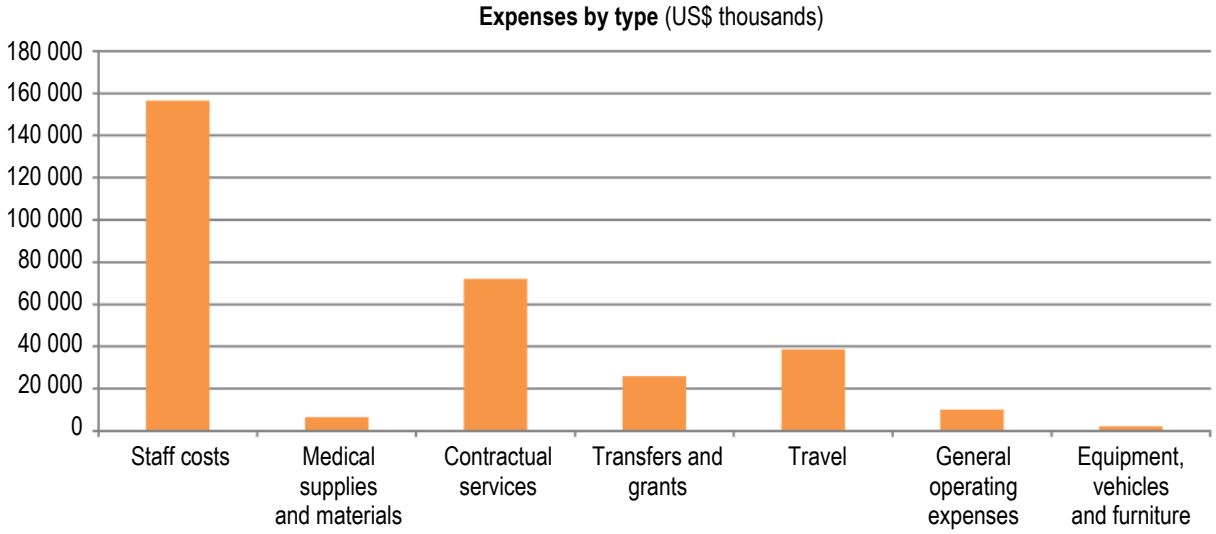
Expenditure details for the category











Category 2

NONCOMMUNICABLE DISEASES

Key achievements in 2016

In 2016, WHO continued to lead global action to reduce the burden of noncommunicable conditions, focusing on the four primary noncommunicable diseases (cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases) and their major risk factors (tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol), poor nutrition, foodborne diseases, as well as mental health conditions, substance abuse, disability, violence and injuries, oral health, and eye and ear health, through health promotion and risk reduction, prevention, treatment, rehabilitation, monitoring and surveillance, and effectively combating zoonoses.

WHO has promoted international awareness about the fact that premature deaths and disabilities from these conditions cause untold suffering, reduce productivity, curtail economic growth, keep people trapped in chronic poverty, and pose a significant social challenge in the majority of countries. The acknowledgement that these conditions constitute one of the major challenges for development in the 21st century is evidenced by the inclusion of relevant Sustainable Development Goal targets in the 2030 Agenda for Sustainable Development. These targets are based on guidance provided by the World Health Organization and commitments undertaken at the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases.

In April 2016, the United Nations General Assembly declared a United Nations Decade of Action on Nutrition 2016–2025. WHO contributed to the Special Session of the United Nations General Assembly on the World Drug Problem and was assigned several tasks in the outcome document, which was adopted by the General Assembly through resolution S-30/1 in April 2016.

In June 2016, the United Nations Economic and Social Council encouraged members of the United Nations Interagency Task Force on the Prevention and Control of Noncommunicable Diseases to reflect the new

Sustainable Development Goal targets on noncommunicable diseases in their national development plans and policies.

In May 2016, the Sixty-ninth World Health Assembly, in resolution WHA69.7, endorsed the Brasilia Declaration on Road Safety (the outcome document of the second Global High-level Conference on Road Safety and, in resolution WHA69.5, endorsed the WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children. In resolution WHA69.9, the Health Assembly welcomed with appreciation the technical guidance on ending the inappropriate promotion of foods for infants and young children; in decision WHA69(12) it welcomed the report of the WHO Commission on Ending Childhood Obesity; and in resolution WHA69.6 it noted that the Director-General had received two reports from the working groups of the WHO global coordination mechanism on the prevention and control of noncommunicable diseases that recommended ways and means of encouraging Member States to realize their commitment to engage with the private sector and finance national noncommunicable disease responses.

The Ninth Global Conference on Health Promotion, which focused on how to promote health in national Sustainable Development Goal responses, resulted in the adoption of the Shanghai Declaration on Health Promotion, which sets out bold political choices for health that governments may wish to include in their ambitious national responses to the 2030 Agenda for Sustainable Development.

With regard to global joint programmes with other United Nations agencies, UNICEF and WHO launched the Global Partnership to End Violence Against Children and its package of proven solutions known as INSPIRE. FAO and WHO have started to scale up technical support to strengthen national food safety capacities by launching a joint FAO/WHO global tool to assess national food control systems. The second FAO/WHO Project and Fund for Enhanced Participation in Codex (Codex Trust Fund) was launched in January 2016. Coordinated technical assistance was provided by WHO, FAO and the World Organisation for Animal Health (OIE) to combat zoonoses and antimicrobial resistance at the animal-human interface. The joint ITU/WHO programme, Be He@althy, Be Mobile, has entered its second phase, and its mTobaccoCessation programme in India has now reached 2 million users. UNODC and WHO signed a memorandum of understanding to support countries in their efforts to see more drug users channelled through the public health system instead of through the courts and criminal justice system. The World Bank and WHO have started to work together to move mental health from the margins to the mainstream of the global development agenda.

The World Bank and WHO organized a high-level event on mental health and development in Washington DC, as a part of the Spring 2016 Annual Meeting of the World Bank. This was the first time the World Bank had focused on mental health, acknowledging and highlighting the link between mental health and development and providing starting points from which countries could use mental health activities to enhance their development efforts. The Director-General of WHO and the President of the World Bank opened the event. A background paper and a report with recommendations were published.

Progress is being made with regard to the availability of new and updated noncommunicable disease mortality and risk exposure data. WHO has also updated country comparable data and estimates on a key set of noncommunicable disease and risk factor indicators to enable reporting on progress towards achieving global voluntary targets for 2025 and noncommunicable disease-related targets included in the 2030 Agenda for Sustainable Development.

Some Member States have made remarkable progress in implementing the four time-bound national commitments for 2015 and 2016 to reduce premature mortality from noncommunicable diseases, as set out in the Outcome Document of the second High-level Meeting of the United Nations General Assembly on Non-

communicable Diseases. With support from WHO, Member States including Brazil, Canada, Chile, Colombia, Costa Rica, the Islamic Republic of Iran, the Russian Federation, and the United Kingdom of Great Britain and Northern Ireland are making major strides.

Current evidence suggests, however, that the rate of decline in premature mortality from noncommunicable diseases remains insufficient to meet Sustainable Development Goal 3, target 3.4, by 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment. In order to rapidly scale up national capacities to address noncommunicable diseases, WHO organized the first Global Meeting of National Noncommunicable Disease Programme Managers and Directors (Geneva, 15–17 February 2016) to help countries in scaling up their national noncommunicable disease responses, taking into account that noncommunicable diseases remains the programme area most frequently selected as a priority programme area at the country level. Similarly, regional meetings of national noncommunicable disease programme managers and directors were held in all WHO regions.

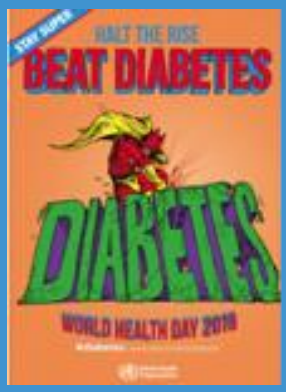
In order to meet the rapidly increasing demand for technical support, WHO launched the Global Hearts Initiative in September 2016, which is a collaborative arrangement between WHO, United States Centers for Disease Control and Prevention, the World Heart Federation, the World Stroke Organization, the International Society on Hypertension, and the World Hypertension League, to scale up the prevention and control of cardiovascular diseases in low- and middle-income countries.

The Global Hearts Initiative comprises three technical packages: SHAKE (to lower population salt consumption), HEARTS (to incorporate cardiovascular disease management at the primary health care level) and MPOWER (to help countries implement specific provisions of the WHO Framework Convention on Tobacco Control) and has so far provided technical support to 14 countries. Technical support was also provided to countries to undertake actions to promote the intake of healthy foods, reduce the intake of unhealthy foods and sugar-sweetened beverages, strengthen the legislative process and legislation for tobacco control, or reduce the impact on children of marketing of foods high in saturated fats, trans-fatty acids, free sugars, or salt. WHO supported more than 30 Member States in strengthening or establishing noncommunicable disease surveillance and monitoring systems to track national progress and report against the global accountability framework on noncommunicable diseases, including the WHO Global Monitoring Framework. This included support for planning and implementation of noncommunicable disease risk factor surveys using the WHO STEP-wise approach to noncommunicable disease risk factor surveillance (adults) or the Global school-based student health survey approach (adolescents).

Tajikistan launches National Programme on Rehabilitation of Persons with Disabilities

The multisectoral National Programme on Rehabilitation of Persons with Disabilities, 2017–2020, seeks to improve health, rehabilitation and social protection for people with disabilities, to create an enabling environment with equal opportunities for all in Tajikistan, and thus contribute to the implementation of the Sustainable Development Agenda.

The Programme focuses on all individuals with long-term physical or intellectual impairments due to noncommunicable diseases, infectious diseases (including those affected by the national polio outbreak in 2010), neurological disorders, mental illness, injuries, and conditions following surgery as well as due to ageing process. Launched in October 2016, it is the culmination of the technical support provided by WHO to the Ministry of Health and Social Protection since 2013, with financial support from the United States Agency for International Development and the United Nations Partnership to Promote the Rights of Persons with Disabilities. WHO contributed to the introduction of policy, systems and services for a disability rehabilitation programme, which in turn has led to the development of the National Programme for 2017–2020. Implementing the Programme will require action by government institutions, United Nations agencies, the donor community, national and international organizations, the media, people with disabilities and the organizations representing them.



In 2016, WHO marked World Health Day by issuing a call for action on diabetes. In its first Global Report on Diabetes, WHO highlighted that even in the poorest settings, governments must ensure that people are able to eat healthily, be physically active, and avoid excessive weight gain, and that the health systems are able to diagnose and treat people with diabetes.

The WHO-led United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases provided technical support to 16 countries to help governments influence public policies in sectors such as agriculture, food production, pharmaceutical production, taxation, trade and urban development, to ensure health gains on noncommunicable diseases. To strengthen governments' effective leadership on mental health conditions, WHO provided support to 20 Member States with regard to implementing the WHO Mental Health Action Plan 2013–2020.

With a view to promoting exchanges of experience among Member States, WHO launched the noncommunicable diseases document repository in 2016, which provides access to over 1400 documents containing noncommunicable disease targets, policies, and guidelines submitted by Member States to WHO. Furthermore, practice communities on governance, health care, prevention and noncommunicable disease surveillance for national noncommunicable disease programme managers and directors were established to facilitate the exchange of lessons learnt.

Similarly, all WHO tools to address noncommunicable conditions are centralized in a single platform on the WHO website. Three examples of such tools published in 2016 are: the tools for developing, implementing and monitoring national multisectoral action plans for noncommunicable diseases prevention and control; a revised version of the mhGAP Intervention Guide on management of mental, neurological and substance abuse disorders in non-specialised settings (which is being used in 90 countries); and a tool to support data systems for improving cervical cancer programming.

The WHO Global Communication Campaign on Noncommunicable Diseases was launched on the occasion of the Economic and Social Council High-level Political Forum on the 2030 Agenda for Sustainable Development in July 2016. The report of the WHO technical meeting on fiscal policies for diet and the prevention of noncommunicable diseases called for action to consider taxes to improve access to healthy dietary choices.

In July 2016, the decision by the World Bank's Internal Centre for Settlement of Investment Disputes confirmed that tobacco control measures applied by Uruguay did not violate the terms of an investment agreement between Uruguay and Switzerland, under which the dispute had been initiated. The decision was informed by a joint submission, or amicus brief, from WHO and the secretariat of the WHO Framework Convention for Tobacco Control.

WHO, in collaboration with FAO, provided the Codex Alimentarius Commission and Member States with 53 detailed risk assessments and other scientific advice on chemical and microbiological hazards in food, supporting the adoption of more than 4000 Codex standards in 2016.

The WHO Global Coordination Mechanism on Noncommunicable Diseases made progress in engaging non-State actors to support Member States in their national efforts to attain Sustainable Development Goal target 3.4 by 2030. The governments of France and Mauritius, in their capacities as Co-Chairs of the WHO Global Dialogue Meeting on the role of non-State actors in supporting Member States in their national efforts to tackle noncommunicable diseases as part of the 2030 Agenda for Sustainable Development, issued a statement calling on NGOs, private sector entities, philanthropic foundations and

academic institutions on how to increase their contributions to national noncommunicable disease responses. Under the Coordination Mechanism, two working groups were established, the first on how to include noncommunicable diseases in programmes on communicable diseases, child and maternal health, and sexual and reproductive health. The second working group was on how to align international cooperation with national multisectoral plans on noncommunicable diseases aimed at attaining Sustainable Development Goal 3, target 3.4.

Challenges and lessons learned

The WHO Secretariat and Member States, United Nations organizations and non-State actors will need to discuss, in more depth, the reasons for the slow progress in addressing noncommunicable diseases. They will need to identify obstacles, and agree on innovative solutions to overcome bottlenecks. Although there has been an increase in the number of countries with an operational national noncommunicable diseases policy with a budget for implementation, low- and middle-income countries are generally struggling to move from today's commitment to implementing tomorrow's ground-breaking solutions. The main obstacles include:

- a lack of commitment and policy expertise to integrate measures to address noncommunicable diseases into national responses to the 2030 Agenda for Sustainable Development;
- unmet demands for technical support to be provided through bilateral and multilateral channels to strengthen national capacity, which would enable countries to develop their own national multisectoral noncommunicable disease responses;
- slow progress in engaging whole-of-government and key sectors beyond health, which is a prerequisite in developing national multisectoral noncommunicable disease responses, including the implementation of the "best buy" interventions for noncommunicable diseases;
- weak health systems and inadequate national capacity in public health;
- insufficient analytical, legal and fiscal administrative capacity to increase domestic taxes on health-harming products in order to reduce risk factors for noncommunicable diseases and contribute to increased mobilization of domestic resources to implement national responses;
- industry interference that blocks the implementation of certain measures; and
- a change in patterns of health financing, whereby more of the burden is placed on domestic public resources, supplemented by international assistance.

Priorities for 2017

The implementation of strategies and interventions launched in 2016 is also a priority. Several Member States plan to implement the following technical packages: INSPIRE to tackle violence against children, Global Hearts to address cardiovascular disease, the package on emergency care, and the Model Disability Survey. A new package of road safety interventions, Save LIVES, will be launched in May during United Nations Road Safety Week, which will be dedicated to managing speed, a major risk factor for road traffic crashes. In follow-up to the Global Plan of Action on Disability WHO will also strengthen its work on rehabilitation, starting by convening more than 200 stakeholders in a major meeting, Rehabilitation 2030, in February, to identify next steps.

WHO, in collaboration with the World Bank and UNDP, has started to support the development of national economic investment cases in Fiji and Viet Nam, which will help raise awareness about the national public health burden caused by noncommunicable diseases, the relationship between noncommunicable diseases, poverty and socio-economic development, the cost of action vs. inaction, and the return on investment. At the global level, WHO has started to develop a costed business plan for noncommunicable diseases, which will be launched at the WHO Global Conference on Noncommunicable Diseases (Montevideo, 18–20 October 2017) in preparation for the third High-level Meeting of the United Nations General Assembly on Non-communicable Diseases.

Tax on sugary drinks in Estonia planned following continuous support and a presentation of the evidence

A government proposal to implement tax on sugar-sweetened beverages from 2018 is the key outcome of the WHO Regional Office for Europe's comprehensive and continuous support to Estonia to promote action on overweight and obesity. This support encompasses capacity building, technical assistance, policy advice, advocacy, and involves working across different sectors and government departments, including the ministries of social affairs, finance, rural affairs and their sub-agencies. The national survey conducted for the first time under the WHO Childhood Obesity Surveillance Initiative revealed that 26% of first-grade students are already overweight or obese. An evidence brief for policy was developed under the umbrella of the Evidence-Informed Policy Network to inform about how to reduce the consumption of sugar-sweetened beverages and their negative health impact in Estonia. The mapping of these beverages on the market by sugar content and price, as well as working with researchers to model the health and monetary benefits of potential tax scenarios, provided additional support.

The childhood obesity survey, evidence brief for policy and policy advice based on WHO's normative work and policy documents, including sugar guidelines and the European Food and Nutrition Action Plan 2015–2020 have contributed to the development of the green paper on nutrition and physical activity.

The Conference is expected to result in an outcome document which will set out a road map of national commitments which Member States may implement between 2018 and 2030 to attain Sustainable Development Goal target 3.4.

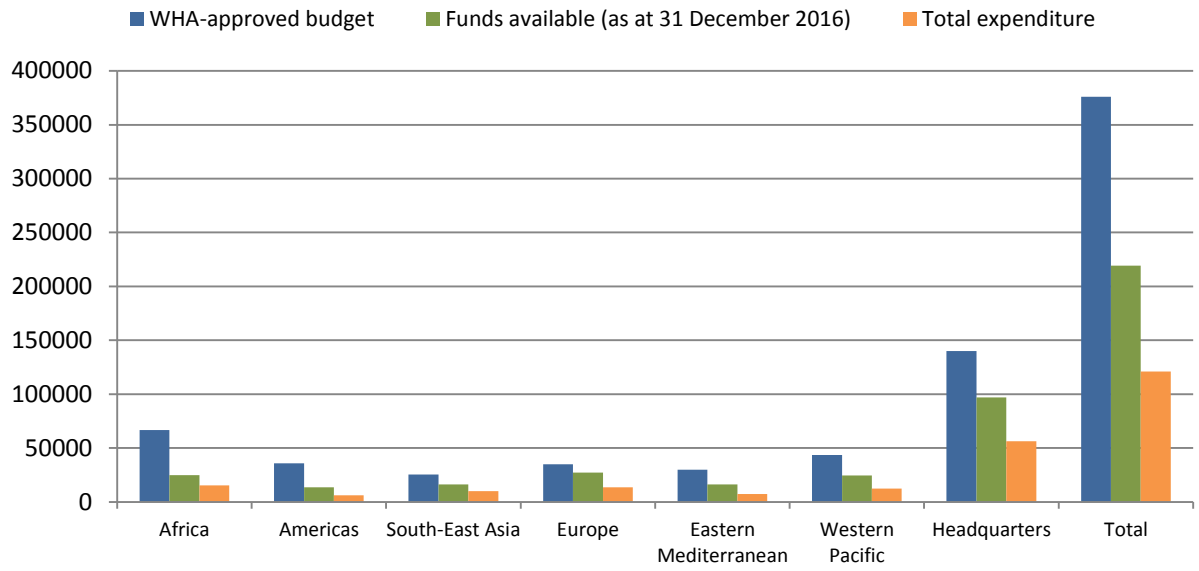
WHO will continue to support countries to collect noncommunicable diseases data, including risk factor exposure and mortality, to enable reporting against the Sustainable Development Goal-related noncommunicable disease targets. WHO will implement the 2017 noncommunicable disease country capacity survey to generate detailed information on individual country capacity to address noncommunicable diseases, and to determine the current strengths and weaknesses in their noncommunicable disease infrastructure, policy response, surveillance and health-systems response. WHO will use this information, together with other data on noncommunicable diseases to produce an updated noncommunicable diseases progress monitor, and will update the noncommunicable diseases document repository with new country level information.

In pursuing a new business model to scale up technical support provided by WHO (within the same parameters set for the programme budget), WHO has also started to develop an integrated support model in eight Member States. The aim is to arrive at a focused action model to provide technical assistance in a coordinated manner across the six noncommunicable disease-related programme areas, and across the three levels of the Organization, with the engagement of relevant stakeholders. The model will also enable category 2 to fast track results in a small number of Member States interested in taking a global lead.

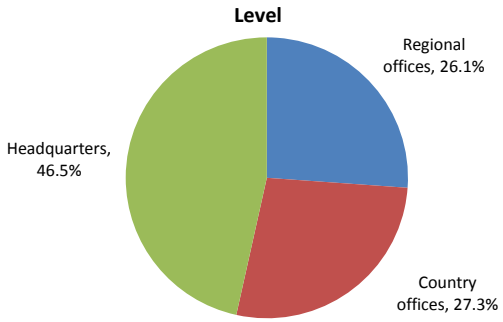
Key figures for category 2

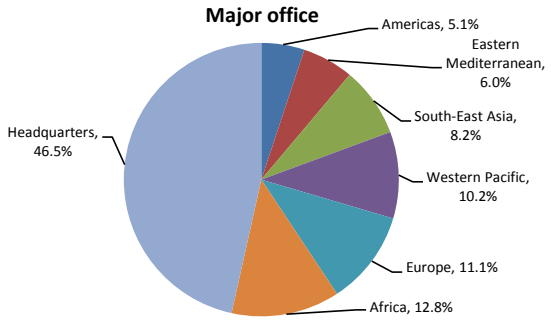
The total approved budget for category 2 was US$ 376 million. Available resources as at the end of 2016 were US$ 219 million or 58% of the approved programme budget. Expenditure was US$ 121 million or 32% of the approved programme budget and 55% of the funds available. With 58% of available resources, category 2 has the lowest available funding after the first year of implementation when compared to the other categories. Available funds for the regions vary from 37% in the African Region to 64% in the South-East Asia Region. Overall expenditure at 32% can be explained by the low level of funding available when compared with the approved programme budget. Expenditure against funds available is at 55% overall, which shows a good capacity to spend despite the limitations mentioned in some regions, including the security situation, when funds are available.

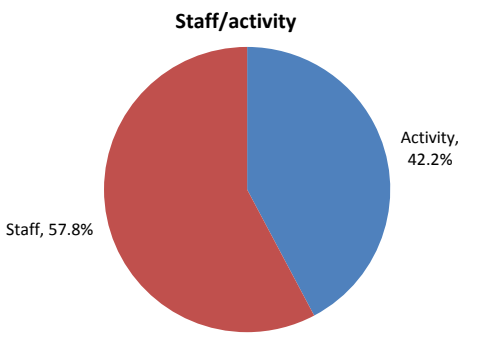
Budget and expenditure by major office

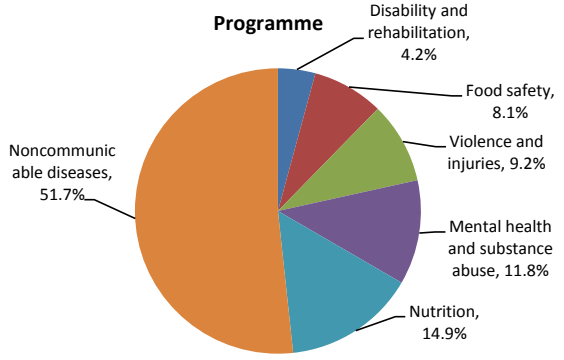


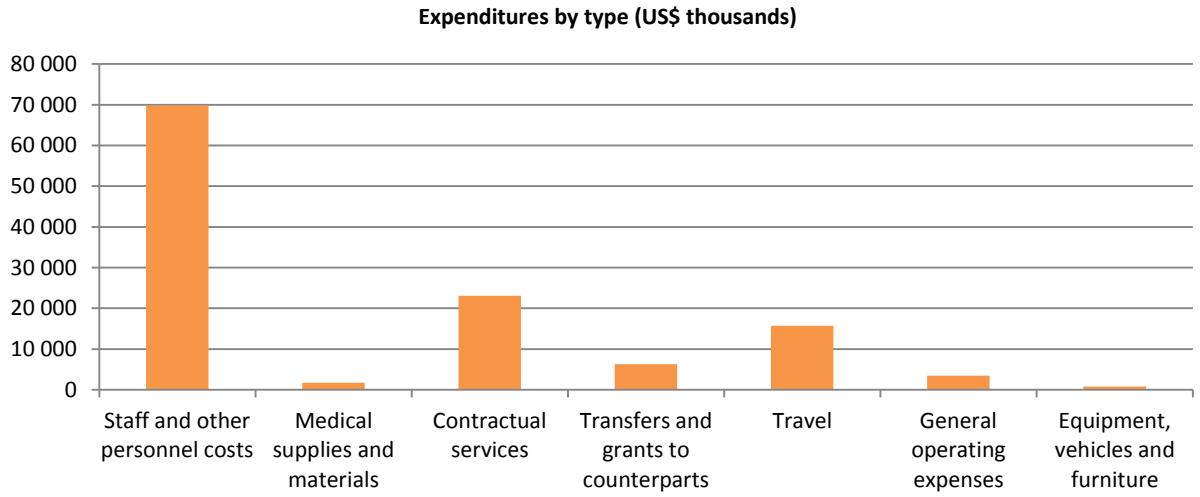
Expenditure details for the category










Expenditures by type (US$ thousands)
80 000
70 000
60 000
50 000
40 000
30 000
20 000
10 000
0
Staff and other personnel costs
Medical supplies and materials
Contractual services
Transfers and grants to counterparts
Travel
General operating expenses
Equipment, vehicles and furniture

Category 3

PROMOTING HEALTH THROUGH THE LIFE-COURSE

Key achievements in 2016

The objectives under category 3 include promoting good health at all key stages of life, taking into account the need to address health equity, social, economic and environmental determinants of health, and human rights, with a focus on gender equality. Category 3 is by its nature cross-cutting, and has an additional mandate to ensure adoption of its themes across all programmes and categories, thereby leading the work to put into practice an integrative and multisectoral approach to improving health and attaining the health-related Sustainable Development Goals.

The key achievements in 2016 are expressed under the five programme areas within the category: (i) reproductive, maternal, newborn, child and adolescent health, (ii) ageing and health, (iii) gender, equity and human rights mainstreaming, (iv) social determinants of health, and (v) health and the environment.

Member States have made significant progress in women's, children's and adolescents' health over the past two decades. Globally, maternal and child deaths decreased by around 50%, and contraceptive prevalence increased by almost 10%. The number of adolescents in the world today, 1300 million, is greater than ever before, and they have better opportunities to improve their health and well-being.

The case has been made for high returns on investment in women's, children's and adolescents' health which also translate into social and economic benefits. The value of evidence-based, cost-effective investments and interventions and of enabling health and multisectoral policies is accepted, yet, as countries move towards the Sustainable Development Goals, far too many women, children and adolescents worldwide still have little or no access to essential, good-quality health services and education, clean air and drinking-water, adequate sanitation and good nutrition. Many face violence and discrimination, are unable to participate fully in society, and encounter other barriers to realizing their human rights.

As a result, the annual death toll remains unacceptably high, and most of these deaths could have been prevented. Many more suffer illness and disability and fail to reach their full potential, resulting in enormous losses and costs for countries, now and in the future. Today we have both the knowledge and the opportunity to end preventable deaths among all women, children and adolescents, to greatly improve their health and well-being and to bring about the transformative change needed to shape a more prosperous and sustainable future. That is the ambition of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030).

That Global Strategy encapsulates the health-related Sustainable Development Goals and their targets, and the holistic approach of the 2030 Agenda for Sustainable Development in the area of women's, children's and adolescents' health. In 2016, the Sixty-ninth World Health Assembly, in resolution WHA69.2, invited Member States to commit to its implementation. The Global Strategy provides a road map for attaining the ambitious objectives of the Goals with evidence-based action areas for the health sector and other sectors and communities. Its guiding principles include equity, universality, human rights, development effectiveness and sustainability. In 2016, WHO collaboratively created mechanisms and frameworks to support Member States in the financing, implementation and monitoring of the Global Strategy. The Secretariat has been instrumental in providing Member States with technical support and guidance in some related areas, including the development of an indicator and the monitoring framework, adolescent health, a health systems response to address interpersonal violence, the establishment of a High-level Working Group on Health and Human Rights of Women, Children and Adolescents, and support to the Global Financing Facility. Its monitoring framework has 60 indicators and aims to minimize the burden on countries of reporting to the global level by aligning them with the indicators of the Sustainable Development Goals and agreed-on global health initiatives. The Health Assembly in resolution WHA69.2 (2016) requests the Director-General to provide adequate technical support to Member States in implementing national plans and to report regularly on progress. Regional initiatives have been endorsed to strengthen support to countries in implementing and monitoring the Strategy. For example, in 2016 the Regional Committee for Europe adopted the strategy on women's health and well-being in the European Region and an action plan for sexual and reproductive health.

With respect to ageing and health, populations around the world are rapidly growing older. Between 2000 and 2050, the proportion of the world's population aged 60 years or over will double to about 22%. These extra years of life and the consequent reshaping of society have profound implications for each person and the communities we live in. Unlike most of the changes that society will experience in the next 50 years, these trends are mostly predictable.

A landmark in 2016 was the Health Assembly's adoption of the Global strategy and action plan on ageing and health in resolution WHA69.3. The resolution provides a strong political mandate and a clear policy framework that is built around the concept of healthy ageing, as outlined in WHO's World report on ageing and health published in 2015. The strategy emphasizes that in some areas there is sufficient evidence to justify immediate policies to foster healthy ageing, but it also highlights the many gaps in knowledge and the lack of capacity and partnerships to deliver an effective response. The strategy is designed to link closely to the Sustainable Development Goals and proposes an initial five-year plan of action to fill these gaps, to be followed by a Decade of Healthy Ageing from 2020 to 2030. To prioritize the concrete steps that require WHO leadership during the action plan, the Secretariat convened expert working groups and undertook extensive Organization-wide consultations. This process has identified 10 steps towards a Decade of Healthy Ageing which will be disseminated to stakeholders in early 2017 for further input. The challenge will then be to resource this ambitious, but essential, agenda.

Significant progress was made in 2016 in each of the five strategic objectives of the Global strategy on ageing and health, including: work towards preparing evidence-based guidelines for the integrated care of older people in primary care settings, development of guidance on establishing long-term care systems in low-resource settings, and work to refine the concepts and to reach global consensus on how to measure and monitor healthy ageing globally. In cooperation with the European Commission, a comprehensive set of tools was developed for local and regional government levels for age-friendly environments in Europe. The movement of age-friendly cities, communities and regions continues to grow strongly (and has recently been augmented by inclusion of a number of dementia-friendly policy initiatives).

Referring to gender, equity and human rights mainstreaming, equity is a central concept in the Sustainable Development Goals. In 2016, 65 countries experienced a reduction of health inequities, including gender inequality, and 70 countries (compared to 63 in 2015) were enabled to implement at least two WHO-supported activities to integrate gender, equity and human rights in their health policies and programmes. The major achievements comprise: (i) the development of a country-support package and the provision of country support through technical assistance for further mainstreaming of equity, gender and human rights across WHO programme areas and countries' programmes, policies and strategies; (ii) development and adoption of mechanisms and policy frameworks on gender, equity and human rights in the Secretariat and Member States; (iii) increased accountability and performance assessment; and (iv) a strengthened network of focal points for gender, equity and human rights throughout all WHO regions and headquarters. The Secretariat focused on 15 programme areas to integrate equity, gender and human rights into the Organization's policies, programmes and strategies.

Work on social determinants of health focused on integrating health into all sectors of policy-making. That step offers a crucial opportunity for strengthening primary health prevention; the Health in All Policies approach is essential for combining the forces of multiple stakeholders.

In 2016, 45 countries received training to increase intersectoral capacities and skills at the country level to implement a Health in All Policies approach.

The major achievements at the three levels of the Organization comprise: (i) development of national roadmaps and strategies for implementation of the Health in All Policies approach; (ii) increased capacity for intersectoral work and creation of a Health in All Policies trainers' platform to facilitate the growth of institutions and trainer networks; (iii) provision of support to Member States to strengthen domestic mechanisms for intersectoral actions for noncommunicable diseases; (iv) provision of support to Member States through normative guidance for adaptation of the Health in All Policies approach to specific sectors, in particular housing; and (v) strengthening of multisectoral and multi-agency networks of partners that deal with key determinants. The strengthened linkages between the Secretariat and key sectors and global partners are essential to the implementation of the Sustainable Development Goals and the related social determinants of health.

In the context of health and the environment, significant health returns will accrue from the joint action, including work on and climate change. For example, reports of the Intergovernmental Panel on Climate Change (the largest body of scientific evidence on climate change) establish that extreme weather events such as heatwaves, flooding and tropical storms are increasing in frequency in many parts of

WHO in South Sudan: build, equip and deploy to save the lives of mothers

With 789 deaths per 100 000 live births, South Sudan remains among 40 countries with the highest maternal mortality rates in the world, despite progress between 1990 and 2015 when the maternal mortality rate decreased by 54.4% from 1730 deaths per 100 000 live births. The availability of skilled birth attendants is one of the most critical factors that affect maternal and newborn survival. However, as a result of the continuing and worsening crisis in the country, South Sudan has an extremely low ratio of health workers to population. The global strategy on human resources for health: workforce 2030 puts forward a threshold of 4.5 doctors, nurses and midwives per 1000 population in order to attain the health-related Sustainable Development Goals. South Sudan has 1.5 physicians and 2 nurses per 100 000 population.

With the support from the Government of Canada, WHO has been implementing a five-year project on strengthening comprehensive emergency obstetric and neonatal care in South Sudan in order to improve access and availability with provision of good- quality care. WHO has constructed six maternity complexes and two maternal waiting homes which are fully equipped. Eighteen national medical officers have been sponsored to specialize in obstetrics and gynaecology in East Africa, and highly qualified doctors, obstetricians and midwives have been recruited and deployed to serve in the six maternity complexes, and lead referral and outreach awareness programmes that will be key links between the facilities and the communities they serve. Through the same support, WHO has strengthened the six maternity complexes and maternal waiting homes to become centres of excellence where midwifery students and medical officers from Juba Teaching Hospital, six health science institutes and the task-shifting programme can be trained in standardized care in emergency obstetric care while training to strengthen health systems to be more sustainable and providing life-saving interventions along the life course. During the protracted crisis this project has been able to provide emergency and life-saving interventions and build the capacity of mid-level health workers to deliver basic life-saving services in six former states.

the world, raising the risks of associated deaths and ill-health. Many of the sources of air pollution, a cause of 6.5 million deaths each year and the single greatest environmental threat to health today, are also significant sources of greenhouse gas emissions, driving climate change. Actions to redress both issues can result in significant benefits to both health and the environment. Such activity and the Sustainable Development Goal framework covering a range of environmental determinants of health in relevant contexts, for instance, energy policies and urban development, provide the context for WHO's work in this area. Major achievements include: (i) the co-convening, together with the Government of France, of the second WHO Global Conference on Climate Change and Health in Paris in July 2016; (ii) establishment of a Health, Environment and Climate Coalition and related collaboration between WHO, UN Environment and WMO in the margins of the 22nd Conference of the Parties to the United Nations Framework Convention on Climate Change (Marrakech, Morocco, 15 November 2016), and (iii) the launching of the "BreatheLife" campaign (www.breathelife2030.org) aimed at catalysing city-level action to improve air quality and mitigate the effects of climate change on health at the 3rd United Nations Conference on Housing and Sustainable Urban Development (Quito, 17–20 October 2016), at which with more than a dozen cities declared commitments.

In addition to the above, WHO published a global assessment of the burden of disease for about 90 environmentally related diseases in its report in 2016 on "Preventing disease through healthy environments". Notably, it showed a much greater link than previously recognized between environmental factors and noncommunicable diseases. The top five causes of death caused by the environment are noncommunicable diseases, largely because of the adverse health impacts of exposure to air pollution.

WHO has also published the burden of disease attributable to chemicals, providing a substantial evidence base for the draft roadmap to enhance the engagement of the health sector in the Strategic Approach to International Chemicals Management developed in response to resolution WHA69.4 (2016). Within the context of support provided under the International Health Regulations (2005), the Secretariat provided technical support to Member States for the public health response to 17 separate chemical events.

Regional offices continue to play a fundamental role in supporting interministerial processes on health and environment, which frame the overall political context for this work. For example, the Regional Committee for the Western Pacific in 2016 endorsed the new Western Pacific Regional Framework for Action on Health and Environment on a Changing Planet. Negotiations on the political outcomes of the Sixth Ministerial Conference on Environment and Health in Europe (due to be held in June 2017) have been initiated, and in the Eastern Mediterranean Region a new Regional Strategy on Health and Environment and Framework (2017–2030) was developed in collaboration with the League of Arab States and UNEP.

Challenges and lessons learned

Attainment of the health-related Sustainable Development Goals requires integrated work across health topics and sectors but with respect for unique country contexts. In many instances, mechanisms for such integration are lacking. Explicit prioritization and resourcing to make this happen are crucial in Member States and at all levels of the Organization. Intersectoral coordination to address social and environmental health determinants at the country level is often weak, that is to say, Member States are neither yet engaged in nor effectively able to influence policy and

decision-making processes in the main sectors with influence over environmental and occupational determinants of health. At the same time, it is hard to apply a "one-size-fits-all" approach to programming and the adoption and application of global tools, guidance and standards.

Cross-cutting areas requiring mainstreaming, such as gender, equity, rights and social determinants of health often face a range of challenges, including: (i) weak budget allocations; (ii) limited financial resources and difficulties in mobilizing resources; (iii) a shortage of staff; and (iv) a lack of visibility.

In a changing political and development landscape, efforts to expand coverage of health interventions and quality of care have faced hindrances. For example, in the area of reproductive, maternal, newborn, child and adolescent health, policies and regulations that restrict access to family planning and abortion services for some women and girls - which are proven to save lives and prevent ill-health - are common challenges experienced in countries, and are exacerbated in certain political environments.

Another challenge is to speak with one voice and adopt unified approaches across the Organization. For example, in healthy ageing, an important task is to ensure that all parts of the Secretariat share and communicate a clear vision, and innovative internal mechanisms for engagement have been developed, in particular, the WHO Ageing Coordination Forum.

Priorities for 2017

Given the cross-cutting nature of the work of category 3 and the many external partners involved in this work, strong collaboration across WHO programmes and beyond WHO is essential to making progress and achieving global goals. Cooperation between the different levels of the Organization was an asset, for example, in the implementation of activities under the ageing and health programme area, which allowed for streamlining into other programmes. Regarding collaboration beyond the health sector, WHO's positioning as the custodial agency for several indicators of the Sustainable Development Goals, especially those for other sectors than health per se, provides a major opportunity to demonstrate how central health is to the wider 2030 Agenda for Sustainable Development.

Provision of support by regional and country offices needs to be tailored to the capacity of a country's health ministry. In some countries, support will be needed for implementation whereas in other countries support may instead entail advice on strategies and policies. Further capacity is needed within the Secretariat, for example in the area of social determinants of health, to establish a stable community of trainers and to further strengthen capacity-building in countries and across the regions.

For certain cross-cutting themes under category 3, it is important to ensure that institutional mechanisms distinguish and provide visibility for these areas of work. For tackling the environmental determinants of health, a different approach to institutional arrangements – one that spans beyond and across traditional sectoral silos – is necessary.

A greater focus is needed on improving the quality of care, in particular, around childbirth. To further reduce child morbidity and mortality, integrated care that covers all aspects of childhood development needs to be provided at the primary health care level. Adolescent health activities need to move away from a sole focus on risk prevention towards adopting a more comprehensive approach that seeks to ensure safe physical, psychological and social transitions from childhood to adulthood.

Greater action is needed to tackle gender-based violence, which continues to be an expanding area of work. As Member States' awareness of the problem grows, so also do their demands for support from the Secretariat.

In the context of ageing and health, countries should be encouraged to conduct rapid domestic analyses and undertake visits to the best-performing countries in the region in order to improve the development of policies and strategies.

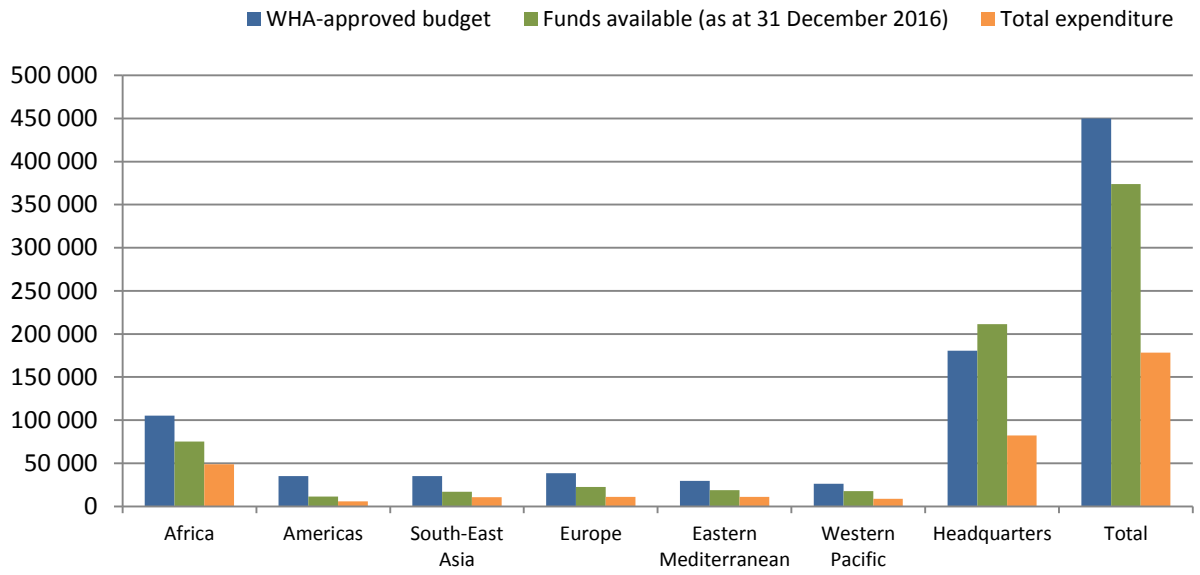
Collaboration with external partners needs enhancing. For example, greater collaboration with academics and researchers in the next year should be facilitated so as to advance work on ageing and health.

Overall, the vulnerability of the financing of the work in category 3, with its comparatively small donor base, needs to be redressed. The high degree of dependence on a relatively small number of donors increases vulnerability to possible changes in political priorities.

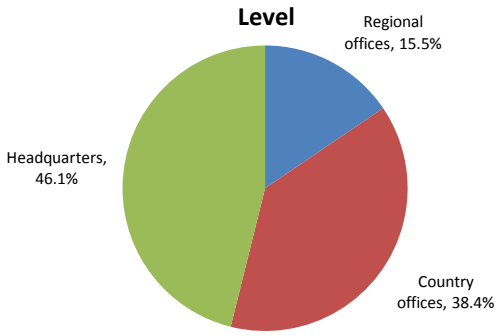
Key figures for category 3

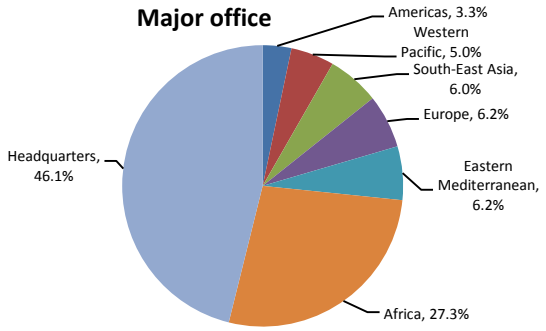
The total programme budget allocated to category 3 was US$ 450 million. Available resources as at the end of 2016 were US$ 374 million or 83% of the Programme budget 2016–2017. Expenditure was US$ 178 million: 40% of the total programme budget allocated and 48% of the funds available. The positive situation of funds available at headquarters is driven by operational and implementation research linked specifically to the Special Programme of Research, Development and Research Training in Human Reproduction. Research is a core function of WHO and the global orientation of work explains its budgetary location under headquarters. Conducting research requires significant levels of funds, and a large part of these highly specified funds is for the Special Programme. These research funds cannot be diverted to activities under other programme areas or to other regional locations under this category. Meanwhile, the other four programme areas under category 3 (Ageing and health; Gender, equity and human rights mainstreaming; Social determinants of health; and Health and the environment) are unable to attract the level of voluntary donor funding needed, and they remained underfunded at the end of 2016.

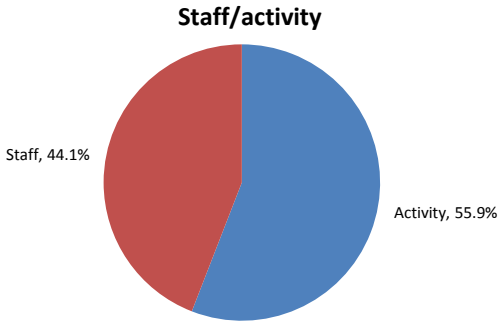
Budget and expenditure by major office

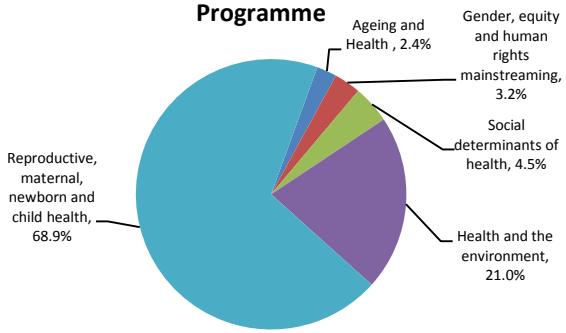


Expenditure details for the category

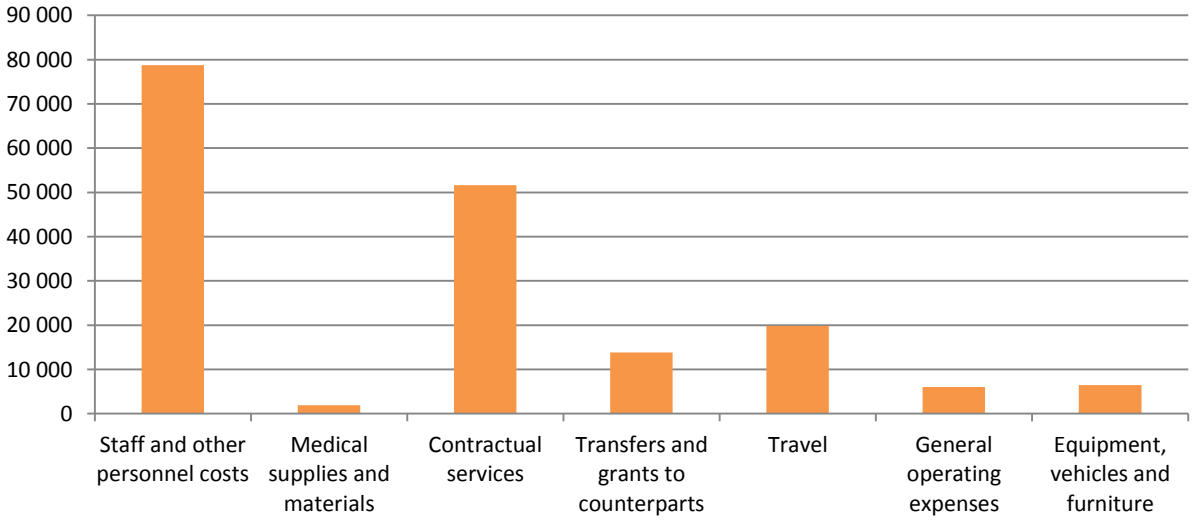








Expenditures by type (US$ thousands)



Category 4

HEALTH SYSTEMS

Key achievements in 2016

When all 193 Member States of the United Nations adopted the 2030 Agenda for Sustainable Development in New York in 2015, they set out an ambitious agenda for a safer, fairer and healthier world by 2030. Throughout 2016, global commitment to achieve universal health coverage has increased, and consultations to improve understanding of the importance of universal health coverage in the context of the Sustainable Development Goals have continued (in particular in the WHO South-East Asia and Western Pacific regions). WHO has made significant efforts to develop a consensus on priorities for health systems strengthening to promote universal health coverage. WHO headquarters pioneered the "Fit for Purpose, Fit for Context" approach to tailored interventions on health systems. The Regional Office for Africa developed a health systems action framework for universal health coverage and the Sustainable Development Goals, and the Regional Office for Europe has drawn up a roadmap to implement the 2030 Agenda for Sustainable Development, based on universal health coverage. The Regional Office for the Western Pacific has promoted a regional action framework on the Sustainable Development Goals, which mobilizes parliamentarians and WHO collaborating centres.

Global health agencies are increasingly advocating a change in perspective, moving away from vertical programmes towards a broader and more coordinated approach to health systems strengthening that is fully aligned to national health strategies. In this context, the Government of Japan, which held the Presidency of the G7 in 2016, announced the G7 Ise-Shima Vision for Global Health. Japanese and German political leaders, as the outgoing and incumbent G7 presidents during the reporting period, have spearheaded advocacy for universal health coverage within implementation of the 2030 Agenda for Sustainable Development. In December 2016, signatories to the International Health Partnership Global Compact (IHP+) decided to broaden the Partnership's scope to work towards attaining universal health coverage by 2030, and thus established "UHC 2030", as a platform for taking the universal health coverage movement forward. WHO, together with the World Bank, has been instrumental in driving this evolution forward. Also in 2016, the Sixth Tokyo International Conference on African Development culminated in the adoption of the Nairobi Declaration, through which African governments

and development partners expressed their commitment to achieving universal health coverage in Africa. WHO played a significant technical advisory role in these efforts.

With regard to the development of national health plans and strategies, there are encouraging examples across all WHO regions. The Regional Office for the Eastern Mediterranean has been instrumental in supporting the re-establishment of national health oversight in countries affected by rapid decentralization. Most parts of the world have seen a slight expansion in access to health services and coverage of key interventions. There have also been some improvements in financial protection. Yet, in many countries, large coverage gaps remain, in particular for poor and marginalized segments of the population. Despite a reduction in the burden of communicable diseases, malnutrition, unmet family planning needs and maternal mortality rates remain stubbornly high in many parts of the world. At the same time, the burden of noncommunicable diseases, such as cancer, cardiovascular disease, diabetes and mental health disorders, is growing. Noncommunicable diseases now account for 63% of deaths globally, with 80% of these deaths occurring in low- and middle-income countries. In order to respond to this challenge, efforts are being made in all WHO regions to enhance coherence between interventions. To that end, universal health coverage strategies have been integrated with the tuberculosis strategy in the European Region, with interventions on noncommunicable diseases in the European and Western Pacific regions, and with measures to address emerging diseases in the Region of the Americas.

At the global level, there has been a call to improve coordination between the closely interrelated issues of health systems strengthening, universal health coverage and improving health security.

In all Regions, the WHO Secretariat has supported Member States in shaping an integrated and people-centred approach to service delivery that ensures equitable and fair access to high quality, comprehensive health services that are efficient, resilient and responsive to the needs of people and communities. In the Region of the Americas, for example, health systems were strengthened to enhance the response to Zika virus disease. The framework on integrated people-centred health services, adopted in 2016 by the Sixty-ninth World Health Assembly in resolution WHA69.24, aims to address these issues by calling for a fundamental shift in the way health services are managed and delivered. The framework presents a compelling vision of a future in which all people have access to health services that are safe, effective, timely, affordable, and of acceptable quality, and are provided in a way that is coordinated around their needs and respects their preferences. Developed as a universal vision, the framework can be adapted to all countries whether high-, medium- or low-income, with mature or fragile health systems. Many Member States have aligned donors and disease programmes in the process of developing health strategies and service packages; the Eastern Mediterranean Region has actively promoted family practice at the primary health care level to increase coverage and improve quality of care.

The road to universal health coverage: El Salvador

In the WHO Region of the Americas, progress is being made with regard to the implementation of roadmaps for universal health coverage, with 15 Member States implementing universal health coverage strategies and 25 reporting advances in the development of comprehensive financing strategies. El Salvador, for example, has improved access to health services through a comprehensive care model based on primary health care and eliminating direct payment at the point of care (user fees). This includes strengthening service delivery networks, improving stewardship of the national health authority by harmonizing regulation and developing new legislation on health to provide a legal framework to ensure the sustainability of the transformations that have taken place.

With regard to the health workforce, changing epidemiology and demographics will generate demand for 40 million new health worker jobs by 2030, mostly in high- and middle-income countries. Without action, there will also be a global shortfall of 18 million health workers needed to achieve and sustain universal health coverage, primarily in low- and lower-middle-income countries.

In response to the adoption, on 17 December 2015, of United Nations General Assembly resolution 70/183, Global health and foreign policy: strengthening the management of international health crises, the United

Nations Secretary-General established the High-Level Commission on Health Employment and Economic Growth on 2 March 2016. The Commission was co-chaired by Mr François Hollande, President of France, and Mr Jacob Zuma, President of South Africa. Dr Margaret Chan, WHO Director-General, Mr Angel Gurría, Secretary-General of the Organisation for Economic Co-operation and Development, and Mr Guy Ryder, Director-General of the International Labour Organization served as co-Vice-Chairs. Presidents Hollande and Zuma launched the Commission's final report on 20 September 2016 at the United Nations General Assembly in New York. The report concluded that returns on investment in health are estimated to be nine to one, and around one quarter of economic growth between 2000 and 2011 in low-income and middle-income countries is estimated to have resulted from improvements to health. Investing in skills and expanding health employment will also contribute to the economic empowerment of women and youth.

The report reflects a much-needed multidisciplinary approach, including economics, education, health, human rights, and labour. It makes a strong case that investing in the health workforce can accelerate progress across many of the Sustainable Development Goals. At its Seventy-first session, the United Nations General Assembly discussed the report and adopted resolution 71/159, Global health and foreign policy: health employment and economic growth. This was immediately followed by the High-Level Ministerial Meeting on Health Employment and Economic Growth: From Recommendations to Action, which was held in Geneva on 14 and 15 December 2016 at which commitments to action on the Commission's recommendations were announced by various stakeholders. In line with the Commission's recommendations, the WHO Regional Office for the Eastern Mediterranean has promoted family practice by developing a strategy to increase the number of family practitioners. Workforce regulation in the Region was supported by the adoption of new legislation in several Member States. In the European Region, a framework for action towards a sustainable health workforce has been drafted, and Member States in South-East Asia reviewed progress in transformative education and rural retention, as part of the Decade for Health Workforce Strengthening in South-East Asia (2014–2023).

The high price of innovative medicines is challenging the sustainability of health systems in countries with all levels of economic development. In order to support Member States in their efforts to ensure access to essential medicines, the WHO Secretariat provided input into the deliberations of the United Nations Secretary-General's High-level Panel on Access to Medicines. WHO also launched the much-needed Fair Pricing Forum, which intends to convene all stakeholders to develop principles on pricing of medicines and other health technologies. These efforts at global level are supported at the regional level by a variety of interventions, such as the elaboration of principles for the rational use of high-cost medicines in the Region of the Americas, and strategies on access to medicines in the European and African regions. Efforts to strengthen national regulatory authorities were scaled up at the global level and in the Region of the Americas and the South-East Asia Region.

In March 2016, WHO launched the Health Data Collaborative at the Forty-seventh session of the United Nations Statistical Commission in New York. The Collaborative includes 38 development partners that have made specific commitments on how they will enhance their efforts to strengthen country health information systems in the context of the 2030 Agenda for Sustainable Development.

WHO published its first seminal status document on the health-related Sustainable Development Goal targets and indicators in the 2016 edition of World health statistics. This provided an assessment of the current capacity of country health information systems to monitor the health-related Sustainable Development Goal targets and indicators, and gave a baseline overview of the global, regional and country situations in 2016. Several regional and country offices worked with Member States on issues related to monitoring progress towards the Sustainable Development Goals and universal health coverage to enhance progress assessment and accountability. For example, the Regional Office for Europe developed a methodology to measure financial protection and health services coverage, which it applied in 25 Member States. The Regional Office for South-East Asia completed a first measurement of universal health coverage in the Region. In the Western Pacific Region, a Monitoring and Evaluation Framework on Sustainable Development Goals and Universal Health

Coverage was developed to allow close tracking of the progress of universal health coverage and the Sustainable Development Goals. All these tools will be useful in enabling Member States to track their progress.

Work towards the launch (in January 2017) of the Global Observatory on Health Research and Development was completed in 2016. The WHO Regional Office for Africa issued a Regional Research for Health Strategy and the Regional Office for the Eastern Mediterranean completed the second round of its Leadership for Health programme. In the Regional Office for the Western Pacific, support was provided to Member States to enhance their capacity for evidence-based decision-making and health policy practical research.

Challenges and lessons learned

Although support is generally strong for universal health coverage through strengthening health systems in countries, challenges persist with regard to the extent of political commitment and engagement with partners in applying health systems strengthening measures. Close coordination within the various ministries in national governments, as well as the mobilization and sustainability of financial and human resources, are needed.

Given that health is a major economic driver, commercial interests are high. In several cases where the main drivers of inequalities are well known and are the target of reform plans, implementation has been blocked or delayed due to entrenched interests, suggesting that in future, greater attention will need to be paid to developing more politically insightful implementation strategies.

In countries that depend on external aid, the activities of global health initiatives with disease-specific programmes can lead to a fragmentation of health system interventions. The UHC 2030 platform can be used to overcome this fragmentation.

In some countries, shortcomings persist in the production and availability of reliable data on which to base policy development, and in the capacity to generate and use data for decision-making. In addition, in many countries, investments in health continue to prioritize specialized and hospital-based services.

Limited institutional and human resource capacity in national agencies responsible for areas such as financing, pricing, reimbursement, procurement, supply chain management and regulation remains a challenge in many countries.

Out of pocket expenditure continues to be a key issue, presenting decision-makers with significant challenges about future sustainability. In many countries, there is insufficient political and financial support for ensuring equitable access to health services of good quality, which poses a risk for the achievement of universal health coverage.

For WHO, unstable funding for staff (at all three levels of the Organization) and activities remains a key challenge to programme implementation.

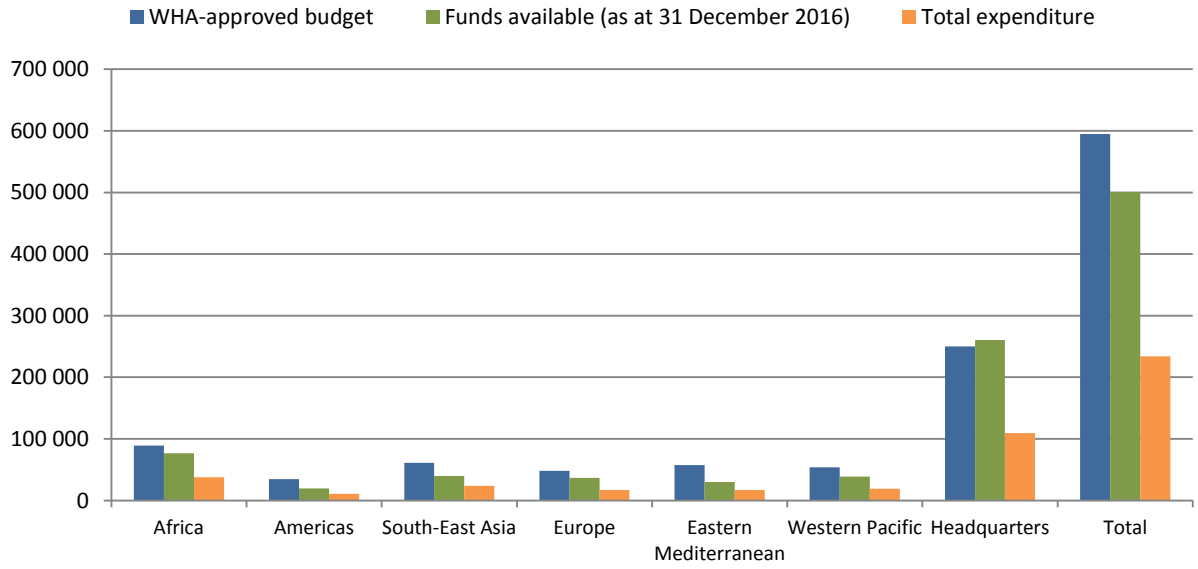
Priorities for 2017

The WHO Secretariat will continue to work closely across its health systems and disease programmes to support Member States in strengthening partnerships for public policy and identifying key entry points to address long-standing and emerging health issues. In addition, support will be provided across all levels of the Organization to monitor universal health coverage and the Sustainable Development Goals. Although the priorities set for 2017 remain highly relevant, challenges in securing resources may mean that further prioritization is required, notably in the area of health systems information and evidence.

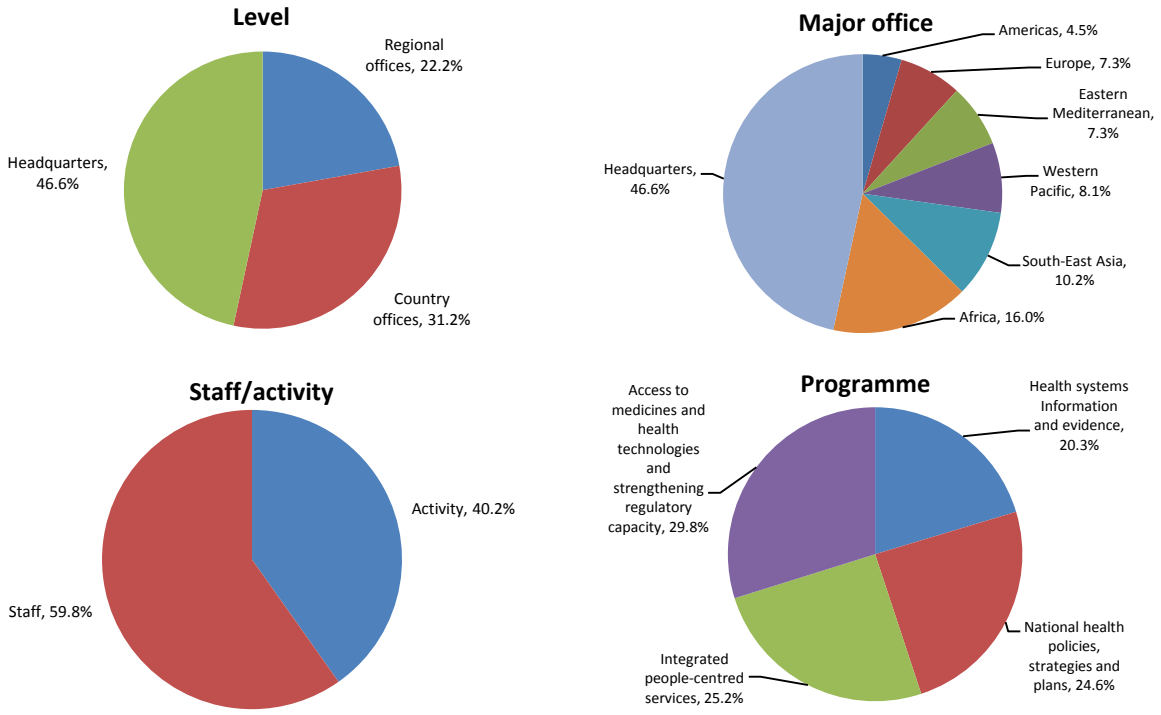
Key figures for category 4

The total approved budget for category 4 was US$ 594 million. Available resources as at the end of 2016 were US$ 501 million or 84% of the approved programme budget. Expenditure was US$ 234 million or 39% of the approved programme budget and 47% of the funds available. The high availability of funds at headquarters is due to the highly specified resources that relate to the work of the WHO Prequalification of Medicines Programme. Expenditure against the programme budget of 39% was low due to the low level of available resources, especially at the Regional Office for the Eastern Mediterranean Region (51%). The Regional Office for the Eastern Mediterranean reported that the implementation of the global strategy and plan of action on public health, innovation and intellectual property, as well as work in countries to plan, develop and implement an eHealth strategy, are at risk.

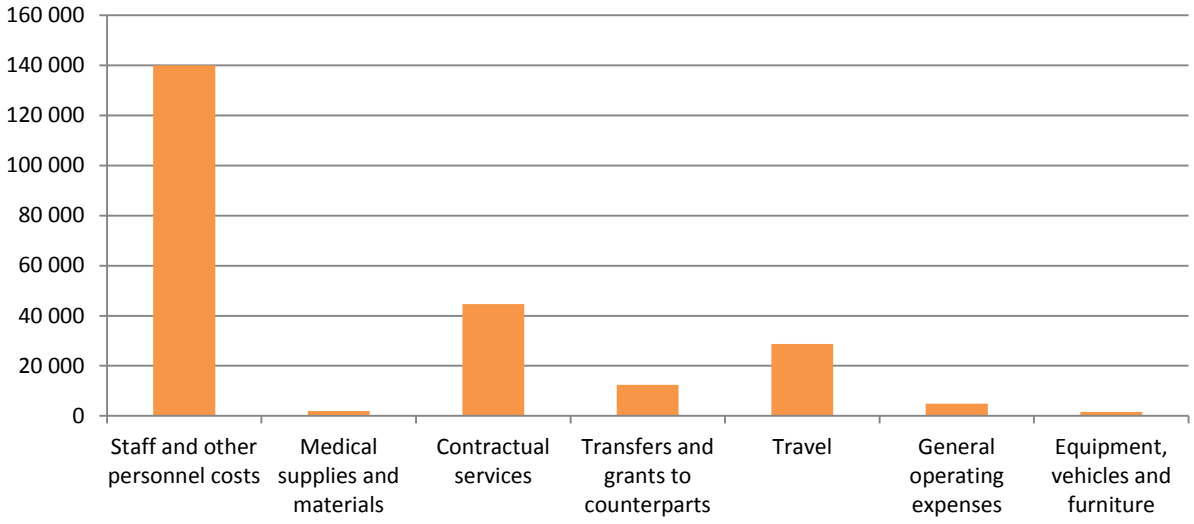
Budget and expenditure by major office



Expenditure details for the category



Expenditures by type (US$ thousands)



Category E

WHO HEALTH EMERGENCIES PROGRAMME

Key achievements in 2016

The Ebola virus disease crisis in West Africa resulted in the launch of the WHO Health Emergencies Programme in July 2016, following the decision by Member States at the Health Assembly in May 2016. Based on several comprehensive multilateral reviews and in order to overcome systemic weaknesses, the new entity was designed as a single programme across the three levels of the Organization. As one programme, it has one workforce, one budget, one line of accountability, one set of processes and systems and one set of benchmarks. Its mission is to provide support to countries, and to coordinate international action, to prevent, prepare for, detect, respond to and recover from outbreaks and emergencies. In the Programme budget 2016–2017 four technical and operational outcomes were defined for the new Programme. This mid-term report provides examples of the Programme's first achievements measured against these outcomes.

The Programme was launched just after the declaration in June 2016 of the end of the Ebola virus disease outbreak in West Africa, following a highly complex and coordinated two-year multilateral response. Although that response is over, WHO continues to engage in the long-term prevention and control of Ebola and the long-term care of survivors. During the Ebola virus disease epidemic, medicines regulators from the most affected countries (Guinea, Liberia and Sierra Leone), other African countries such as Gabon, Kenya and Mali, and Canada, the European Union and the United States of America played a pivotal role in fast-tracking vaccine clinical trials with support from the Secretariat. The findings, published in December 2016, demonstrated that at least one Ebola vaccine candidate was effective. This result was obtained in record-breaking time: 18 months in comparison with the usual five to six years it usually takes to test the efficacy of a vaccine. The vaccine (rVSV-ZEBOV) was studied in a trial involving 11 841 people in Guinea during 2015. Among the 5837 people who received the vaccine, no case of Ebola virus disease was recorded 10 days or more after vaccination, but there were 23 cases among those who did not receive the vaccine. The trial was led by WHO together with Guinea's

Ministry of Health, Médecins sans Frontières, the Norwegian Institute of Public Health and the Canadian Government in collaboration with other international partners.

One outcome of the Programme is that health events are detected, and risks are assessed and communicated for appropriate action. On 1 February 2016 the Director-General declared a Public Health Emergency of International Concern in response to the public health risk posed by the outbreak of Zika virus infection. This declaration came after increasing evidence that the virus was associated with neurological complications in newborns. WHO published a comprehensive strategic response framework and operational plan two weeks later to guide the international community's response, and incident management teams in every WHO region developed context-specific regional strategies. In the Region of the Americas, PAHO deployed 175 experts on 80 separate missions to 30 countries and territories, and convened 22 workshops at regional level, reaching more than 400 participants to provide guidance on how to tackle the disease. In the African Region, Cabo Verde reported more than 7000 suspected cases of Zika virus infection between 21 October 2015 and 6 March 2016, and its first case of microcephaly on 15 March 2016. At the request of the country's health ministry, the Programme deployed multidisciplinary teams, with members from the Region and headquarters, to identify operational gaps, support the country's response, and support the finalization of a national response plan. In July and August 2016 the Regional Office for Africa led a mission to Guinea-Bissau to boost surveillance, preparedness and response capacities after the country reported four suspected cases of Zika virus disease. The Regional Office for Europe convened a regional technical consultation on Zika virus in Lisbon in June 2016, following the publication of the Zika virus disease risk assessment for the European Region. As a result of the consultation, the Regional Office developed a training curriculum for health professionals to increase awareness of invasive mosquitoes and vector-borne diseases. In February 2016, WHO launched the Pacific Zika Action Plan in consultation with regional development partners. Following a regional risk assessment exercise, the Secretariat supported Zika preparedness and response in Fiji, Marshall Islands, Micronesia (Federated States of) and Samoa, all of which experienced outbreaks of Zika virus disease in 2016. In the South-East Asia Region, the Secretariat is providing support to Member States in assessing and strengthening their response capacities with appropriate guidance on effective surveillance and management of Zika virus disease. In addition, the hospital surveillance network of the maternal child health programme in the South-East Asia Region has been strengthened and expanded so that 200 hospitals in nine countries are now screening babies for Zika virus-related microcephaly.

Another Programme outcome is that all countries are equipped to mitigate risks from high-threat infectious hazards. In early 2016 WHO also received official notification of an outbreak of yellow fever in Luanda, Angola, which subsequently spread rapidly throughout other provinces. From February onwards cases of yellow fever exported from Angola were reported in the Democratic Republic of the Congo, China, Kenya and Mauritania. Within two weeks of Angola's notification and request, WHO arranged the shipment of more than 1.7 million vaccine doses from the global emergency stockpile managed by the International Coordinating Group for Vaccine Provision. At the same time, the Programme worked with a total of 56 partner organizations to support the development of a joint yellow fever strategic response plan. The strategy called for 27 million doses of yellow fever vaccine (financed by the GAVI Alliance and the Government of Angola) to immunize at-risk populations in Angola and in the Democratic Republic of the Congo — a huge logistics challenge. WHO deployed 15 logisticians to plan and transport more than 10 million syringes, vaccine doses in more than 38 000 vaccine carriers by truck, car, motorcycle, boat and often by foot to 8000 vaccination sites. In total, about 20 million people were vaccinated in 73 districts in Angola. In the Democratic Republic of the Congo close to 13.5 million people received the yellow fever vaccine. With a global shortage in yellow fever vaccine and the amplification and extension of the outbreak, the decision was taken to use fractional doses in and around Kinshasa to ensure the maximum population coverage. The last confirmed case reported in Angola was on 23 June, and the last reported case in the Democratic Republic of the Congo was on 12 July 2016. In September 2016, recognizing the limits of global stockpiles and the need for a long-term preventative approach, WHO brought together a coalition of more than 40 partners to prepare a new strategy for eliminating yellow fever epidemics (for the period 2017–2026). The strategy, supported by the GAVI Alliance, aims to protect the most vulnerable populations, address the

underlying risks of limited global stockpiles by ensuring a ready supply of yellow fever vaccine, build resilience in urban centres, and prevent international spread.

The comprehensive review in 2016 of the Pandemic Influenza Preparedness Framework was a welcome opportunity to take stock of the progress made since the Framework was launched in 2011. Indications are that the Framework has been implemented with great success so far thanks to the commitment of Member States that support their specialized influenza laboratories in the Global Influenza Surveillance and Response System, vital partners such as industry and civil society, and leadership from WHO. Implementation has already significantly increased global preparedness by securing access to hundreds of millions of doses of pandemic influenza vaccine that will be available to WHO in real time when the next pandemic strikes. Surveillance has been boosted by the Global Influenza Surveillance and Response System, with 131 Member States reporting almost half a million influenza probe results to FluNet, and 86% of 172 reporting laboratories assessed as having 100% diagnostic accuracy. In addition, more than 1000 individuals from 120 countries are now trained in specialized pandemic influenza risk communication. Moreover, the Framework's updated risk communication essentials have been translated into seven languages and were accessed almost 8000 times during 2016. Concerns about the sharing of viruses are being addressed with the development of targeted and specific guidance for countries and laboratories.

For the Programme's outcome that populations affected by health emergencies have access to essential life-saving health services and public health interventions, WHO leads and coordinates more than 80 health partners in a whole-of-country response for the Syrian Arab Republic that is managed through offices in Damascus, Gaziantep (Turkey) and Amman. These offices regularly convene meetings of health partners to plan, implement and monitor the overall health response. In 2016, health partners focused on four core functions: coordination, health information, health systems and filling gaps in health care delivery. WHO and its partners prepared joint contingency plans, improved information sharing and strengthened cross-line and cross-border operations. Major achievements include the delivery of 11 million treatments across the country, including 1.7 million treatments delivered through 34 cross-border operations to besieged and hard-to-reach locations. All 18 besieged areas in the Syrian Arab Republic were reached with humanitarian health assistance, including the vaccination of children against childhood diseases. WHO expanded disease surveillance during 2016 through the Early Warning and Response Network, with 1618 sentinel sites across the country reporting to the network, and nutritional surveillance services for children under 5 years of age extended to 445 health care centres. WHO also provided training for more than 41 000 health care staff on a range of topics including trauma care, first aid, primary health care, reproductive health and the management of noncommunicable diseases.

Regarding the outcome "all countries assess and address critical gaps in preparedness for health emergencies, including in core capacities under the International Health Regulations (2005) and capacities for all hazard health emergency risk management", in the past 12 months, 30 countries from all six WHO regions have conducted joint external evaluations, with a total population of more than 1200 million. More than 360 experts have been mobilized globally to participate in the evaluations, which take place over several weeks. After the evaluation, countries undertake national action planning workshops and costing exercises. In February 2017, the Government of the United Republic of Tanzania requested the Secretariat's support to cost the National Action Plan for Health Security. The resulting budgeted plan covers key areas of prevention, detection and response, other hazards covered by the International Health Regulations (2005), and points of entry. In 2017, a further 25 countries will undertake such evaluations, 16 of these before end-June, and 27 countries have expressed interest in the process for 2018. Through evaluation of country capacities to manage public health risks, Member States, the WHO Health Emergencies Programme and partners can work together to fill critical gaps and save lives when events occur.

The WHO's R&D Blueprint for action to prevent epidemics was developed as a result of lessons learned from the Ebola response. The R&D Blueprint, issued in May 2015, is a global strategy and preparedness plan that allows the rapid activation of research and development activities during epidemics. It aims to fast-track the availability of effective tests, vaccines and medicines that can be used to save lives and avert large-scale crises. With WHO as

convener, the broad global coalition of experts who have contributed to the Blueprint come from medical, scientific and regulatory backgrounds. In decision WHA68(10) (2015), the Health Assembly welcomed the development of the Blueprint. During 2016 initiatives under the Blueprint focused on accelerating the development and introduction of tools to prevent, detect and respond to the Zika virus infections and work with partners to develop and initiate the Coalition for Epidemic Preparedness Innovations.

Challenges and lessons learned

A major challenge for the new programme is mobilizing appropriate financing. In 2016, only 56% of its core funding requirements were met out of the total core budget of US$ 485 million, and only 33% of the funding requirements for WHO's country-level response operations were met out of the total US$ 656 million required. The Secretariat is addressing this through continuing engagement with key Member States, developing internal mechanisms for more sustainable flexible funding, implementing a new business model at country level to ensure capacities to mobilize and manage resources locally, and the hiring of a Director of External Relations at headquarters to lead this work.

Human resources is another challenging area: how to attract, recruit and retain qualified and experienced individuals who are a good match for the Programme's priorities and expectations. The Secretariat has widened the applicant pool by advertising vacancies through United Nations and partner networks, accelerating normal recruitment processes, establishing an internal roster for rapid deployment of existing staff for emergency response, and working to expand partnerships through which to take advantage of networks for complementary human resource expertise.

Capacity gaps are another challenge to success. The Programme is providing support to Member States in order to strengthen their capacities. At the same time efforts are underway in the new programme to build the internal capacities, skills and readiness required to achieve programmatic results.

On a daily basis, the Programme faces the challenge of establishing itself while getting the job done – following up thousands of signals of potential events each month, and responding to multiple major outbreaks and emergencies. It is accelerating the implementation of the WHO emergency reforms and the recruitment of staff – particularly at country level – to ensure that technical and operational priorities are met.

The number and gravity of new and ongoing outbreaks and emergencies are challenging in themselves. At the end of 2016 there were 47 ongoing responses to acute and protracted events at country level, with support from regional offices and headquarters. It must use its limited resources – including its technical expertise – to forge ahead on prevention, preparedness and normative work, while responding to the demands and expectations of outbreak and emergency response.

The complexity of coordinating multiple partners and networks, and as many viewpoints, makes coordination a big challenge. The Programme's design includes a unit that brings together four important networks: the Global

Developing a national action plan for health security – United Republic of Tanzania

The magnitude and frequency of disease outbreaks and health emergencies in Africa, new emerging risks such as Zika virus, the expansion of known diseases like cholera and Ebola virus disease and the re-emergence of others such as yellow fever, all demonstrate the urgent need for sustained preparedness and capacity-building in Member States.

The United Republic of Tanzania is no exception, experiencing outbreaks of, for instance, cholera, Rift Valley fever, dengue, anthrax and aflatoxin poisoning, with high morbidity, mortality and socioeconomic impact. Member States have agreed to work together to prevent, detect and respond to public health emergencies under the International Health Regulations (2005). A World Health Assembly (WHA) decision in May 2016 requested the Director-General to develop a global implementation plan. The resulting document recommended, inter alia, that Member States, with the support of the Secretariat and development partners, develop and implement national action plans for preparedness, taking into account the differences in governance and public health capacity among countries. This includes the voluntary Joint External Evaluation of the core capacities required under the International Health Regulations (2005). The United Republic of Tanzania was the first country to conduct a joint external evaluation, in February 2016, and the first to convene a workshop to develop the national action plan for health security (in November 2016).

Outbreak Alert and Response Network, the network of Emergency Medical Teams, the Global Health Cluster, and the Standby Partnerships. Together with the Programme's technical networks, these partnerships are exploring new ways of working together to simplify coordination before and during emergency responses.

The Programme benefits greatly from its design as a single programme, but experience demonstrates that the wide range of challenges it faces must be tackled in a practical and context-specific way. The Programme aims to standardize as much as possible, while remaining flexible and able to respond quickly and effectively.

Priorities for 2017

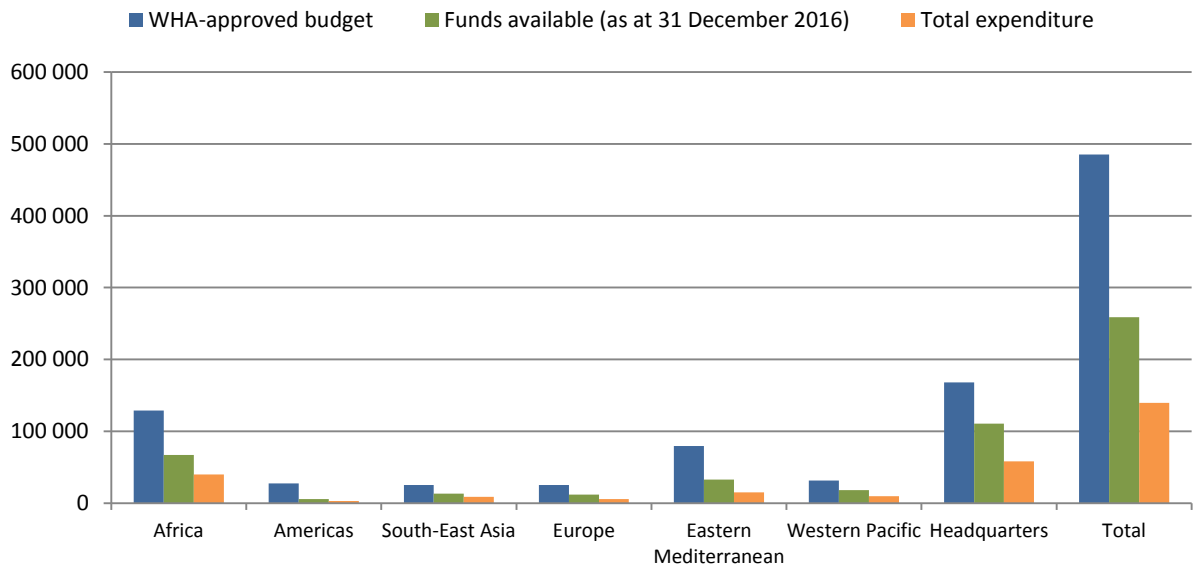
Based on experience since July 2016, the Programme's immediate priorities are: (1) ensuring robust and timely risk assessment and response to every significant new acute event (an all-hazards approach); (2) fostering strengthened partnerships for coordinated and predictable collective action; (3) developing and supporting the implementation of high-quality, comprehensive action plans for national prevention and preparedness; (4) implementing the country business model in countries with major emergencies and high-risk countries with protracted emergencies so that results are delivered in line with the expectations of the response plan; and (5) developing high-profile disease-specific strategies and applying them at country level.

The Secretariat will also promote acceleration of research and development of diagnostics, treatments and vaccines during emergencies as well as advancing research and development as a preparedness measure in line with the WHO R&D Blueprint. The Programme will also finalize and implement a resource mobilization strategy, enhance internal and external coordination, and intensify WHO's efforts to address health challenges in fragile states.

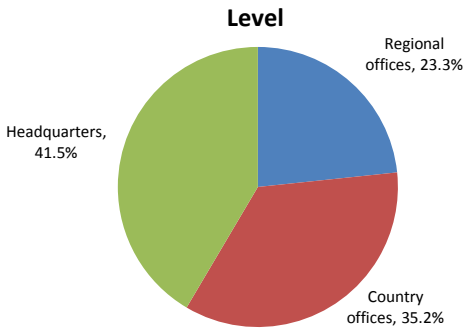
Key figures for category E

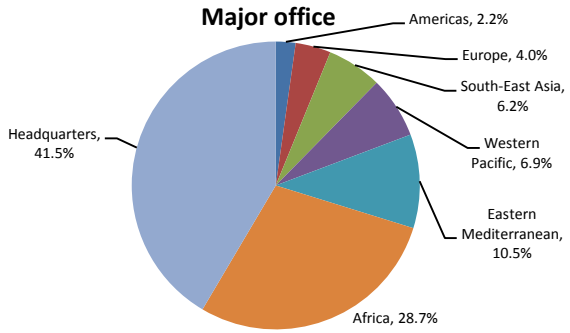
The total approved budget allocation for the WHO Health Emergencies Programme was US$ 485 million. Available resources at the end of 2016 were US$ 258 million or 53% of the approved programme budget allocation. Expenditure was US$ 139 million or 29% of the approved budget and 54% of the funds available. A newly established programme and a major priority for the Organization, the Programme is currently underfunded with only 53% of resources available. It is seeking to redress this situation through engagement with key Member States, developing internal mechanisms for more sustainable flexible funding, and implementing a new business model at country level to ensure capacities to mobilize and manage resources locally.

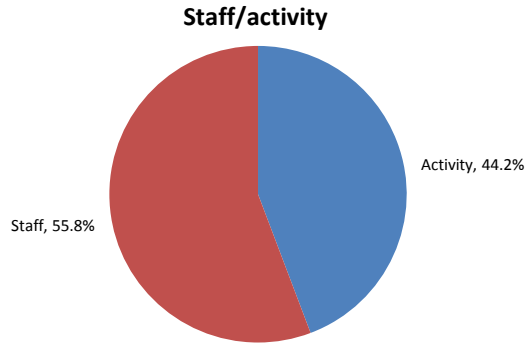
Budget and expenditure by major office

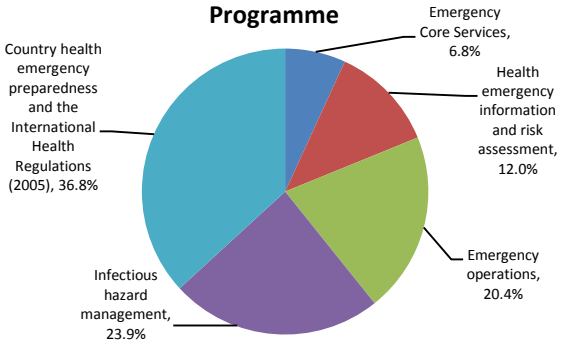


Expenditure details for the category

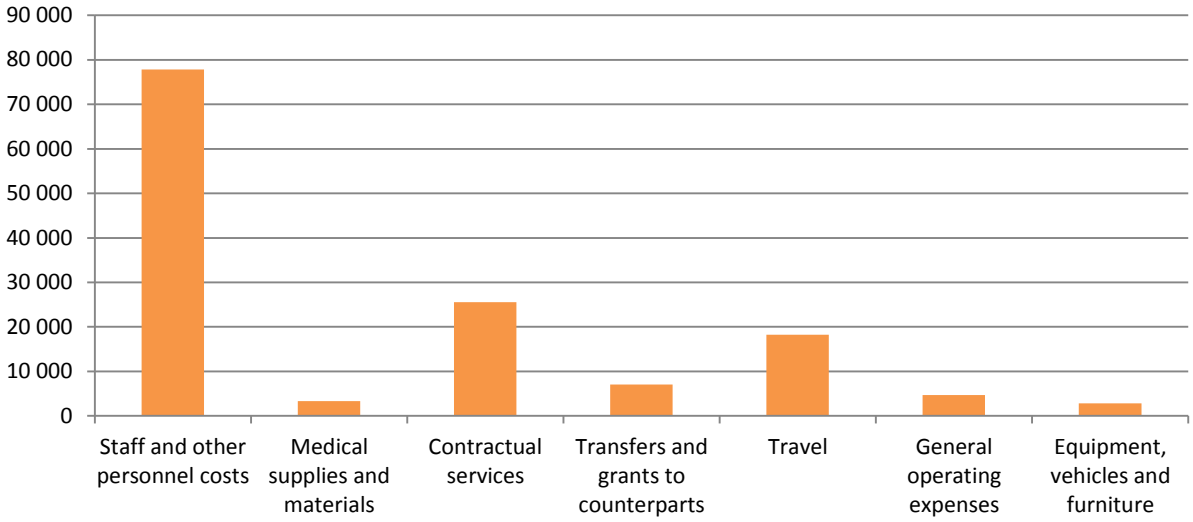








Expenditures by type (US$ thousands)

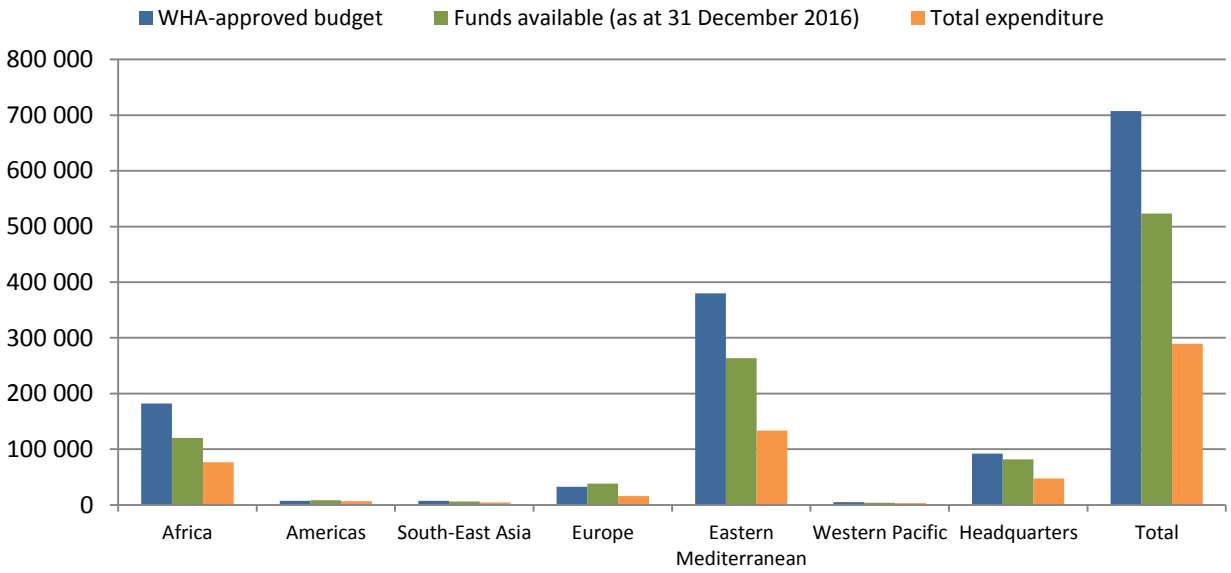


Key figures for outbreak and crisis response

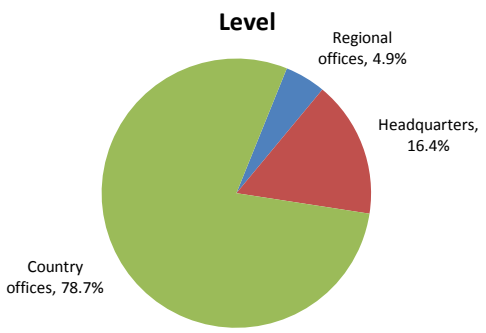
The budget allocation for outbreak and crisis response is event-driven. As at 31 December 2016, the budget for outbreak and crisis response was US$ 707 million and available resources were US$ 523 million or 74% of the approved programme budget allocation. Expenditure was US$ 289 million or 41% of the approved programme budget allocation and 55 % of the funds available.

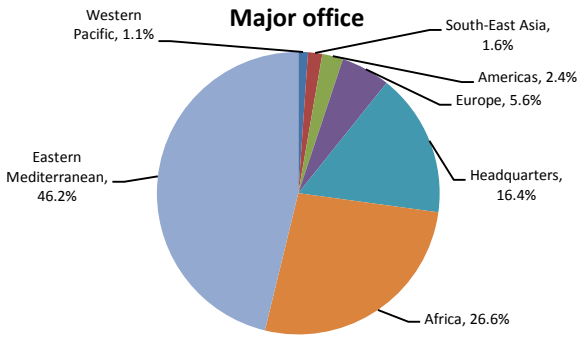
Budget and expenditure by major office

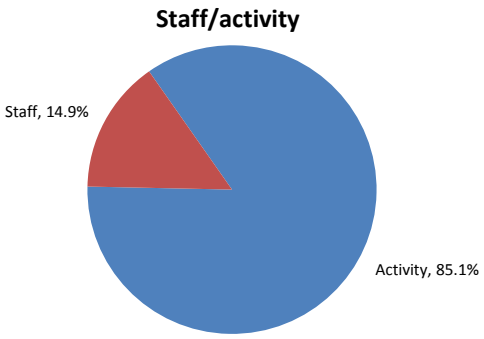
With the exception of the Regional Office for Europe, all major offices have implemented 50% or above of available resources.

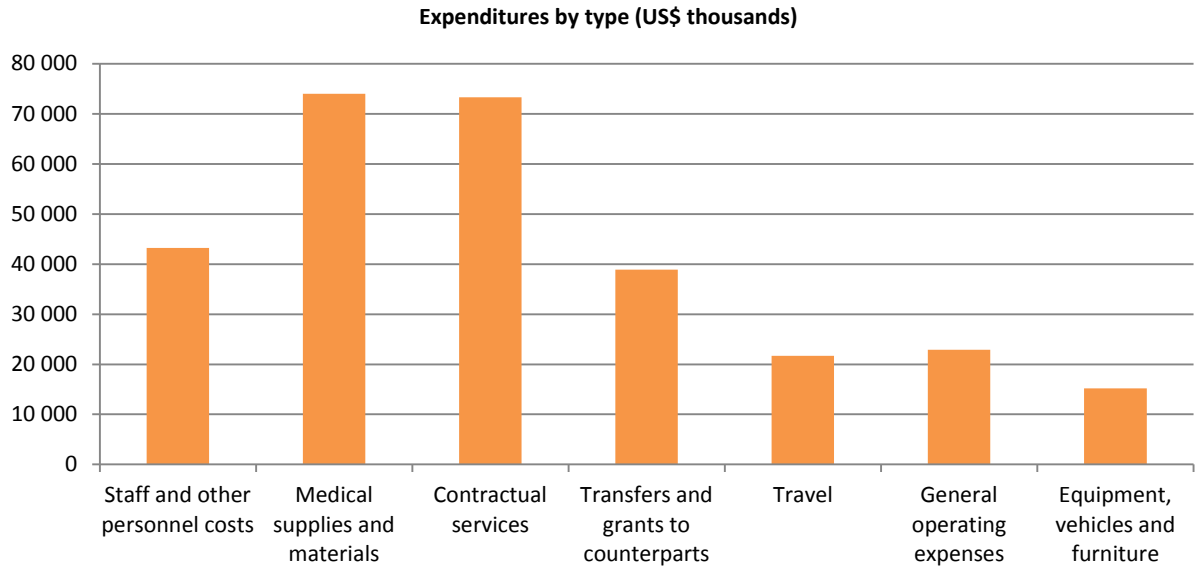


Expenditure details for the outbreak and crisis response








Expenditures by type (US$ thousands)
80 000
70 000
60 000
50 000
40 000
30 000
20 000
10 000
0
Staff and other personnel costs
Medical supplies and materials
Contractual services
Transfers and grants to counterparts
Travel
General operating expenses
Equipment, vehicles and furniture

Category 6

CORPORATE SERVICES/ENABLING FUNCTIONS

Key achievements in 2016

Strategic guidance and leadership was provided by WHO senior management to ensure the consideration of and to promote health in a range of global processes and to consolidate the link between WHO's role in global health governance, the 2030 Agenda for Sustainable Development, its 17 Sustainable Development Goals and WHO's six leadership priorities.

WHO has continued to strengthen its role in governance for health, for example by: positioning and promoting health in such high-level global processes as the United Nations High-Level Meeting on Antimicrobial Resistance and the Secretary-General's High-Level Panel on the Global Response to Health Crises, High-Level Panel on Access to Medicines and High-Level Commission on Health Employment and Economic Growth.

With respect to health in the Sustainable Development Goals, WHO has developed six instruments of change, which provide a framework for Member States and the Secretariat in taking forward work on the 2030 Agenda.

The adoption by the Sixty-ninth World Health Assembly of WHO's Framework of Engagement with Non-State Actors was a milestone in 2016. The implementation of the Framework across all levels of the Organization required the establishment of a register of non-State actors and the development of a set of criteria and principles for from nongovernmental organizations, philanthropic foundations and academic institutions.

The new procedures for the election of the Director-General of WHO, adopted by the Health Assembly, have substantially increased the transparency of the process. They have included a forum for candidates.

In anticipation of the end of polio transmission and in managing the transition to a post-eradication period, a comprehensive plan is being developed and implemented. It includes an updated overview undertaken in 2016 of WHO's polio-related human resources, and an updated projection

of the financial liabilities under different scenarios, with recommendations to reduce liabilities and enhance polio-related human resource planning. The plan will also address the consequences of the polio transition on other related programmes and the need to maintain core polio-related functions after eradication.

For WHO reform, while being mainstreamed at the end of 2015, all reform outputs that are currently under consideration have reached the implementation stage in 2016. The progress of reform is monitored against predefined success indicators and the findings are published regularly. WHO's reform of its work in health emergencies was implemented in 2016 across the Organization in line with the recommendations of the reports of the Secretary-General's Global Health Crises Task Force.

Internal controls and accountability remained a high priority for WHO in 2016. In order to strengthen implementation of the internal control and accountability frameworks, the Internal Control Framework Self-Assessment Checklist tool was developed and disseminated throughout the Organization. Annual accountability compacts between the Director-General and senior management in headquarters are now published on the WHO website together with delegations of authority and letters of representation of regional directors. Work began on the development of an Organization-wide accountability plan to track the key areas in which the Organization needs to demonstrate accountability. The strengthening of internal controls was evidenced through a decrease in outstanding reports pertaining to direct financial contribution and an increase in activities to enhance assurance that all money is spent for the stated purpose. Strengthening of internal procedures and controls can also be seen in the area of procurement through the amendment of WHO's policy and procedures on procurement and its dissemination to all staff. Such action improves transparency and strengthens due diligence with regard to prospective bidders and thereby protects the Organization's interests.

Another important action in 2016 was the development and publication of the principal risks of the Organization, which complement the first full risk-management cycle.

In 2016 significant progress has been made to strengthen the third line of defence by increasing the capacity for audits and investigations. Equally important, progress has been made in efforts to strengthen the administrative capacity to respond to audit observations, particularly at country level. The Organization had closed 19 of the 33 open internal audits. Furthermore, the time taken to successfully close five audits of country offices issued early in 2016 was less than four months from the report being issued. "Overdue open recommendations", excluding responses "not yet due", have increased marginally from 4.0% to 4.8% (mainly attributable to one audit report). During the same period, closed recommendations have decreased from 83.9% to 61.8%.

On 13 December 2016, the newly established WHO Budapest Centre officially opened. This headquarters outpost office, which was selected on the basis of a comparative analysis of various locations, currently hosts 22 staff, most of whom work on the internal administration of justice. The need for strengthening WHO's Internal Justice System was highlighted in recommendations made by an independent panel of experts as part of the WHO managerial reform. Having the new positions based in Geneva would have required an increase of US$ 5.1 million, a sum that could not be accommodated within the Programme budget 2016–2017. The new arrangement sets an example for finding cost-effective alternatives when new functions need to be added. As a consequence, a procurement team is now being established in Budapest.

Cambodia

In June 2016, Dr Shin Young-soo, Regional Director for the Western Pacific, joined Dr Mam Bunheng, Minister of Health of Cambodia, for the launch of the updated Cambodia–WHO Country Cooperation Strategy 2016–2020. WHO is renewing its country cooperation strategies in the Western Pacific Region as Member States update their national health plans and embrace the 2030 Agenda for Sustainable Development. A more thorough approach has been adopted with a process that includes a robust analysis of a country's strategic vision in a time of rapid change and development as well as WHO's evolving role in the public health arena. While aligned with the national health policies, strategies and plans, the strategic agenda for country cooperation in the Region will focus on three common priorities: advancing universal health coverage, achieving health security and implementing health-related Sustainable Development Goals.

In line with the promotion of ethical behaviour, decent conduct and fairness across the Organization and following on from the entry into force of the WHO policy on whistleblowing and protection against retaliation in 2015, the Integrity Hotline was launched in 2016 – it is a confidential, externally managed, service for the reporting of allegations of suspected wrongdoing, and available to WHO staff and non-staff members. The Secretariat launched a Respectful Workplace initiative in collaboration with the WHO staff associations. It is based on the results of a staff survey and includes training and awareness-raising. Furthermore, a new system of internal justice came into force later in 2016 with the creation of a Global Board of Appeal to replace the Headquarters Board of Appeal and the Regional Boards of Appeal. The new system is strengthening prevention, with a new policy on mediation and emphasis on the role of the Ombudsman's Office. Early resolution of conflicts is also privileged through the introduction of administrative reviews.

In 2016 WHO formally joined the International Aid Transparency Initiative, a voluntary, multistakeholder initiative that seeks to increase the transparency of development cooperation and increase its effectiveness in tackling poverty.

Following the early completion of workplans, for the first time the Organization started the biennium 2016–2017 with nearly all workplans approved. In addition, the new programmatic and financial report for 2014–2015 was submitted on time for the Health Assembly in 2016. This unified report better demonstrated linkages between results achieved and financial implementation.

The focus on improving the predictability, alignment, flexibility, transparency and reduced vulnerability of the financing of WHO was maintained with the convening in October 2016 of an extraordinary session of the Financing Dialogue in response to the underfunding of the Programme budget 2016–2017. As a result, several new financing commitments were made, which helped to reduce the financing gap but which to date have been insufficient to finance fully the Programme budget 2016–2017.

In the area of human resources, the first geographical mobility exercise took place in early 2016. It was the first Organization-wide corporate staffing exercise aiming at ensuring a variety of skill sets and competencies at all levels of the Organization. The exercise was qualitatively successful as it allowed lessons on the process to be learned and improvements to be recommended and made. These improvements have led to the successful launch of the second mobility compendium in January 2017. In support of geographical mobility, the Organization has also established numerous professional and personal support initiatives for mobility candidates, including hand-over procedures, language and cultural programmes, and mentoring.

A global WHO policy on gender equality in staffing was adopted. It aims to increase by 1.5% each year during the next five years the number of women in P4 positions and above. An Implementation Advisory Group for the Global Action Plan on Gender Equity has been established with representatives of management and staff association representatives from the entire organization.

Significant progress was made in relation to the construction project at headquarters when Member States adopted the Geneva buildings renovation strategy (demolition of existing temporary buildings, construction of a new annex and subsequent renovation of the existing main building) and the confirmation of financing by the Host State of the construction of the new annex through a 50-year, interest-free loan.

With regards to information technology, approval was given by the Director-General for the creation of a Global IT fund to provide a predictable mechanism to finance key strategic investments that will benefit all offices across the Organization. The report on this initiative, contained in document EBPBAC25/3, was noted by the Programme, Budget and Administration Committee of the Executive Board at its twenty-fifth meeting.

WHO's strategic communication was strengthened in 2016 through the development and launch of the WHO Strategic Communications Framework for Effective Communications. It provides planning questions, tactics and resources for a broad array of communication functions across the Organization, from public relations to advocacy, behavioural change and emergency risk communications. Focused on six principles of risk communication, the Framework can be used by communicators who have varied levels of expertise to improve their current level of practice.

Challenges and lessons learned

The financial situation of the Organization demanded strong stewardship in 2016 to cope with an unbalanced funding level across the different technical areas and a reduction in the funding of the core voluntary contributions account, all also affecting to a significant extent category 6 which depends greatly on flexible funding. Potential savings have been identified and services have been reviewed with regard to possible efficiency gains. Further close management of the financial situation as well as a plan a value-for-money plan are expected for 2017.

Since its launch at the end of 2015, the 2030 Agenda for Sustainable Development (with its 17 Sustainable Development Goals) has become a guiding force for WHO's work. Recognizing that the Goals embrace all aspects of health, the Director-General has established a global coordination team for work on the Goals, under new leadership in the Director-General's Office and across all major offices. The team has established six main lines of action, endorsed by the Executive Board, to guide Member States towards achieving the Goals, and to guide the Director-General in providing support to Member States.

Some early results are: stronger orientation of the Proposed programme budget 2018–2019 towards the Goals; orientation of the World Health Statistics report for 2017 to the six lines of action; improved communications between headquarters, regional offices and country offices; streamlined reporting on progress towards the Goals through the United Nations system (for example, on health and poverty, and on information and communication technologies); initiation of work towards a training module on health in sustainable development; placing the Goals in the WHO Global Observatory on Health Research and Development; and first steps towards aligning WHO country cooperation strategies with the Goals.

Improving performance at country level: Burundi

The WHO Country Office in Burundi experienced difficulties in accomplishing its managerial key performance indicators in 2016. When the new WHO Representative assumed his new duties in February 2016, he mobilized his staff members to implement fully WHO's accountability and internal control frameworks. To support him, a performance monitoring and assessment mission was launched, involving experts from Regional Office for Africa, an Inter-country Support Team and headquarters. The review helped the WHO Representative to improve risk and compliance management as well as accountability in administration and programme delivery. For instance, workflows and internal controls were strengthened in all enabling functions and the Country Office's responsiveness to emergencies and cooperation with key stakeholders was reinforced. As a result, the Country Office has improved its operations and performances in terms of key performance indicators.

In addition, even though the actions initiated and implemented throughout the WHO reform process were not explicitly framed against the backdrop of the 2030 Agenda for Sustainable Development, they aimed to address the issues that will position the Organization to best operationalize the close links between health and sustainable development and to respond to the growing pressures on multilateral organizations like WHO in the context of new social, political and economic realities.

Examples for the above include the WHO Country Cooperation Strategy: Guide 2016 or the Handbook for the induction of heads of WHO offices in countries, territories and areas which is currently under review, and which will include an updated chapter on the Sustainable Development Goals, universal health coverage, the WHO Health Emergencies Programme and the International Health Regulations (2005). Similarly, heads of WHO country offices were regularly provided latest information and developments on the 2030 Agenda and WHO's work in support of the Sustainable Development Goals and related perspectives.

Priorities for 2017

Given the current financial situation, a prioritization of activities is indispensable. Growing demands can align with decreasing budgets only to some extent (by increasing efficiencies) but within limits. The budget for

category 6 is expected to decrease for the biennium 2018–2019, a development that is already being responded to in 2017, particularly in view of the financial situation.

During 2017, the Organization will work on the development of a value-for-money plan with the aim of identifying potential efficiency savings across the Organization. The initiative will be driven by category 6, but the identified activities are expected to go beyond that. The plan will be submitted to the Seventy-first World Health Assembly for consideration in 2018.

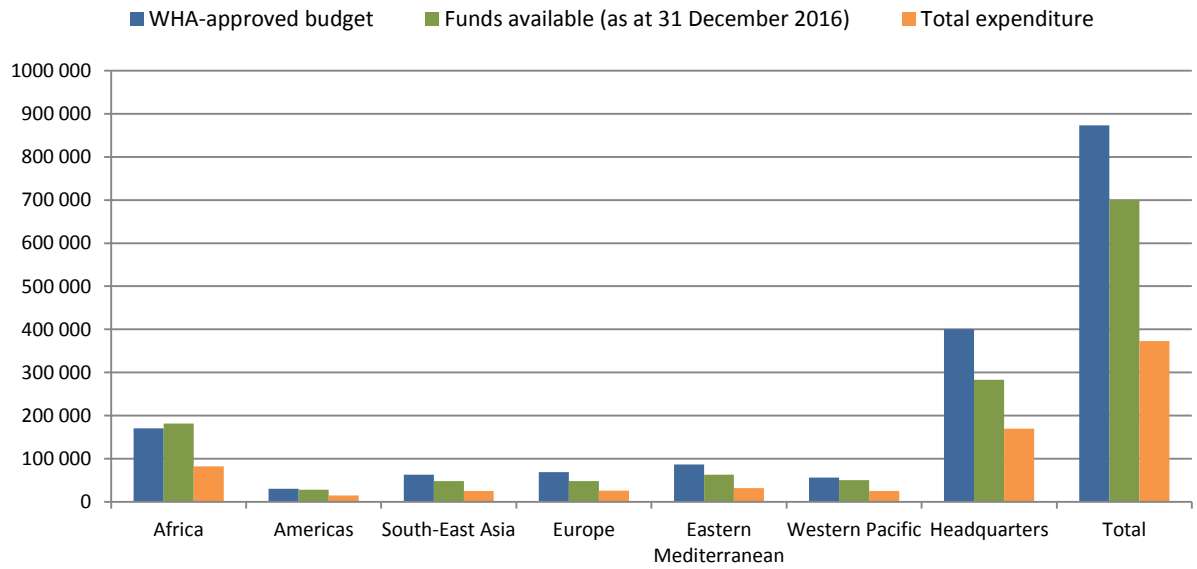
In addition, work will continue to identify concrete efficiency measures for the biennium 2016–2017 .These will be further discussed at the annual meeting of directors of administration and finance and of programme management in 2017. These and other practical measures on reprioritization of activity and salary expenses as at end-2016 by both the Director-General's Office and the General Management cluster aim at mitigating the effect of the potential overall funding gap in category 6 and the Organization as a whole.

The transition from the current administration to that of the Director-General to be appointed in May 2017 and his or her senior leadership will be the highest priority in 2017; the change may have a significant impact on the priorities for 2017.

Key figures for category 6

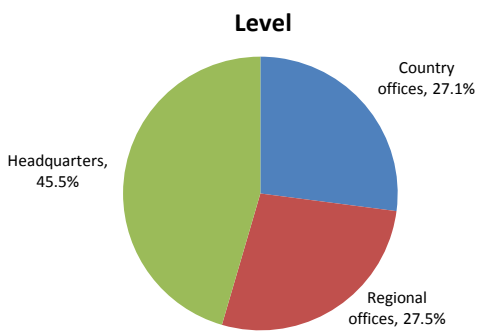
The total budget allocation for category 6 in 2016–2017 was US$ 874 million. This figure includes the post occupancy charge of US$ 140 million.[1] Available resources as at the end of 2016 were US$ 700 million or 80% of the budget allocation. Expenditure was US$ 373 million or 43% of the approved programme budget and 53% of the funds available. More funds are available in the Regional Office for Africa than allocated in the approved budget because of funding received from the Department for International Development of the United Kingdom of Great Britain and Northern Ireland and the Bill and Melinda Gates Foundation in support of the Transformation agenda of the World Health Organization Secretariat in the African Region 2015–2020. Overall funding and expenditure under this category is on track. Efforts on gaining further cost-efficiencies are continued as described in the programmatic section above.

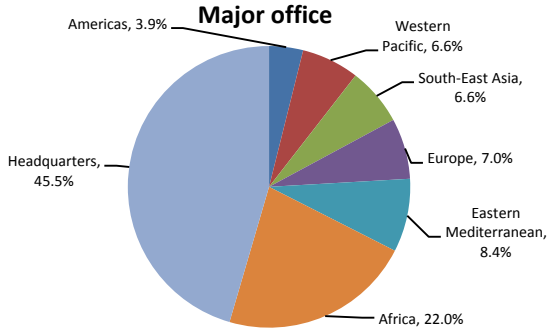
Budget and expenditure by major office

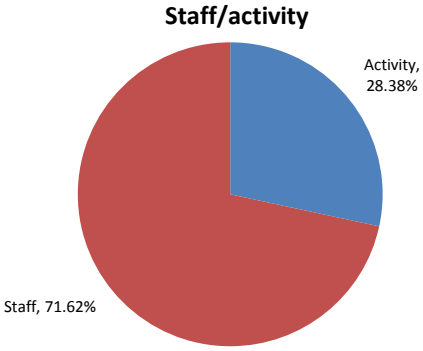


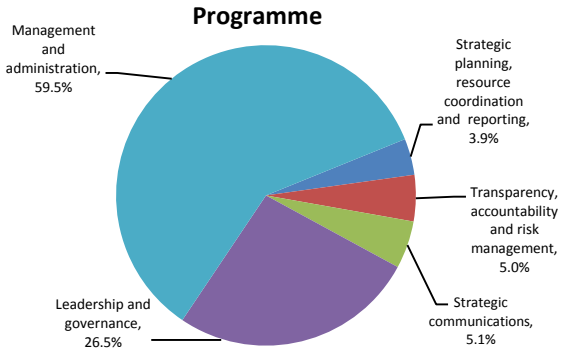
[1] Post occupancy charge is a separate cost-recovery mechanism to recover costs of administrative services directly attributable to the work of all categories.

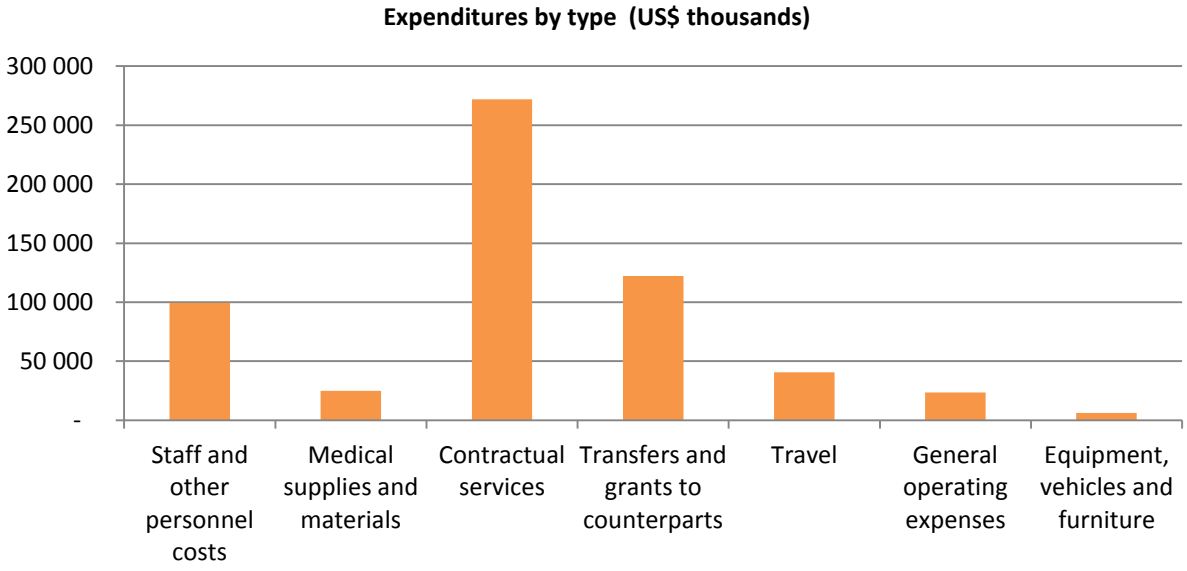
Expenditure details for the category











POLIO ERADICATION

Key achievements in 2016

WHO's role in the Global Polio Eradication Initiative is to provide technical support to countries and regions, with a particular emphasis on endemic countries and those at risk of outbreaks of wild or vaccine-related poliovirus.

WHO provides technical guidance on acute flaccid paralysis and environmental surveillance for poliovirus detection, and offers logistical support and quality assurance to the polio laboratory network. It conducts surveillance data analysis to identify programmatic gaps, gives guidance on and monitors supplementary polio immunization activities to raise population immunity and stop transmission of circulating polioviruses, and carries out outbreak response assessments. Technical support has been enhanced where necessary through surge deployments. Surveillance quality is monitored weekly through global surveillance indicator goals.

Strong progress continues to be made since the World Health Assembly called for the worldwide eradication of poliomyelitis in 1988.[1] At the time, poliomyelitis was endemic in more than 125 countries around the world and more than 350 000 children a year were paralysed for life by the poliovirus. Today, transmission of wild poliovirus is at its lowest levels ever, with endemic transmission occurring in parts of only three countries – Pakistan, Afghanistan and Nigeria (in order of burden of disease).

In 2016, 37 cases of polio were reported worldwide. Only one wild serotype (poliovirus type 1) continues to be detected; wild poliovirus type 2 was officially declared eradicated in 2015 and no cases of paralytic poliomyelitis due to wild poliovirus type 3 have been detected anywhere since November 2012. Today, more than 16 million people are walking who otherwise would have been paralysed. An estimated 1.5 million childhood deaths have

[1] Resolution WHA41.28, Global eradication of poliomyelitis by the year 2000 (http://www.who.int/ihr/polioresolution 4128en.pdf, accessed 27 March 2017).

been prevented through the systematic administration of vitamin A during polio immunization activities. The world stands on the brink of an historic global public health success.

This progress has been made possible by the global network of support and the engagement of stakeholders, first and foremost Member States. Every year, more than 20 million volunteers administer polio vaccines and other life-saving medicines to more than 400 million children worldwide. To date, the global effort to eradicate polio has saved more than US$ 27 000 million, and the global eradication of poliovirus will result in savings of an additional US$ 20 000–25 000 million, funds which can be applied to the delivery of other life-saving health interventions.

In 2016, a total of 12 outbreak response assessments were conducted in seven different countries (Democratic Republic of the Congo, Guinea, Lao People's Democratic Republic, Madagascar, Myanmar, South Sudan and Ukraine).

Consultants were deployed for a total of 1110 man-months in 2016, to support surveillance strengthening and improve the quality of supplementary immunization activities. Some 220 STOP volunteers were deployed to high-risk countries.

During 2016, WHO contributed to the implementation of 192 supplementary immunization activities with oral polio vaccine (OPV), conducted in 43 countries including endemic, high-risk and outbreak countries. More than 2000 million doses of OPV were used. A further 1.9 million doses of inactivated polio vaccine (IPV) were supplied to Nigeria, 1.4 million to Pakistan, almost 400 000 to India and 100 000 to Afghanistan. Guidelines on outbreak preparedness and response, classification of vaccine-derived polio viruses and field investigations were produced during 2016.

Field surveillance reviews were conducted in Afghanistan, Guinea, Nigeria and Pakistan, as well as in other West African countries. Desk reviews for the high-risk countries were conducted twice in the course of the year.

Global Polio Eradication Initiative partners continue to engage closely with all Member States and the broader international development community in an effort to secure the additional US$ 1 300 million required to achieve a lasting polio-free world.

Challenges and lessons learned

Progress towards polio eradication is fragile. This was underscored in August 2016 with the confirmation of four new cases of paralytic poliomyelitis due to wild poliovirus type 1 in Borno State, north-eastern Nigeria. These were the first cases reported in the African Region since July 2014. This confirms the urgent need to ensure the rapid and sustainable achievement of a polio-free world, as emphasized in resolution WHA68.3 (2015), in which the Health Assembly urged Member States to fully finance and implement the Polio Eradication and Endgame Strategic Plan (the Endgame). In order to effectively guide and oversee progress towards interrupting poliovirus transmission, the scope of the Global Polio Eradication Initiative Independent Monitoring Board is currently being revised to focus more on achieving this critical objective.

The case of Nigeria underscores the importance of maintaining high-level acute flaccid paralysis surveillance. The Government of Nigeria immediately launched an aggressive outbreak response, conducting several rounds of supplementary immunization activities using bivalent OPV. The outbreak was declared a national public health emergency, and Nigeria was put back on the list of countries in which polio is endemic. Furthermore, health ministers at the Regional Committee for Africa declared the polio outbreak to be a regional public health emergency for

Polio in Afghanistan: reaching every child in conflict-affected and security-compromised settings

Between July and December 2016, more than 50 000 children were vaccinated with OPV at the Torkham border in Nangarhar, the busiest border crossing in Afghanistan, by vaccination teams supported by the Ministry of Public Health, WHO and UNICEF. Polio teams are working at 17 border points to ensure that all children entering Afghanistan are immunized against polio. More than 280 permanent transit teams vaccinate children who travel in and out of security-compromised areas and children travelling to other destinations to ensure that every child on the move receives two drops of the oral polio vaccine.

countries in the Lake Chad subregion, generating a wider outbreak response covering Cameroon, the Central African Republic, Chad and Niger, as well as Nigeria.

Improved access in some conflict-affected areas was utilized to rapidly raise immunity among newly accessible populations. Additional measures were taken to heighten the sensitivity of subnational surveillance. The Brazzaville Initiative was launched to improve the sensitivity of surveillance in Nigeria and a number of other high-risk African countries.

The outbreak response was coordinated in the context of the humanitarian emergency in the region, and the polio infrastructure was able to support the delivery of other critical health needs, such as measles campaigns. Nigeria continues to have strong immunity to the poliovirus in most locations but these cases underscore the risk posed by low-level undetected transmission, and the urgent need to strengthen subnational surveillance everywhere.

The emergency operations centres in Afghanistan and Pakistan continued to strengthen collaboration and government ownership in both countries, with priorities set through strong national emergency action plans. The centres in the two countries also worked together to reach high-risk groups along the border, in response to increasing evidence that mobile populations are the main vehicle by which the virus is circulating. The number of permanent transit points was increased, and cross-border teams, permanent transit teams and special nomadic teams are helping to reach children on the move.

Although the progress seen in 2016 is heartening, there is a real risk of backsliding in these countries and elsewhere if performance does not continue to improve in 2017.

The IPV supply situation continues to deteriorate, with manufacturers encountering challenges that impede delivery of the contracted IPV supply. Available supply is being allocated globally using a risk-based approach that is regularly reviewed and revised by WHO and partners. The Global Polio Eradication Initiative continues to work with other partners and manufacturers to further alleviate the supply constraint.

Progress is being made by harnessing the lessons learned in polio eradication. Furthermore, technical best practice documents are being drafted that can be used to train staff in the field for other vaccine-preventable diseases.

Global and national resource mobilization strategies have been developed and implemented, and continue to be updated and adjusted to respond to changing circumstances and new opportunities, risks and challenges. Very importantly, financial resources have increased and past pledges continued to be materialized.

Priorities for 2017

It is expected that in 2017 the number of supplementary immunization activities in Member States will decrease, with the exception of the three countries in which the disease is endemic − Afghanistan, Pakistan and Nigeria. As those activities are scaled down, the number of polio-funded staff is also expected to decrease.

The withdrawal of the type 2 component of OPV has been fully accomplished in all countries and will, therefore, no longer be a priority for the Global Polio Eradication Initiative.

Priorities for 2017 include:

- interrupting transmission of polio in the three remaining endemic countries;
- ensuring appropriate and timely outbreak response in relation to wild and vaccine-derived polio outbreaks;
- maintaining the polio-free status of countries which are no longer endemic;
- supporting countries' efforts to in mitigate the negative impact of the global IPV shortage;

- maintaining focus on and monitoring sensitivity of acute flaccid paralysis surveillance at national and subnational levels;
- maintaining polio laboratory network performance;
- implementing the environmental surveillance expansion plan;
- coordinating implementation of activities in line with the requirements of WHO's global action plan for poliovirus containment (GAPIII);
- continuing transition planning and implementation to address the implications for the polio-related human resources in WHO, the consequences of the polio transition on other related programmes, and the need to maintain core post eradication polio-related functions; and
- addressing complacency issues.

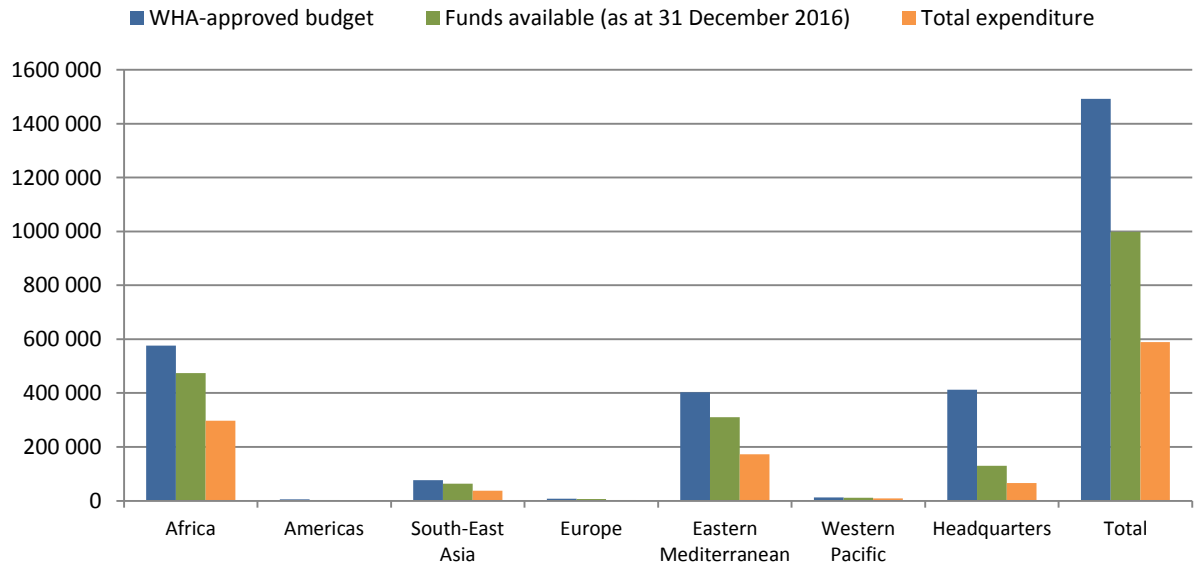
The Global Polio Eradication Initiative will work with donors and partners to ensure that these priority areas are fully funded.

Key figures for polio eradication

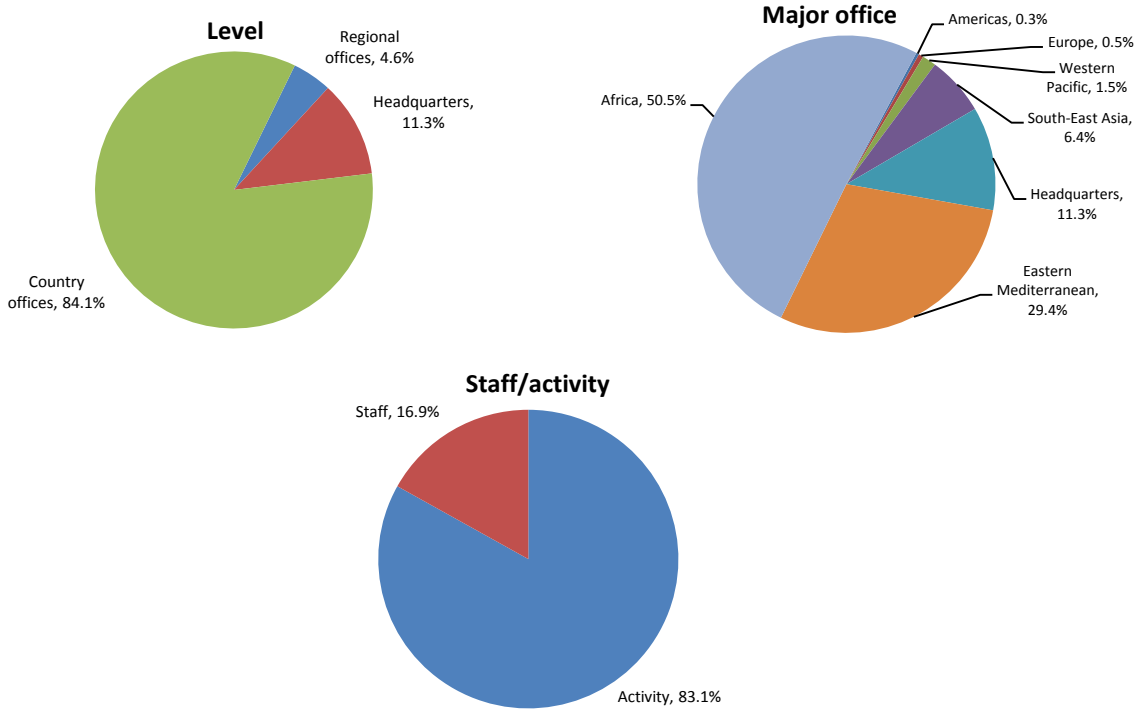
The total budget for polio eradication was US$ 1492 million. Available resources as at the end of 2016 were US$ 999 million or 67% of the budget. Expenditure was US$ 589 million or 39% of the budget and 59% of the funds available. Overall, implementation was on track across all polio workplans with the exception of transition planning, which was lower than intended.

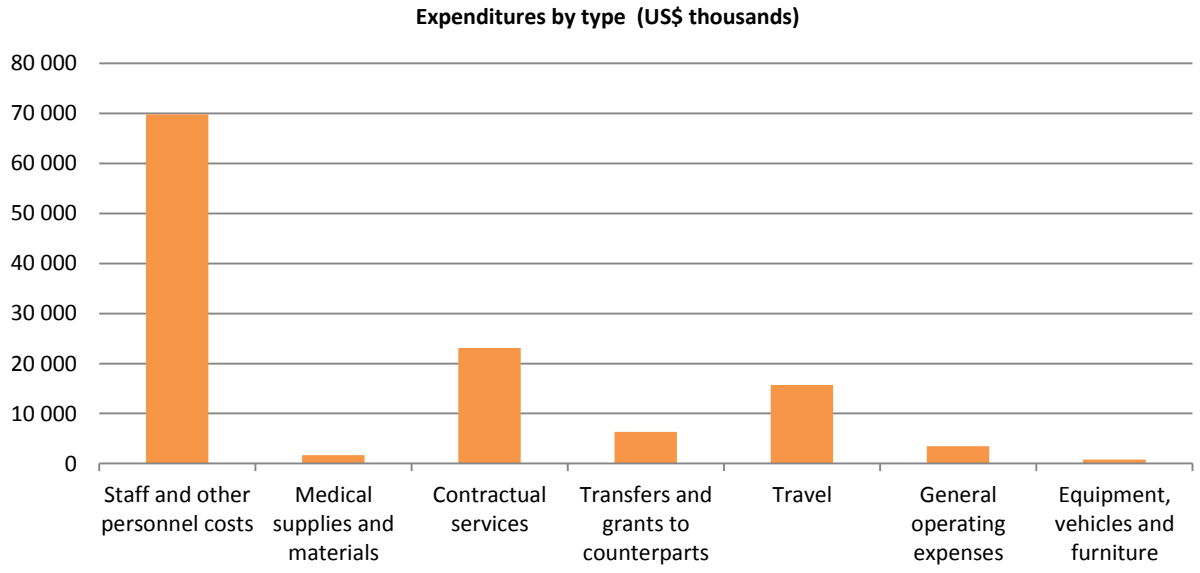
As the Global Polio Eradication Initiative is scaled down, polio resources, will decrease rapidly over the next few years and will ultimately stop. As a part of the transitioning process, essential functions that will need to be sustained to maintain a polio-free world are being defined. Furthermore, priority areas in public health that could benefit from the polio assets are being identified. The generation of adequate resources from non-Global Polio Eradication Initiative partners, including from governmental sources, to support work in these priority non-polio areas is a critical element of the transitioning process.

Budget and expenditure by major office



Expenditure details for polio eradication





SECTION 2. STATEMENT OF INTERNAL CONTROL

Scope of responsibility

As Director-General of the World Health Organization, I am accountable to the World Health Assembly for the administration of WHO and for the implementation of WHO programmes. Under Financial Regulation XII, I am accountable for maintaining a sound system of internal control, including internal audit and investigation, to ensure the effective and efficient use of the resources of WHO and the safeguarding of its assets.

Purpose of internal control

Internal control is designed to reduce and manage rather than eliminate the risk of failure to achieve the Organization's aims, objectives and related policies. Therefore, it can provide reasonable but not absolute assurance of effectiveness. It is based on an ongoing process designed to identity the principal risks, evaluate the nature and extent of those risks and manage them efficiently, effectively and economically.

Internal control is a key role of management and an integral part of the overall process of managing operations. As such it is the responsibility of WHO management at all levels to:

- establish a control environment and culture that promotes effective internal control;
- identify and assess risks that may affect the achievement of objectives including the risk of fraud and corruption;
- specify and propose policies, plans, operating standards, procedures, systems and other control activities to minimize, mitigate and/or limit the risks associated with exposure identified;
- ensure an effective flow of information and communication so that all WHO personnel have the information they need to fulfill their responsibilities; and
- monitor and effectiveness of internal control.

On an operational level, WHO's internal control system operates continually at all levels within the Organization through internal control processes to ensure the above objectives.

My first statement on WHO's internal control processes, as described above, applies for the year ended 31 December 2016, and up to the date of the approval of the Organization's 2016 financial statements.

WHO's operating environment

WHO operates in over 150 countries, sometimes in challenging operating environments. This operating environment may expose WHO to situations where there is a high level of inherent risk, including in terms of the security of employees and its ability to maintain high standards of internal control. WHO (and the UN in general) monitors the security situation in each country in which it operates, taking strategic decisions where necessary to adapt WHO's operations and limit the risk exposure of its personnel. All risks at an office level are captured in a formal risk register, subject to regular review by managers and escalated to more senior levels for attention as required.

The Internal Control Framework and risk management

The Internal Control Framework was issued in November 2013; the WHO Accountability Framework in March 2015 and the Corporate Risk Management Policy in November 2015. The Internal Control Self-Assessment checklists were completed in 2015 by each budget centre across the Organization. In 2016, the checklist was updated and rolled out using a new user-friendly electronic platform. Improved communications on WHO's sources and uses of funds, through the WHO web portal, also supports better control with respect to WHO's budget monitoring.

The objectives of WHO's risk management approach are twofold: to support informed decision-making and to embed risk management in corporate operational processes. A corporate risk management policy has been

established that includes tools to identify, assess, respond to and monitor risks in a structured, systemic and prompt manner.

This includes a planned approach to risks, including risk acceptance levels, and accountability for risk mitigation. It provides senior management with appropriate information about risks and establishes an effective reporting process. The policy firmly embeds risk management in WHO's strategic and operational planning and budgeting cycles, as well as in the accountability and internal control frameworks. An annual risk report is presented to the Director-General and Member States through the Executive Board.

The corporate risk management policy complements the bottom-up phase of risk identification and prioritization with a top-down phase of validation and escalation.

As the Director-General of the Organization, I have the overall responsibility for assessing risks associated with the implementation of programmes and projects and the overall operations of the Organization.

Review of effectiveness of internal controls

My review of the effectiveness of WHO's system of internal controls is mainly based on the following:

(a) An annual 'Letter of Representation' is signed by all Regional Directors and Assistant Directors-General confirming the importance in ensuring adequate internal controls are in place as well as many other assurances on key internal controls.

(b) The Internal Control Self-Assessment checklist is completed and submitted by all budget centre managers – 56 in HQ and 166 in the regions, including all WHO Representatives. This reviews all key controls and each budget centre manager rates compliance to those key statements.

(c) Reports issued by the Office of Internal Oversight (IOS) and the reports of the WHO External Auditor, which provide independent and objective information on compliance and control effectiveness, together with recommendations for improvement.

(d) The Independent Expert Oversight Advisory Committee (IEOAC), which reviews all audit reports, risk reports, as well as financial reports and other information relevant to the overall control framework. Reports of the IEOAC are provided to me, and to the Executive Board, with the purpose of advising upon risk management, financial and internal control matters, identifying any potential areas for improvement, and providing advice on how to address weaknesses.

Significant control and risk issues noted

Following the completion of internal control checklists and the risk register by each WHO budget centre, the consolidated findings were reviewed by the department of Compliance Risk and Ethics (CRE) and the findings presented to the Global Policy Group (GPG). I have concluded that the most significant risks currently facing the Organization are as follows:

- full financing of the Organization's approved programme budget;
- fully financing the new Emergency Programme, coupled with the risk of a major emergency before the new program is fully operational;
- funding of long term liabilities, notably the after service healthcare costs;
- business continuity impacts arising from the Director-General election/new Director-General (and new senior team) taking office;
- polio transition, notably risks to those programs and/or offices most dependent on polio funds;
- business continuity risks linked to a major incident affecting WHO operations (for example, natural disaster or major terrorist attack);
- failure to prevent and effectively address fraud/corruption; and

- cyber security risks (hacking of digital assets, leading to data loss or theft, unavailability of services, financial or reputational damage).

For each of the above risks, I have discussed mitigating actions with Assistant Directors-General and Regional Directors and assigned responsibilities to ensure that such actions are implemented.

Critical findings from internal audit (IOS) reports were reported to member states in 2016 based upon the findings from audits conducted during 2015, and noted particular concerns in respect of security in some offices (compliance with UN standards), use of "non-staff" contracts, such as Special Service Agreements (SSAs), and controls over use of Direct Financial Contribution (DFC) in some offices. IOS will report separately the results of their 2016 work, which is expected to emphasize continued concerns in some offices in these same areas, despite good improvements made in other areas.

The Independent Expert Oversight Advisory Committee (IEOAC) report for 2016 emphasized the need to ensure that risk management becomes an effective and integral part of the management process; to ensure adequate funding for ASHI and Polio unfunded liabilities, the need to ensure adequate governance is in place for the IT projects; and raised concerns over financing for emergency reform.

Statement

I believe that internal control is operating effectively. However, no matter how well designed, has inherent limitations – including the possibility of circumvention – and therefore can provide only reasonable assurance. Furthermore, because of changes of conditions, the effectiveness of internal control may vary over time.

I am committed to addressing any weaknesses in internal controls noted during the year brought to my attention.

Based on the above, I conclude that, to the best of my knowledge and information, there are no material weaknesses which would prevent the external auditor from providing an unqualified opinion on the Organization's financial statements nor are there other significant matters arising which would need to be raised in the present document for the year ended 31 December 2016 and up to the date of approval of the financial statements.

Margaret Chan

Director General

Geneva, 4 April 2017

SECTION 3. FINANCIAL REPORT including audited financial statements for 2016

Certification of the financial statements for the year ended 31 December 2016

In accordance with Article 34 of the Constitution and Financial Regulation XIII of the World Health Organization, attached are the financial statements for the year ended 31 December 2016. The financial statements, accounting policies and notes to the financial statements have been prepared in compliance with International Public Sector Accounting Standards (IPSAS). The financial statements are also prepared according to the Financial Regulations of the World Health Organization and its Financial Rules. The financial statements and notes have been audited by the Organization's External Auditor, the Republic of the Philippines Commission on Audit, whose opinion is included in this report.

Although the Organization has adopted an annual financial reporting period as stipulated in the revised Financial Regulation XIII,[1] the budgetary period remains a biennium (Financial Regulation II). Therefore, for the purposes of making comparisons between the actual expenses and the planned budget, the biennium's budget is set against two years of annual expenses. The Statement of Comparison of Budget and Actual Amounts (Statement V) provides this comparison by category.

In addition to the General Fund (the programme budget), two other fund groups are included in WHO's financial statements: Member States – other, and the Fiduciary Fund. Details of the revenue and expenses for each of these three main fund groups can be found in Schedule I of the report.

In 2016, the Organization provided services to five other entities: The Trust Fund for the Joint United Nations Programme on HIV/AIDS (UNAIDS), the International Drug Purchase Facility (UNITAID), the International Agency for Research on Cancer (IARC), the International Computing Centre (ICC), and the Staff Health Insurance (SHI). Separate financial statements are prepared for each entity, and these are subject to separate external audits. The funds managed by WHO on behalf of these entities[2] are included within the Statement of Financial Position (Statement I).

The financial statements for the year ended 31 December 2016, together with the notes to the statements and supporting schedules I and II, have been reviewed and approved.

Nicholas R. Jeffreys
Comptroller

Dr Margaret Chan
Director General

Geneva, 4 April 2017

[1] See resolution WHA62.6 (2009).
[2] Excludes IARC where funds are not managed by WHO.

Letter of transmittal

Republic of the Philippines
COMMISSION ON AUDIT
Commonwealth Avenue, Quezon City, Philippines

LETTER OF TRANSMITTAL

3 April 2017

Dear Sir/Madam,

I have the honour to present to the Seventieth World Health Assembly, the External Auditor's report and opinion on the financial statements of the World Health Organization for the financial year ended 31 December 2016.

I record my appreciation to the World Health Assembly for the honor and privilege to serve as External Auditor of WHO.

Yours sincerely,

Michael G. Aguinaldo
Chairperson, Commission on Audit
Republic of the Philippines
External Auditor

The President of the Seventieth World Health Assembly
World Health Organization
Geneva, Switzerland

Opinion of the External Auditor

Republic of the Philippines
COMMISSION ON AUDIT
Commonwealth Avenue, Quezon City, Philippines

INDEPENDENT AUDITOR'S REPORT

To the World Health Assembly

Opinion

We have audited the financial statements of the World Health Organization (WHO), which comprise the statement of financial position as at 31 December 2016, and the statement of financial performance, statement of changes in net assets/equity, statement of cash flow, and statement of comparison of budget and actual amounts for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the WHOas at 31 December 2016, and its financial performance,changes in net assets/equity, cash flow, and comparison of budget and actual amounts for the year then ended, in accordance with International Public Sector Accounting Standards (IPSAS).

Basis for Opinion

We conducted our audit in accordance with International Standards on Auditing (ISAs) issued by the International Auditing and Assurance Standards Board. Our responsibilities under those standards are described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the WHOin accordance with the ethical requirements that are relevant to our audit of the financial statements, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Other Information

Management is responsible for the other information. The other information comprises the information included in the WHO mid-term programmatic and financial report for 2016-2017 including audited financial statements for 2016, but does not include the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially

inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with IPSAS, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing the WHO's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the WHOor to cease operations, or has no realistic alternative but to do so.

Those charges with governance are responsible for overseeing the WHO's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatements, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economics decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with ISAs, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the WHO's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.

- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty

exists related to events or conditions that may cast significant doubt on the WHO's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Report on Other Legal and Regulatory Requirements

Further, in our opinion, the transactions of the WHO that have come to our notice or which we have tested as part of our audit have, in all significant respects, been in accordance with the WHO Financial Regulations.

In accordance with Regulation XIV of the WHO Financial Regulations, we have also issued a long-form report on our audit of the WHO.

Michael G. Aguinaldo
Chairperson, Commission on Audit
Republic of the Philippines
External Auditor

Quezon City, Philippines
3 April 2017

Financial statements

World Health Organization

Statement I. Statement of Financial Position

As at 31 December 2016
(In thousands of US dollars)

Description	Notes	31 December 2016	31 December 2015 (restated)
Current assets			
Cash and cash equivalents	4.1	436 890	431 318
Short-term investments	4.2	2 717 079	2 754 259
Receivables – current	4.3	871 808	866 016
Staff receivables	4.4	10 243	10 702
Inventories	4.5	39 554	53 152
Prepayments and deposits	4.6	9 615	12 474
Total current assets		4 085 189	4 127 921
Non-current assets			
Receivables – non-current	4.3	207 278	197 472
Long-term investments	4.2	95 846	93 900
Property, plant and equipment	4.7	70 964	65 124
Intangibles	4.8	4 788	2 806
Total non-current assets		378 876	359 302
TOTAL ASSETS		**4 464 065**	**4 487 223**
LIABILITIES			
Current liabilities			
Contributions received in advance	4.9	68 346	57 079
Accounts payable	4.1	41 129	53 597
Staff payable	4.11	2 005	2 156
Accrued staff benefits - current	4.12	46 648	46 722
Deferred revenue	4.13	379 908	339 418
Financial liabilities	4.2	24 668	53 177
Other current liabilities	4.14	63 348	108 747
Inter-entity liabilities	4.15	1 020 690	1 008 911
Long-term borrowings – current	4.16	583	
Total current liabilities		**1 647 325**	**1 669 807**
Non-current liabilities			
Long-term borrowings – non-current	4.16	33 139	27 477
Accrued staff benefits – non-current	4.12	1 259 809	1 143 843
Deferred revenue – non-current	4.13	207 278	197 472
Total non-current liabilities		**1 500 226**	**1 368 792**
TOTAL LIABILITIES		**3 147 551**	**3 038 599**
NET ASSETS/EQUITY			
General Fund	6.1	2 168 181	2 209 331
Member States – other	6.2	(894 760)	(803 581)
Fiduciary funds	6.3	43 093	42 874
TOTAL NET ASSETS/EQUITY		**1 316 514**	**1 448 624**
TOTAL LIABILITIES AND NET ASSETS/EQUITY		**4 464 065**	**4 487 223**

The section on significant accounting policies and the accompanying notes form part of the financial statements.

World Health Organization

Statement II. Statement of Financial Performance

For the year ended 31 December 2016
(In thousands of US dollars)

Description	Notes	31 December 2016	31 December 2015 (restated)
REVENUE	5.1		
Assessed contributions		470 036	462 651
Voluntary contributions		1 751 811	1 838 443
Voluntary contributions in-kind and in-service		87 749	129 913
Reimbursable procurement		25 294	26 170
Other revenue		29 186	17 965
Total revenue		**2 364 076**	**2 475 142**
EXPENSES	5.2		
Staff costs		910 791	910 462
Medical supplies and materials		244 462	265 481
Contractual services		675 720	744 096
Transfers and grants		249 210	311 717
Travel		200 331	233 539
General operating expenses		131 785	191 715
Equipment, vehicles and furniture		55 762	67 716
Depreciation and amortization		2 836	2 433
Total expenses		**2 470 897**	**2 727 159**
Finance revenue	5.3	62 682	21 042
TOTAL (DEFICIT) / SURPLUS FOR THE YEAR		**(44 139)**	**(230 975)**

The section on significant accounting policies and the accompanying notes form part of the financial statements.

World Health Organization

Statement III. Statement of Changes in Net Assets/Equity

For the year ended 31 December 2016
(In thousands of US dollars)

Description	Notes	31 December 2016	Surplus/(deficit)	Other adjustments (refer to note 4.12)	31 December 2015 (restated)
General Fund	6.1	2 168 181	(41 150)		2 209 331
Member States - other	6.2	(894 760)	(3 208)	(87 971)	(803 581)
Fiduciary Fund	6.3	43 093	219		42 874
TOTAL NET ASSETS/EQUITY		**1 316 514**	**(44 139)**	**(87 971)**	**1 448 624**

The section on significant accounting policies and the accompanying notes form part of the financial statements.

World Health Organization

Statement IV. Statement of Cash Flow

For the year ended 31 December 2016
(In thousands of US dollars)

Description	31 December 16	31 December 2015 (restated)
CASH FLOWS FROM OPERATING ACTIVITIES		
TOTAL (DEFICIT) / SURPLUS FOR THE YEAR	(44 139)	(230 975)
Depreciation and amortization	2 836	2 433
Unrealized (gains)/losses on investments	(989)	1 003
Unrealized (gains)/losses on revaluation of long-term borrowings	808	525
(Increase)/decrease in accounts receivable – current	(5 792)	(32 776)
(Increase)/decrease in staff receivables	459	(256)
(Increase)/decrease in inventories	13 598	(2 735)
(Increase)/decrease in prepayments	2 859	(12 091)
(Increase)/decrease in accounts receivable – non-current	(9 806)	84 817
Increase/(decrease) in contributions received in advance	11 267	(4 628)
Increase/(decrease) in accounts payable	(12 468)	22 018
Increase/(decrease) in staff payable	(151)	379
Increase/(decrease) in accrued staff benefits – current	(74)	(9 101)
Increase/(decrease) in deferred revenue	40 490	(27 425)
Increase/(decrease) in other current liabilities	(45 399)	66 030
Increase/(decrease) in inter-entity liabilities	11 779	(78 647)
Increase/(decrease) in accrued staff benefits – non-current	27 995	38 224
Increase/(decrease) in deferred revenue – non-current	9 806	(84 817)
Net cash flows from operating activities	**3 079**	**(268 022)**
CASH FLOWS FROM INVESTING ACTIVITIES		
(Increase)/decrease in short-term investments	36 702	59 071
(Increase)/decrease in long-term investments	1 475	(22 616)
Increase/(decrease) in financial liabilities	(30 463)	28 281
(Increase)/decrease in property, plant and equipment	(8 044)	(3 241)
(Increase)/decrease in intangibles	(2 614)	(327)
Net cash flows from investing activities	**(2 944)**	**61 168**
CASH FLOWS FROM FINANCING ACTIVITIES		
Increase/(decrease) in long-term borrowings – current	583	
Increase/(decrease) in long-term borrowings – non-current	4 854	5 281
Net cash flows from financing activities	**5 437**	**5 281**
Net increase/(decrease) in cash and cash equivalents	**5 572**	**(201 573)**
Cash and cash equivalents at beginning of the year	**431 318**	**632 891**
Cash and cash equivalents at end of the year	**436 890**	**431 318**

The section on significant accounting policies and the accompanying notes form part of the financial statements.

World Health Organization

Statement V. Statement of Comparison of Budget and Actual Amounts

For the year ended 31 December 2016
(In thousands of US dollars)

Description	Programme budget 2016–2017[1]	Revised Programme budget 2016–2017[1]	Expenses 2016	Difference – Programme budget and expenses	Implementation (%)
Categories					
1 Communicable diseases	765 000	783 500	293 910	489 590	38%
2 Noncommunicable diseases	339 900	376 000	120 899	255 101	32%
3 Promoting health through the life-course	381 700	381 700	157 379	224 321	41%
4 Health systems	594 500	594 500	234 085	360 415	39%
5 Preparedness, surveillance and response	379 700				
Emergencies		485 100	139 597	345 503	29%
6 Corporate services/enabling functions	733 500	733 500	319 032	414 468	43%
Polio, Outbreak and Crisis Response and Special Programmes	1 190 600	2 316 636	917 283	1 399 353	40%
Total	**4 384 900**	**5 670 936**	**2 182 185**	**3 488 751**	**38%**
Basis differences					
Tax Equalization Fund expenses			16 740		
Special arrangements			46 100		
Other non-programme budget utilization			(14 920)		
Total basis differences			**47 920**		
Timing differences					
Programme budget expenses for prior periods			80 275		
Total timing differences			**80 275**		
Total expenses – General Fund			**2 310 380**		
Entity differences					
Expenses under Common Fund, Enterprise Fund, Special Purpose Fund, and Fiduciary Fund			72 868		
In-kind/in-service expenses			87 649		
Total entity differences			**160 517**		
Total expenses as per the Statement of Financial Performance (Statement II)			**2 470 897**		

The section on significant accounting policies and the accompanying notes form part of the financial statements.

[1] See resolution WHA 68.1 (2015) and decision WHA69(9) (2016).

Notes to the financial statements

1. Basis of preparation and presentation

The financial statements of the World Health Organization have been prepared in accordance with the International Public Sector Accounting Standards (IPSAS). They have been prepared using the historical cost convention. Investments and loans, however, are recorded at fair value or amortized cost. Where a specific matter is not covered by IPSAS, the appropriate International Financial Reporting Standards (IFRS) have been applied.

These financial statements have been prepared under the assumption that WHO is a going concern, and will meet its mandate for the foreseeable future (IPSAS 1-Presentation of Financial Statements).

These financial statements are presented in United States dollars and all values are rounded to the nearest thousands, also denoted as US$ thousands (US$ 000's).

Functional currency and translation of foreign currencies

Foreign currency transactions are translated into United States dollars at the prevailing United Nations Operational Rates of Exchange, which approximates to the exchange rates at the date of the transactions. The Operational Rates of Exchange are set once a month, and revised mid-month if there are significant exchange rate fluctuations relating to individual currencies.

Assets and liabilities in currencies other than United States dollars are translated into United States dollars at the prevailing United Nations Operational Rates of Exchange year-end closing rate. The resulting gains or losses are accounted for in the Statement of Financial Performance.

The non-United States dollar denominated assets and liabilities in the investment portfolios are translated into United States dollars at the month-end closing rate used by the custodian.

Materiality and the use of judgments and estimates

Materiality[1] is central to WHO's financial statements. The Organization's process for reviewing accounting materiality provides a systematic approach to the identification, analysis, evaluation, endorsement and periodic review of decisions taken involving the materiality of information, spanning a number of accounting areas. The financial statements include amounts based on judgments, estimates and assumptions by management. Changes in estimates are reflected in the period in which they become known.

Financial statements

In accordance with IPSAS 1, a complete set of financial statements has been prepared as follows:

- Statement of Financial Position;
- Statement of Financial Performance;
- Statement of Changes in Net Assets/Equity;
- Statement of Cash Flow;
- Statement of Comparison of Budget and Actual Amounts; and
- Notes to the financial statements, comprising a description of the basis of preparation and presentation of the statements, a summary of significant accounting policies, and other relevant information.

[1] Omissions or misstatements of items are material if they could, individually or collectively, influence the decisions or assessments of users made on the basis of the financial statements.

2. Significant accounting policies

2.1 Cash and cash equivalents

Cash and cash equivalents are held at nominal value and comprise cash on hand, cash at banks, collateral deposits, commercial paper, money market funds and short-term bills and notes. All investments that have a maturity of three months or less from the date of acquisition are included as cash and cash equivalents. This includes cash and cash equivalents held in the portfolios managed by external investment managers.

2.2 Investments and financial instruments

Financial instruments are recognized when WHO becomes a party to the contractual provisions of the instrument until such time as the rights to receive cash flows from those assets have expired or have been transferred and the Organization has transferred substantially all the risks and rewards of ownership. Investments can be classified as being: (i) financial assets or financial liabilities at fair value through surplus or deficit; (ii) held-to-maturity; (iii) available-for-sale; or (iv) bank deposits and other receivables. All purchases and sales of investments are recognized on the basis of their trade date.

Financial assets or financial liabilities at fair value through surplus or deficit are financial instruments that meet either of the following conditions: (i) they are held-for-trading; or (ii) they are designated by the entity upon initial recognition at fair value through surplus or deficit.

Financial instruments in this category are measured at fair value and any gains or losses arising from changes in the fair value are accounted for through surplus or deficit and included within the Statement of Financial Performance in the period in which they arise. All derivative instruments, such as swaps, currency forward contracts or options are classified as held-for-trading except for designated and effective hedging instruments as defined under IPSAS 29 (Financial Instruments: Recognition and Measurement). Financial assets in the externally managed portfolios designated upon initial recognition as at fair value through surplus or deficit are classified as current assets or non-current assets according to the time horizon of the investment objectives of each portfolio. If the time horizon is less than or equal to one year, they are classified as current assets, and if it is more than one year, they are classified as non-current assets.

Held-to-maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity dates that WHO has both the intention and the ability to hold to maturity. Held-to-maturity investments are stated at amortized cost using the effective interest rate method, with interest revenue being recognized on an effective yield basis in the Statement of Financial Performance.

Available-for-sale investments are classified as being available-for-sale where WHO has not designated them either as held-for-trading or as held-to-maturity. Available-for-sale items are stated at fair value (including transaction costs that are directly attributable to the acquisition of the financial asset) with value changes recognized in net assets/equity. Impairment charges and interest calculated using the effective interest rate method is recognized in the Statement of Financial Performance. As at 31 December 2016, no available-for-sale financial assets were held by the Organization.

Bank deposits and other receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. Accrued revenue related to interest, dividends and pending cash to be received from investments are included herein. Bank deposits and other receivables are stated at amortized cost calculated using the effective interest rate method, less any impairments. Interest revenue is recognized on the effective interest rate basis, with the exception of short-term receivables for which the recognition of interest would be immaterial.

Other financial liabilities include payables and accruals relating to investments and are recognized initially at fair value and subsequently measured at amortized cost using the effective interest rate method, with the exception of short-term liabilities for which the recognition of interest would be immaterial.

2.3 Accounts receivable

Accounts receivable are non-derivative financial assets with fixed or determinable payments that are not traded in an active market. Current receivables are for amounts due within 12 months of the reporting date, while non-current receivables are those that are due more than 12 months from the reporting date of the financial statements.

Voluntary accounts receivable are recognized based on the payment terms specified in a binding agreement between WHO and the contributor. Where no payment terms are specified, the full amount receivable is recognized as currently due. Assessed accounts receivable are recognized annually, at the beginning of the year as per the assessments approved by the Health Assembly. Accounts receivable are recorded at their estimated net realizable value and not discounted as the effect of discounting is considered immaterial.

An allowance for doubtful accounts receivable is recognized when there is a risk that the receivable may be impaired. Changes in the allowance for doubtful accounts receivable are recognized in the Statement of Financial Performance (Statement II).

2.4 Inventories

WHO recognizes medicines, vaccines, humanitarian supplies, and publications as part of its inventory. Inventories are valued taking the lower amount of (i) cost or (ii) net realizable value, using a weighted average basis. A physical stock count is conducted once every year. Packaging, freight and insurance charges are allocated based on the total value of inventory purchases and added to the inventory value.

Where inventories have been acquired through a non-exchange transaction (i.e. inventories were donated as an in-kind contribution), the value of inventory is determined by reference to the donated goods' fair value at the date of acquisition.

When inventories are sold, exchanged or distributed, their carrying amount is recognized as an expense.

2.5 Prepayments and deposits

Prepayments relate to amounts paid to suppliers for goods or services not yet received. Deposits relate to amounts paid as security for the leasing of office space. Deposits and prepayments are recorded at cost.

2.6 Property, plant and equipment

Property, plant and equipment with a value greater than US$ 5000 are recognized as non-current assets in the Statement of Financial Position. Property, plant and equipment are stated at historical cost, less accumulated depreciation and any impairment losses. Property, plant and equipment acquired through a non-exchange transaction are recognized at fair value at the date of acquisition. WHO considers all assets of this type to be non-cash generating.

Depreciation is calculated on a straight-line basis over the asset's useful life except for land, which is not subject to depreciation. Property, plant and equipment are reviewed annually for impairment to ensure that the carrying amount is still considered to be recoverable. The estimated useful lives of the asset classes that make up property, plant and equipment are provided in the table below.

Asset class	Estimated useful life (in years)
Land	N/A
Buildings – permanent	60
Buildings – mobile	5
Furniture, fixtures and fittings	5
Vehicles and transport	5
Office equipment	3
Communications equipment	3
Audio visual equipment	3
Computer equipment	3
Network equipment	3
Security equipment	3
Other equipment	3

Improvements are capitalized over the remaining life of the asset when the improvement results in an increase in the useful life of the asset or adds usable space. The residual value of the asset and the cost of the improvement will be amortized over the adjusted useful life (remaining life). Normal repair and maintenance costs are expensed in the year where the costs are incurred.

A transitional provision, which ends on 31 December 2016, has been applied for the initial recognition of property, plant and equipment that were purchased or donated before 1 January 2012. Land and building assets were recognized by location commencing from 1 January 2012 to 31 December 2016.

As allowed under the transitional provision, property, plant and equipment acquired during 2016 other than land and building assets were expensed at the date of purchase and have not been recognized as assets in 2016.

2.7 Intangibles

Intangible assets that are above the pre-established threshold of US$ 100 000 are stated at historical cost less accumulated amortization and any impairment losses. Amortization is determined over the estimated useful life of the assets using the straight-line method of amortization. The estimated useful life of “software acquired externally” is between two and six years.

WHO’s intangible assets are assumed to have a residual value of zero as intangible assets are not sold or transferred at the end of their useful life. Intangible assets are reviewed annually for impairment. Some intangible assets may have a shorter useful life.

2.8 Leases

A lease is an agreement whereby the lessor conveys to the lessee (the Organization), in return for a payment or series of payments, the right to use an asset for an agreed period of time. Every lease is reviewed to determine whether it constitutes a financial or operating lease. Necessary accounting entries and disclosures are made accordingly.

Where WHO is the lessor, lease revenue from operating leases is recognized as revenue on a straight-line basis over the lease term. All costs associated with the asset incurred in earning the lease revenue, including depreciation, are recognized as an expense.

2.9 Contributions received in advance

Contributions received in advance arise from legally binding agreements between WHO and its contributors – including governments, international organizations and private and public institutions – whereby contributions are received in advance of the amounts concerned falling due to the Organization.

2.10 Accounts payable and accrued liabilities

Accounts payable are financial liabilities for goods or services that have been received by WHO and invoiced but not yet paid for.

Accrued liabilities are financial liabilities for goods or services that have been received by WHO and which have neither been paid for nor invoiced to WHO.

Accounts payable and accrued liabilities are recognized at cost, as the effect of discounting is considered immaterial.

2.11 Employee benefits

WHO recognizes the following categories of employee benefits:

- short-term employee benefits that fall due wholly within 12 months following the end of the accounting period in which employees render the related service;
- post-employment benefits;
- other long-term employee benefits;
- termination benefits.

WHO is a member organization participating in the United Nations Joint Staff Pension Fund (the Fund), which was established by the United Nations General Assembly to provide retirement, death, disability and related benefits to employees. The Fund is a funded, multi-employer defined benefit plan. As specified by Article 3(b) of the Regulations of the Fund, membership in the Fund shall be open to the specialized agencies and to any other international, intergovernmental organization that participates in the common system of salaries, allowances and other conditions of service of the United Nations and the specialized agencies.

The Fund exposes participating organizations to actuarial risks associated with the current and former employees of other organizations participating in the Pension Fund, with the result that there is no consistent and reliable basis for allocating the obligation, plan assets, and costs to individual organizations participating in the plan. WHO and the UNJSPF are not in a position to identify WHO's proportionate share of the defined benefit obligation, the plan assets and the costs associated with the plan with sufficient reliability for accounting purposes; this is also true for other organizations participating in the Pension Fund. WHO has therefore treated it as a defined contribution plan in line with the requirements of IPSAS 39 (Employee Benefits). WHO's contributions to the Fund during the financial period are recognized as expenses in the Statement of Financial Performance (Statement II).

2.12 Provisions and contingent liabilities

Provisions are recognized for future liabilities and charges where WHO has a present legal or constructive obligation as a result of past events and it is probable that the Organization will be required to settle the obligation.

Other commitments, which do not meet the recognition criteria for liabilities, are disclosed in the notes to the financial statements as contingent liabilities when their existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events that are not wholly within the control of WHO.

2.13 Contingent assets

Contingent assets will be disclosed when an event gives rise to a probable inflow of economic benefits or service potential and there is sufficient information to assess the probability of the inflow of economic benefits or service potential.

2.14 Deferred revenue

Deferred revenue derives from legally binding agreements between WHO and its contributors, including governments, international organizations and private and public institutions. Deferred revenue is recognized when:

- a contractual agreement is confirmed in writing by both the Organization and the contributor; and
- the funds are earmarked and due in a future period.

Deferred revenue also includes advances from exchange transactions.

Deferred revenue is presented as non-current assets if the revenue is due one year or more after the reporting date.

2.15 Revenue

Revenue comprises gross inflows of economic benefits or service potential received and receivable by WHO during the year, and represents an increase in net assets/equity. The Organization recognizes revenue following the established criteria of IPSAS 9 (Revenue from Exchange Transactions) and IPSAS 23 (Revenue from Non-Exchange Transactions).

The main sources of revenue for WHO include but are not limited to:

Non-exchange revenue

- **Assessed contributions.** Revenue from contributions from Member States and Associate Members is recorded annually at the beginning of the year as per the assessments approved by the Health Assembly.

- **Voluntary contributions.** Revenue from voluntary contributions is recorded when a binding agreement is signed by WHO and the contributor. Where there are "subject to" clauses in an agreement, WHO does not control the resource and does not record the revenue and amount receivable until the cash is received. Where there are no payment terms specified by the contributor or payment terms are in the current accounting year, revenue is recognized in the current period. Where payment terms specify payment after the year end, the amount is reported as deferred revenue. Where start date of the contract is after 31 December, revenue is recognized in the future accounting year.

- **Contributions in-kind and in-service.** Contributions in-kind and in-service are recorded at an amount equal to their fair market value as determined at the time of acquisition, based on an agreement between WHO and the contributor and upon confirmation from the receiving budget centre of the receipt of the goods or services. An entry corresponding to the expense is recorded in the same period that the contributions in-kind and in-service are recorded as revenue.

Exchange revenue

- **Reimbursable procurement, concessions, and revolving sales.** Revenue from reimbursable procurement on behalf of Member States or from the sale of goods or services is recorded on an accrual basis at the fair value of the consideration received or receivable when it is probable that the future economic benefits and/or service potential will flow to WHO and those benefits can be measured reliably. The corresponding expense is recognized in the same year as the revenue.

2.16 Expenses

Expenses are defined as decreases in economic benefits or service potential during the reporting period in the form of outflows, consumption of assets, or incurrences of liabilities that result in decreases in net assets/equity. WHO recognizes expenses at the point where goods have been received or services rendered (delivery principle) and not when cash or its equivalent is paid.

2.17 Fund accounting

Fund accounting is a method of segregating resources into categories (i.e. funds) to identify both the source and the use of the funds. Establishing such funds helps to ensure better reporting of revenue and expenses. The General Fund, the Special Purpose Fund, the Enterprise Fund and the Fiduciary Fund serve to ensure the proper segregation of revenue and expenses. Any transfers between funds that would result in duplication of revenue and/or expenses are eliminated during consolidation. Intra-fund transfers such as programme support costs within the General Fund are also eliminated.

General Fund

The accounts contained under this fund support the implementation of the programme budget. The General Fund contains the following:

- **Assessed Contributions Fund.** This fund consolidates revenues and expenses arising from assessed contributions from Member States and includes interest and other miscellaneous income.

- **Tax Equalization Fund.** In accordance with resolution WHA21.10 (1968), in which the Health Assembly decided to establish the Tax Equalization Fund, the assessed contributions of all Member States are reduced by the revenue generated by the staff assessment plan. In determining the reduction of assessed contributions to be applied to the Member States concerned, the Tax Equalization Fund is credited with the revenue from the staff assessment plan, the credits being recorded in the name of individual Member States, in proportion to their assessments for the biennium. For those Member States that levy income tax on emoluments received from the Organization by their nationals or others liable to such taxes, the credit from the staff assessment plan is charged with the estimated amount to be levied by those Member States. Those amounts which have been charged are, in turn, used by the Organization to reimburse income tax paid by the staff concerned, as per resolution WHA21.10.

- **Working Capital Fund.** The Fund was established to implement the programme budget pending receipt of assessed contributions in arrears. In accordance with Financial Regulation VII, implementation of that part of the budget financed from assessed contributions may be financed from the Working Capital Fund and thereafter by internal borrowing against available cash reserves of WHO, excluding trust funds. Amounts borrowed are repaid from the collection of arrears of assessed contributions and are credited first against any internal borrowing and then against any borrowing from the Working Capital Fund.

- **Voluntary funds (core, specified and partnerships).** This fund consolidates revenue and expenses arising from voluntary contributions and includes the special account for servicing costs.

Member States – other

The following accounts are contained in Member States – other:

- **Common Fund.** This fund reflects the movement in the asset and liability accounts of the Organization resulting from changes in items such as inventory, depreciation and unrealized exchange gains and losses.

- **Enterprise Fund.** This fund contains accounts that generate self-sustaining revenue. The revenue and expenses under this fund are not included in the reporting of the programme budget. The Enterprise Fund contains the following:

  - **Revolving Sales Fund**.[1] This fund was established to record and report activities for publications.
  - **Concessions Fund**. This fund was established to manage activities for concessionaries. It is financed from amounts paid by the concessionaires for space, equipment utilities and use of facilities made available by the Organization.
  - **Insurance Policies Fund.** This fund was established to manage activities for commercial insurance policies. It is financed from benefits received from the applicable commercial insurance policies.
  - **Garage Rental Fund.** This fund was established mainly to record and report activities for the maintenance of a garage facility in Geneva. It is financed by way of a charge towards usage of the garage facility by applicable staff members.
  - **Reimbursable Procurement Fund**.[1] This fund was established to record and report procurement activities undertaken on behalf of Member States.

[1] In accordance with World Health Assembly resolution WHA22.8 (1969) and resolution WHA55.9 (2002), the Revolving Sales Fund is credited with proceeds from the sale of publications, international certificates of vaccination, films, videos, DVDs and other information material. The related costs of production and printing are charged to the Fund.

  - **In-kind Contributions Fund.**[2] This fund was established to record and report in-kind contributions.
  - **Accident and Illness Insurance Fund.** This fund was established in 2016 as a self-insurance mechanism to provide coverage for staff members in case of accident and illness.

- **Special Purpose Fund.** The accounts contained under this fund represent transfers from the General Fund or appropriations by the Health Assembly. The revenue and expenses under this fund are not included in the reporting of the programme budget. The Special Purpose Fund contains the following:

  - **Real Estate Fund.** This fund was established by the Twenty-third World Health Assembly through resolution WHA23.14 (1970). It is funded mainly by appropriation from the regular budget. The Real Estate Fund is also credited with receipts from rentals relating to real estate operations (other than garage rentals and income from the operation of concessions at headquarters), by way of a charge on salary cost of staff members and interest earned.

    The fund was established to meet the costs of the construction of new buildings or extensions to existing buildings, the acquisition of land that may be required, and major maintenance and repairs of real estate assets owned by the Organization. Specific Health Assembly authorization is required for acquisition of land and construction of buildings or building extensions.
  - **Building Loan Fund**. This fund was established to record and report on a loan from the Swiss Government in support of expenses towards the construction of new building in Geneva. It is funded by the Swiss Government loan.
  - **Security Fund**. This fund was established to record and report security expenses. It may be financed by way of appropriation from the regular budget and from voluntary contributions including the Special Account for Servicing Costs.
  - **Information Technology Fund**. This fund was established to meet current and future administrative requirements of the Organization. It may be financed by way of appropriation from the regular budget and from voluntary contributions including the Special Account for Servicing Costs.
  - **Special Fund for Compensation.** This fund was established by the Director-General for the payment of periodic benefits awarded to staff members under WHO compensation rules for service-incurred accidents and illnesses. It may be financed by funds allocated to cover the cost of employing the staff member, benefits received from the commercial accident and illness insurance policies established for this purpose, and by way of any interest earned.
  - **Terminal Payments Fund.** This fund was established to finance the terminal emoluments of staff members, including repatriation grant, accrued annual leave, repatriation travel and removal on repatriation. It is financed by way of a charge on salary cost of staff members and any interest earned.
  - **Non-Payroll Staff Entitlements Fund.** This fund was established to provide financing towards staff entitlements such as home leave, education grant etc. It is financed by way of a charge on salary cost of staff members.
  - **Mobility Fund.** This fund was established to provide financing towards staff mobility entitlements such as assignment grant and reassignment grant. It is financed by way of a charge on salary cost of staff members.
  - **Post Occupancy Charge Fund**. This fund was established to finance corporate and administrative expenses of the Organization. It is financed by way of a charge on salary cost of staff members.
  - **Internal Service Cost Recovery Fund.** This fund was established to record and report services provided between departments within the Organization.
  - **Staff Health Insurance Fund**. This fund was established to record and report after service health liability of the Organization. It is financed by way of a charge on salary cost of staff members.

---

[1] Transactions under the Reimbursable Procurement Fund are from exchange transactions. Total revenue equals total expenses; hence there is no fund balance at year-end (refer to note 2.15).

[2] Transactions under the In-kind Contributions Fund are from non-exchange transactions. Total revenue equals total expenses; hence there is no fund balance at year-end (refer to note 2.15).

- **Stockpiles Replenishment Fund**. This fund was established in 2015 to support emergency procurement needs, mainly for the Eastern Mediterranean Region.
- **Polio Staff Fund**. This fund was established to manage staff liabilities due to the closure of the polio programme.

Fiduciary Fund

This fund accounts for assets that are held by WHO in a trustee or agent capacity for others and that cannot be used to support the Organization's own programmes. The Fund includes the assets of the partnerships that are administered by the Organization and whose budgets are not approved by the Health Assembly. The Fund is not available for operations and does not contribute to the Programme budget 2016–2017, and at 31 December contains the following:

- WHO Framework Convention on Tobacco Control (FCTC)
- Roll Back Malaria Partnership Fund[1]
- Partnership for Maternal, Newborn and Child Health Fund
- Alliance for Health Policy and System Research Fund
- Global Health Workforce Alliance Fund
- European Observatory on Health Systems and Policies
- Expanded Special Project for Elimination of Neglected Tropical Diseases (ESPEN) Fund

2.18 Segment reporting

As required under IPSAS, WHO reports on segments based on its regional structure. Revenue, expenses, assets and liabilities are reported for each major office (region). The use of major offices is in line with the decision making practices of the Member States and the Secretariat, with respect to the allocation of resources. WHO's programme budget is presented by major office, which supports using major offices as the segments. Furthermore, the accountability for results and management of assets and liabilities lies with the heads of each regional office.

2.19 Statement of Cash Flow

The Statement of Cash Flow (Statement IV) is prepared using the indirect method.

2.20 Budget comparison

WHO's budget and accounting basis differ. Budgets within the Organization are approved on a modified cash basis rather than the full accrual basis of IPSAS. In addition, budgets are prepared on a biennial basis.

Although WHO's financial statement covers all the activities of the Organization, budgets are approved only for the General Fund. There are no approved budgets for other funds. All funds are administered in accordance with the Financial Regulations and Financial Rules.

As required under IPSAS 24 (Presentation of Budget Information in Financial Statements), the actual amounts presented on a comparable basis to the budget shall, where the financial statements and the budget are not prepared on a comparable basis, be reconciled to the actual amounts presented in the financial statements, identifying separately any basis, timing, presentation and entity differences. There may also be differences in formats and classification schemes adopted for the presentation of financial statements and the budget.

[1] Roll Back Malaria operations were closed at 31 December 2015. Administrative closure of the fund will be finalized in 2017.

The Health Assembly approved the Programme budget 2016–2017 through resolution WHA68.1 (2015) and amended it through decision WHA69(9) (2016). The Statement of Comparison of Budget and Actual Amounts (Statement V) compares the final budget to actual amounts calculated on the same basis as the corresponding budgetary amounts. As the basis used to prepare the budget and financial statements differ, Note 7 reconciles the actual amounts presented in Statement V to the actual amounts presented in the Statement of Cash Flow (Statement IV).

2.21 Non-consolidated entities

WHO provides administrative services to a number of entities, each of which produces a full set of financial statements that are subject to a separate audit. The following five entities have their own governing bodies and are not governed by the World Health Assembly:

- Trust Fund for the Joint United Nations programme on HIV/AIDS (UNAIDS)
- International Drug Purchase Facility (UNITAID)
- International Agency for Research on Cancer (IARC)
- International Computing Centre (ICC)
- Staff Health Insurance (SHI)

2.22 Pan American Health Organization (PAHO) / Regional Office for the Americas (AMRO)

The Pan American Health Organization is a non-consolidated entity and prepares separate financial statements. WHO's contribution to the Regional Office for the Americas, together with the expenditures for that Regional Office, are consolidated as part of WHO's financial statements.

3. Note on the restatement of balances

a. Effective 1 January 2016, the Organization has changed its accounting policy to recognize employee benefits in accordance with IPSAS 39. As a result actuarial gains and losses for the Staff Health Insurance and the Special Fund for Compensation (SFFC) were accounted directly to net assets/equity. The effect of this change in accounting policy was recognized retrospectively, requiring a restatement of the 2015 comparative numbers.

The impact on the Statement of Financial Performance was as follows:

Description	ASHI	SFFC	Total
Impact on Statement of Financial Performance			
Staff cost	(11 285)		(11 285)
Finance revenue		(334)	(334)
Total restatement	**(11 285)**	**(334)**	**(11 619)**

The impact on the Statement of Financial Position was as follows:

Description	ASHI	SFFC	Total
Impact on Statement of Financial Position			
Non-current liabilities			
Accrued staff benefits – non-current	155 433	861	156 294
Net Assets/Equity			
Member States – other	(155 433)	(861)	(156 294)

b. The removal on repatriation allowance has been reclassified from general operating expenses and reported with staff costs. This reclassification affected only the 2015 Statement of Financial Performance and resulted in a movement of US$ 1.6 million.

4. Supporting information to the Statement of Financial Position

4.1 Cash and cash equivalents

Cash and cash equivalents comprise cash on hand, cash at banks, investments in money market funds, collateral deposits, bank deposits, and short-term highly liquid investments with original maturity dates of three months or less from the date of acquisition.

Cash and cash equivalents are held for the purpose of meeting the short-term cash requirements of the Organization, rather than for longer-term investment purposes. They are held on behalf of the Organization, including the General Fund, the Special Purpose Fund, the Enterprise Fund, the Fiduciary Fund and non-WHO entities administered by the Organization. The figures include cash and cash equivalents held in the portfolios managed by external investment managers. The table below shows cash and cash equivalents by major office.

Description	31 December 2016	31 December 2015
	US$ thousands	
Major office		
Headquarters	115 149	138 587
Regional Office for Africa	26 108	24 515
Regional Office for the Eastern Mediterranean	12 015	11 837
Regional Office for Europe	1 489	1 516
Regional Office for South-East Asia	3 163	2 401
Regional Office for the Western Pacific	3 893	3 660
Cash at banks, investment accounts, in transit and on hand	**161 817**	**182 516**
Headquarters	275 073	248 802
Cash and cash equivalents held by investment portfolios	**275 073**	**248 802**
Total cash and cash equivalents	**436 890**	**431 318**

4.2 Investments and financial instruments

Details of the accounting policies for investments and financial instruments are described in Note 2.2.

WHO's principal investment objectives in descending order of priority are:

- the preservation of capital;
- the maintenance of sufficient liquidity to meet the payment of liabilities on time; and
- the optimization of investment returns.

The Organization's investment policy reflects the nature of its funds, which may be held either short-term pending implementation of programmes, or for a longer term to meet its long-term liabilities.

WHO's investments include funds managed for other entities.

An analysis of the investments of the Organization is provided in the following table.

Investments and financial instruments (in US$ thousands)

Description	Internally managed funds				Externally managed funds					Foreign Exchange Hedging contracts	Grand total 31 December 2016	Grand total 31 December 2015
	Time Deposits and cash	Held-to-Maturity portfolio	Long term portfolio	Total	Short term portfolio A	Short term portfolio B	Short term portfolio C	Short term portfolio D	Total			
Investments under current Assets												
Cash and cash equivalent held by investment portfolio	250 166			250 166	1 240	627	18 878	4 162	24 907		275 073	248 802
Short-term investments												
Financial assets at fair value through surplus or deficit -- held for trading					2 411			1 794	4 205	515	4 720	3 945
Financial assets at fair value through surplus or deficit -- upon initial recognition					405 198	303 872	535 131	533 607	1 777 808		1 777 808	1 760 124
Financial assets at amortized cost												
Bank deposits & other receivables	928 176		27	928 203	1 998	894	1 749	1 707	6 348		934 551	990 190
Total short-term investments	**928 176**		**27**	**928 203**	**409 607**	**304 766**	**536 880**	**537 108**	**1 788 361**	**515**	**2 717 079**	**2 754 259**
Total investments under current assets	**1 178 342**		**27**	**1 178 369**	**410 847**	**305 393**	**555 758**	**541 270**	**1 813 268**	**515**	**2 992 152**	**3 003 061**
Investments under non-current assets											**2 717 079**	
Long-term Investments												
Financial assets at fair value through surplus or deficit -- upon initial recognition			95 846	95 846							95 846	93 900
Financial assets at amortized cost												
Total long-term assets			**95 846**	**95 846**							**95 846**	**93 900**
Total investments under non-current assets			**95 846**	**95 846**							**95 846**	**93 900**
Financial Liabilities under current liabilities												
Financial liabilities at fair value through surplus or deficit for trading					(92)			(2)	(94)	(13 373)	(13 467)	(13 104)
Payables and accruals					(11 199)		(2)		(11 201)		(11 201)	(40 073)
Total financial liabilities					**(11 291)**		**(2)**	**(2)**	**(11 295)**	**(13 373)**	**(24 668)**	**(53 177)**
Total financial liabilities under current liabilities					**(11 291)**		**(2)**	**(2)**	**(11 295)**	**(13 373)**	**(24 668)**	**(53 177)**
Total investment - net	**1 178 342**		**95 873**	**1 274 215**	**399 556**	**305 393**	**555 756**	**541 268**	**1 801 973**	**(12 858)**	**3 063 330**	**3 043 784**

Short-term investments

Short-term investments relating to funds held pending the implementation of programmes are invested in cash and high-quality short-term government, agency, corporate bonds and time deposits as defined in the approved investment policy. Investments included within "financial assets at fair value through surplus or deficit" include fixed-income securities and derivative instruments held to cover projected liabilities and any unexpected cash requirements. Financial assets in the externally managed portfolios designated upon initial recognition as at fair value through surplus or deficit are classified as short-term investments where the investment time horizon objective of these portfolios is less than or equal to one year. For short-term tactical investment reasons, the external managers of these portfolios may from time to time decide to lengthen temporarily the average duration of these portfolios to slightly longer than one year. This will not change the short-term classification of these financial assets unless the investment time horizon objective of the portfolio and the duration of its benchmark have been changed to more than one year. The investments in the "held-to-maturity" portfolio with duration of less than one year are classified as current assets in the category "financial assets at amortized cost". At the end of 2016, there were no investments in the held-to-maturity portfolio. Other receivables include accrued revenue on investments and receivables from investments that were sold before 31 December 2016 and settled after that date.

Description	31 December 2016	31 December 2015
	US$ thousands	
Financial assets at fair value through surplus or deficit – held-for-trading	4 720	3 945
Financial assets at fair value through surplus or deficit – upon initial recognition	1 777 808	1 760 124
Bank deposits and other receivables	934 551	990 190
Total short-term investments	**2 717 079**	**2 754 259**

Long-term investments

Long-term investments for the Terminal Payments Fund are placed in line with the approved investment policy and are invested in high-quality, medium-dated and long-dated, government, agency and corporate bonds. The financial assets at fair value through surplus or deficit upon initial recognition in the Terminal Payments Fund investment portfolio are classified as long-term investments in accordance with the investment time horizon objective of the portfolio and the duration of its benchmark, which are both greater than one year.

Description	31 December 2016	31 December 2015
	US$ thousands	
Financial assets at fair value through surplus or deficit – upon initial recognition	95 846	93 900
Total long-term investments	**95 846**	**93 900**

Financial liabilities

Financial liabilities disclosed under "financial liabilities at fair value through surplus or deficit – held-for-trading" include derivative transactions such as foreign exchange forward contracts and interest rate swaps. Financial liabilities disclosed under "payables and accruals" relate to other financial liabilities from investments, including assets purchased before 31 December 2016 and settled after that date.

Description	31 December 2016	31 December 2015
	US$ thousands	
Financial liabilities at fair value through surplus or deficit – held-for-trading	13 467	13 104
Payables and accruals	11 201	40 073
Total financial liabilities	**24 668**	**53 177**

The fair value hierarchy

The fair value hierarchy represents the categorization of market pricing to indicate the relative ease with which the value of investments held by WHO can be realized.

The majority of the financial instruments held by WHO have quoted prices in active markets which are classified as Level 1. Derivative instruments that are "over-the-counter" are classified as Level 2 because their fair value is observable – either directly as a price, or indirectly after being derived from prices. The instruments shown under the Level 2 fair value measurement category consist of foreign currency hedging forward contracts and derivative contracts in the externally managed portfolios.

Description	Level 1	Level 2	Total
	US$ thousands		
Cash and cash equivalents	**14 539**		**14 539**
Short-term investments			
Financial assets at fair value through surplus or deficit – held-for-trading		4 522	4 522
Financial assets at fair value through surplus or deficit – upon initial recognition	1 777 808		1 777 808
Total short-term investments	**1 777 808**	**4 522**	**1 782 330**
Long-term investments			
Financial assets at fair value through surplus or deficit – upon initial recognition	95 846		95 846
Financial liabilities			
Financial liabilities at fair value through surplus or deficit – held-for-trading	0	(13 466)	(13 466)
Total	**1 888 193**	**(8 944)**	**1 879 249**

Risk management

WHO is exposed to financial risks including credit risk, interest rate risk, foreign exchange risk and investment price risk. The Organization uses derivative financial instruments to hedge some of its risk exposures. In accordance with WHO's Financial Regulations, funds not required for immediate use may be invested. All investments are carried out within the framework of the investment policy approved by the Director-General. Some portfolios are managed by external managers appointed by the Organization to manage funds in accordance with a defined mandate. The Advisory Investment Committee reviews regularly the investment policies, the investment performance and the investment risk for each investment portfolio. The Committee is composed of external investment specialists who can make investment recommendations to the Director-General.

Nature of financial instruments

Investments are categorized as follows:

- **Investments with short-term maturities.** These investments are invested in cash and high-quality short-dated government, agency, and corporate bonds as defined in the approved investment policy.
- **Investments with long-term maturities.** These investments comprise funds managed for the Terminal Payments Fund as defined in the approved investment policy. They are invested in high-quality medium-dated and long-dated, government, agency, corporate bonds and an externally managed global bond index fund.

Credit risk

WHO's investments are widely diversified in order to limit its credit risk exposure to any individual investment counterparty. Investments are placed with a wide range of counterparties using minimum credit quality limits and maximum exposure limits by counterparty established in investment mandates. These limits are applied both to the portfolios managed internally by the Organization's Treasury Unit, and to the portfolios managed by external investment managers. The Treasury Unit monitors the total exposure to counterparties across all internally and externally managed portfolios.

The credit risk and liquidity risk for cash and cash equivalents are minimized by investing only in major financial institutions that have received strong investment grade credit ratings from primary credit rating agencies. The Treasury Unit regularly reviews the credit ratings of the approved financial counterparties and takes prompt action whenever a credit rating is downgraded. The investments with long-term credit ratings are summarized as follows.

Minimum rating category	Total asset value US$ thousands
AAA	328 428
AA+	476 497
AA	66 051
AA-	268 396
A+	156 701
A	62 827
A-	416 117
Not rated	116 918
Total	**1 891 935**

Where the investments and securities are not rated for credit worthiness by the major credit ratings agencies (for example, fixed income securities issued by sovereigns, collateralized mortgage obligations issued by sovereign backed agencies and investment funds), the Treasury Unit ensures that the deposits and securities and the constituent securities in the investment funds are issued by issuers whose credit ratings are equal to or better than the single A minimum credit rating requirement for WHO investments as set out in the investment guidelines for the external portfolio managers which are agreed with the Advisory Investment Committee, and the investment grade minimum credit rating requirement for investments for the Terminal Payments fund, which is also agreed with the Advisory Investment Committee.

Interest rate risk

WHO is exposed to interest rate risk through its short-term and long-term fixed-income investments. The investment duration is a measure of sensitivity to changes in market interest rates, and the effective average duration of the Organization's investments as at 31 December 2016 was 0.5 years for the short-term investments and 6.6 years for the long-term investments. The duration of the long-term investments was lengthened by purchasing longer term fixed income products to better match the duration of the liabilities which are funded by these investments.

Fixed-income derivative instruments may be used by external investment managers to manage interest rate risk under strict investment guidelines. Interest rate instruments of this type are used for portfolio duration management and for strategic interest rate positioning.

Foreign exchange currency risk

WHO receives contributions and makes payments in currencies other than the United States dollar. The Organization is thus exposed to foreign exchange currency risk arising from fluctuations in currency exchange rates. Exchange rate gains and losses on the purchase and sale of currencies, revaluation of cash book balances, and all other exchange differences are adjusted against the funds and accounts eligible to receive interest under the interest apportionment programme. The translation of transactions expressed in other currencies into the United States dollar is performed at the United Nations Operational Rates of Exchange prevailing at the date of transaction. Assets and liabilities that are denominated in foreign currencies are translated at the United Nations Operational Rates of Exchange year-end closing rate. Forward foreign exchange contracts are transacted to hedge foreign currency exposures and to manage short-term cash flows.

Realized and unrealized gains and losses resulting from the settlement and revaluation of foreign currency transactions are recognized in the Statement of Financial Performance (Statement II).

With effect from 2014, 50% of assessed contributions are calculated in Swiss francs to reduce the currency risk of headquarters expenses in that currency.[1]

Hedging foreign exchange exposures on future payroll costs: The United States dollar value of non-dollar expenses in 2017 has been protected from the impact of movements in foreign exchange rates through the transaction of forward currency contracts during 2016. As at 31 December 2016 these forward foreign currency exchange hedging contracts by currency are summarized as follows.

Currency forward bought	(in thousands)	Net amount sold (US$ thousands)	Net unrealized gain/(loss) (US$ thousands)
Swiss franc	106 200	109 893	(4 341)
Euro	84 700	95 091	(5 025)
Indian rupee	952 600	13 393	352
Malaysian ringgit	31 900	7 643	(600)
Philippine peso	687 500	14 206	(610)
Total		**240 226**	**(10 224)**

There was a net unrealized loss on these contracts of US$ 10 million as at 31 December 2016 (unrealized loss of US$ 9 million as at 31 December 2015). Realized gains or losses on these contracts will be recorded on maturity of the contracts and applied during 2017.

Hedging foreign exchange exposures on receivables and payables: Currency exchange risk arises as a result of differences in the exchange rates at which foreign currency receivables or payables are recorded, and the exchange rates at which the cash receipt or payment is subsequently recorded. A monthly programme of currency hedging is in place to protect against this foreign currency risk. On a monthly basis, the exposures in respect of accounts receivable and accounts payable are netted by currency and each significant net foreign currency exposure is bought or sold forward using a forward foreign exchange contract equal and opposite to the net currency exposure.

These exposures are re-balanced at each month-end to coincide with the setting of the monthly United Nations Operational Rates of Exchange. Through this process the exchange gains or losses realized on the forward foreign currency contracts match the corresponding unrealized exchange losses and gains on the movements in net accounts receivable and accounts payable. As at 31 December 2016, the total forward foreign currency exchange hedging contracts by currency were as follows.

Currency forward sold	(in thousands)	Currency forward bought (US$ thousands)	Net unrealized gain/(loss) (US$ thousands)
Australian dollar	3 200	2 302	(5)
Canadian dollar	30 060	22 213	(102)
Swiss franc	2 300	2 249	(17)
Euro	105 800	110 706	(1 094)
Pound sterling	143 500	175 689	(1 044)
New Zealand Dollar	1 000	694	0
Swedish Kroner	179 100	19 637	(261)
Total		**333 490**	**(2 523)**

[1] See resolution WHA66.16 (2013).

There was a net unrealized loss on these contracts of US$ 2.5 million as at 31 December 2016 (unrealized net loss of US$ 9.3 million as at 31 December 2015). Realized gains or losses on these contracts will be recorded on the maturity of the contracts and applied during 2017.

Forward foreign exchange contracts to manage operational cash flows: Forward foreign exchange contracts are also used to manage short-term cash flows of foreign currency balances to minimize foreign currency transaction risk. At 31 December 2016 a total net amount of 28.7 million Swiss francs was forward sold and 3.2 million Euros were bought against the United States dollar. The maturity dates of these forward foreign exchange contracts were in January 2017. Net unrealized gains on these contracts amounted to US$ 0.3 million as at 31 December 2016 (unrealized net losses of US$ 0.5 million as at 31 December 2015).

Sensitivity of forward foreign exchange contracts to movements in the relative value of the United States dollar: A 1% appreciation in the relative value of the United States dollar against the forward foreign exchange hedging contracts mentioned above would result an increase in the net unrealized gain of US$ 1.3 million. A 1% depreciation in the relative value of the United States dollar would result in an increase in the net unrealized loss of US$ 1.3 million.

Forward and spot foreign exchange contracts and other derivative financial instruments are held within the externally managed investment portfolios: In accordance with the investment guidelines set up for each externally managed portfolio, the external investment managers use forward and spot foreign exchange contracts, futures contracts and interest rate swap contracts to manage the currency and interest rate risk of groups of securities within each portfolio. The net values of these instruments as at 31 December 2016, as evaluated by the Organization's investment custodian, are recorded by portfolio under "financial assets/liabilities at fair value – held-for-trading". The outstanding forward and spot foreign exchange contracts are summarized below.

Net sold amount	(in thousands)	US dollar equivalent (in thousands)
Australian dollar	14 898	11 861
Canadian dollar	5 307	3 957
Danish kroner	188 163	26 728
Euro	10 604	11 079
Japanese yen	800 000	6 878
Pound sterling	47 283	58 437
Total		**118 940**

A 1% appreciation in the relative value of the United States dollar against the above-mentioned forward foreign exchange hedging contracts would result in an increase in the unrealized gain of US$ 1.1 million. A 1% depreciation in the relative value of the United States dollar would result in an increase in the unrealized loss of US$ 1.1 million.

The net outstanding interest rate and bond futures contracts are summarized below.

Long positions

Products	Exchange[a]	No. of contracts
Eurodollar MAR 2017	IMM	19
Eurodollar JUN 2017	IMM	24
Eurodollar SEP 2017	IMM	3
Eurodollar SEP 2018	IMM	18
Eurodollar JUN 2019	IMM	12
Australian T-Bond 3Y MAR 2017	ASX	210

Short positions

Products	Exchange[a]	No. of contracts
Eurodollar MAR 2017	IMM	(97)
Eurodollar DEC 2017	IMM	(16)
Eurodollar MAR 2018	IMM	(15)
Eurodollar JUN 2018	IMM	(6)
Eurodollar MAR 2019	IMM	(9)
US 5 year T-Note MAR 2017	CBOT	(172)
30 Day Fed Funds DEC 2016	CBOT	(6)

(a). ASX refers to Australian Securities Exchange. IMM refers to the International Monetary Market and CBOT refers to Chicago Board of Trade. IMM and CBOT are part of Chicago Mercantile Exchange Group.

4.3 Accounts receivable

As at 31 December 2016, total accounts receivable (current and non-current) amounted to US$ 1079 million (US$ 1063 million as at 31 December 2015). The receivable balance includes outstanding amounts for both assessed and voluntary contributions. Accounts receivable are split between current and non-current based on the payment terms of when the amounts become due.

Description	31-December-2016	31-December-2015
	US$ thousands	
Accounts receivable – current		
Assessed contributions receivable[1]	77 381	122 303
Voluntary contributions receivable	818 960	766 328
Reimbursable procurement receivable		59
Revolving sales receivable	155	194
Other receivables	5 281	5 573
Allowance for doubtful accounts receivable	(29 969)	(28 441)
Total accounts receivable – current	**871 808**	**866 016**
Accounts receivable – non-current		
Outstanding rescheduled assessments receivable[1]	19 027	23 039
Voluntary contributions receivable	207 278	197 472
Allowance for doubtful accounts receivable	(19 027)	(23 039)
Total accounts receivable – non-current	**207 278**	**197 472**
Total accounts receivable	**1 079 086**	**1 063 488**

[1] See document A70/41 for details of the status of collection of assessed contributions.

As at 31 December 2016, the total allowance for doubtful accounts receivable was US$ 48.9 million (US$ 51.5 million at 31 December 2015). This figure comprises an allowance of US$ 45.9 million for assessed contributions and an allowance of US$ 3 million for voluntary contributions.

The allowance for assessed contributions receivable includes amounts receivable from prior years, all rescheduled amounts receivable and any current amounts receivable from Member States in arrears. The allowance for voluntary contributions receivable is based on a detailed review of all amounts receivable more than one year overdue and a review of amounts less than one year overdue where there is evidence that the amount is unlikely to be received.

With certain contributors, WHO signs agreements that may span many years of implementation. These agreements do not state the payment terms for the transfer of instalments; instead, they are reimbursed based on quarterly expenses incurred. WHO records the full amount of revenue in the financial year in which the agreement is signed and recognizes the full receivable as currently due. As at 31 December 2016, the total

receivable shown as currently due under this arrangement was US$ 356.4 million outstanding, of which US$ 148.6 million outstanding was due on agreements ending in 2018 and beyond.

Description	31-December-2016	31-December-2015
	US$ thousands	
Opening balance – assessed contributions	48 301	43 453
(Decrease)/increase in allowance for doubtful accounts receivable	(2 311)	4 848
Ending balance – assessed contributions	45 990	48 301
Opening balance – voluntary contributions	3 179	11 673
Write off of account receivable previously provided	–	(9 145)
(Decrease)/increase in allowance for doubtful accounts receivable	-173	651
Ending balance – voluntary contributions	3 006	3 179
Total allowance for doubtful accounts receivable	**48 996**	**51 480**
Allowance for doubtful accounts receivable		
Allowance – current	29 969	28 441
Allowance – non-current	19 027	23 039
Total allowance for doubtful accounts receivable	**48 996**	**51 480**

4.4 Staff receivables

In accordance with WHO's Staff Regulations and Staff Rules, staff members are entitled to certain advances including those for salary, education, rent and travel.

The total balance of staff receivables amounted to US$ 10.2 million as at 31 December 2016 (US$ 10.7 million as at December 2015). The largest balance relates to education grant which represents advances made to staff for the 2017 portion of the 2016–2017 school year.

Description	31 December 2016	31 December 2015
	US$ thousands	
Salary advances	697	839
Education grant advances	7 878	7 724
Rental advances	1 157	1 514
Travel receivables	495	544
Other staff receivables	16	81
Total staff receivables	**10 243**	**10 702**

4.5 Inventories

The total value of inventory as at 31 December 2016 was US$ 39.5 million (US$ 53.2 million as at 31 December 2015).

The movement of inventory items during the year are shown in the table below:

Description	31 December 2015	Net additions	Net shipments	Net disposals and expired items	Net inventory in-transit	31 December 2016
	US$ thousands					
Medicines, vaccines and humanitarian supplies	47 098	60 214	57 015	19 978	3 936	34 255
Publications	6 054	5 161	4 523	1 393		5 299
Total inventory	**53 152**	**65 375**	**61 538**	**21 371**	**3 936**	**39 554**

Total expenses relating to inventories during the period (net shipments, net disposals and expired items) amounted to US$ 82.9 million (US$ 72.6 million as at 31 December 2015). The expenses relating to inventories are reported in the Statement of Financial Performance (Statement II) under “Medical Supplies and materials”. The year-end inventory balance includes shipping cost of 14%.

4.6 Prepayments and deposits

The total value of prepayments as at 31 December 2016 was US$ 9.6 million (US$ 12.4 million as at 31 December 2015). These represent payments to suppliers in advance of the receipt of goods or services. It is common practice for technical service contractors to request payments in advance to support project work. When goods or services are delivered, prepayments are applied to the appropriate expense account.

Prepayments include US$ 0.3 million of deposits (US$ 0.2 million as at 31 December 2015). Deposits represent amounts given to landlords as a security to rent office space.

4.7 Property, plant and equipment

WHO has invoked the transition provision under IPSAS 17 (Property, Plant, and Equipment) which allows a period of up to five years before requiring full recognition of property, plant and equipment. In 2016, the Organization recognized owned land and buildings at regional and country offices. All other assets were expensed upon acquisition.

As at 31 December 2016, the total value of recognized land and buildings (net of accumulated depreciation) was US$ 71 million (US$ 65.1 million as at 31 December 2015). The increase included US$ 8 million in new additions and ongoing construction projects.

In locations where WHO does not own the land, surface rights were granted at no cost. No value has been recognized as the Organization does not have the ability to dispose of these rights in a commercial transaction.

Major office	31 December 2015	Additions	Disposals	Impairments	Depreciation	31 December 2016
	US$ thousands					
Headquarters						
Land	1 000					1 000
Buildings	36 760				(1 110)	35 650
CIP	1 615	8 052	(1 283)			8 384
Total property – Headquarters	39 375	8 052	(1 283)		(1 110)	45 034
Regional Office for Africa						
Land	14	56				70
Buildings	4 051	208			(228)	4 031
CIP	439	875				1 314
Total property – Regional Office for Africa	4 504	1 139			(228)	5 415
Regional Office for South East Asia						
Buildings	172				(28)	144
CIP						
Total property - Regional Office for South East Asia	172				(28)	144
Regional Office for the Eastern Mediterranean						
Buildings	16 294	3 609			(403)	19 500
CIP	3 473	137	(3 610)			
Total property – Regional Office for the Eastern Mediterranean	19 767	3 746	(3 610)		(403)	19 500
Regional Office for the Western Pacific						
Buildings	1 306				(435)	871
CIP						
Total property – Regional Office for the Western Pacific	1 306				(435)	871
Total WHO						
Land	1 014	56				1 070
Buildings	58 583	3 817			(2 204)	60 196
CIP	5 527	9 064	(4 893)			9 698
Total property - WHO	**65 124**	**12 937**	**(4 893)**		**(2 204)**	**70 964**

In 2016, new equipment to the amount of US$ 9.2 million (US$ 22.1 million as at 31 December 2015) was recognized in the assets register. The new equipment amount was higher in 2015 owing to a one-off conversion of assets from the African Region. This figure concerned only individual items with a value above US$ 5000, and is reported in the Statement of Financial Performance (Statement II) under "Equipment, vehicles and furniture". However, as WHO is using the transitional provision, these purchases were expensed upon acquisition. The transition period expired on 31 December 2016. From 1 January 2017, assets will be capitalized based on the remaining useful life. The opening balance for property, plant, and equipment will be restated accordingly. The details of the property, plant, and equipment concerned are as follows.

Description	2016	2015
	US$ thousands	
Vehicles	5 535	15 829
Network equipment	1 364	2 054
Audio visual equipment	622	1 023
Office equipment	525	563
Computer equipment	100	381
Security equipment	308	283
Furniture, fixtures and fittings	88	81
Communications equipment	38	111
Other equipment	605	1 805
Total new equipment	**9 185**	**22 130**

4.8 Intangibles

Intangible assets held as at 31 December 2016 amounted to US$ 4.8 million (US$ 2.8 million as at 31 December 2015), most of which relates to new purchases.

Asset category	31 December 2015	Additions	Disposals/ Transfers	Impairments	Amortization	31 December 2016
	US$ thousands					
Software acquired	2 522	1 107			(632)	2 996
Software under development	284	2 074	(567)			1 792
Total intangible assets	**2 806**	**3 181**	**(567)**		**(632)**	**4 788**

4.9 Contributions received in advance

The amount for contributions received in advance mainly concerns payments received from Member States in 2016 for their 2017 assessed contributions. The balance for advance payments for voluntary contributions reflects funds received for agreements starting in 2017. Unapplied and unidentified receipts are amounts received in 2016 but not yet matched as at 31 December 2016.

Description	31-December-2016	31-December-2015
	US$ thousands	
Assessed contribution advances	50 405	46 145
Advances for voluntary contributions	9 512	5 587
Unapplied and unidentified receipts	8 372	4 762
Other advances	57	586
Total contributions received in advance	**68 346**	**57 079**

4.10 Accounts payable

Accounts payable represents the total amount due to suppliers by major office as at 31 December 2016.

Description	31 December 2016	31 December 2015
	US$ thousands	
Headquarters	12 048	12 619
Regional Office for Africa	9 244	15 637
Regional Office for the Eastern Mediterranean	11 547	14 261
Regional Office for Europe	2 311	2 861
Regional Office for South-East Asia	3 905	4 664
Regional Office for the Western Pacific	2 074	3 555
Total accounts payable	**41 129**	**53 597**

4.11 Staff payable

The balance of staff payable represents the total amount outstanding to staff as at 31 December 2016. Salaries payable consist of balances due to staff pending the finalization of clearance certificates. Bank returns are balances due to staff for which the payment is pending the receipt of updated bank account information.

Description	31 December 2016	31 December 2015
	US$ thousands	
Salaries payable	1 808	1 712
Bank returns	197	278
Travel claims payable		166
Total staff payable	**2 005**	**2 156**

4.12 Accrued staff benefits

Accrued staff benefits include terminal payments, staff health insurance, group accident and illness insurance and liabilities due to service-incurred death or disability (Special Fund for Compensation).

Description	31 December 2016	31 December 2015 (restated)
	US$ thousands	
Accrued staff benefits – current		
Terminal payments	44 339	46 142
Special Fund for Compensation	582	580
Accident and Illness Insurance	1 727	
Total accrued staff benefits – current	**46 648**	**46 722**
Accrued staff benefits – non-current		
Terminal payments	60 072	59 388
Special Fund for Compensation	13 589	14 106
Accident and Illness Insurance	637	
Staff health insurance	1 185 511	1 069 488
Total accrued staff benefits – non-current	**1 259 809**	**1 143 843**
Accrued staff benefits		
Terminal payments	104 411	105 530
Special Fund for Compensation	14 171	15 547
Accident and Illness Insurance	2 364	
Staff health insurance	1 185 511	1 069 488
Total accrued staff benefits	**1 306 457**	**1 190 565**

Terminal payments

The Terminal Payments Fund was established to finance the terminal emoluments of staff members, including repatriation grants, accrued annual leave, repatriation travel and removal on repatriation. It is funded by a charge made to salary.

Liabilities arising from repatriation benefits and annual leave are determined by independent consulting actuaries. However, the accrued leave is calculated on a walk-away basis – that is, as if all staff separated immediately – and, therefore, is not discounted.

The latest actuarial study (as at 31 December 2016) estimated the full terminal payment liability to be US$ 104.4 million (short-term liability, US$ 44.3 million; long-term liability, US$ 60.1 million) compared to US$ 105.5 million as at 31 December 2015, a net reduction of US$ 1.1 million, which is recognized by nature of expense, in the Statement of Financial Performance (Statement II). This calculation does not include costs for the end-of-service grant, separation by mutual agreement or abolishment of posts. The defined benefit obligation amounted to US$ 67.6 million (US$ 67.4 million as at 31 December 2015) for terminal entitlements, and US$ 36.8 million (US$ 38.1 million as at 31 December 2015) for annual leave which is included in the terminal payments current balance.

Staff health insurance

The Secretariat manages its own health insurance scheme as a separate entity. The Staff Health Insurance has its own governance structure and provides for the reimbursement of a major portion of expenses for medically recognized health care incurred by staff members, retired staff members and their eligible family members. The Staff Health Insurance is financed by the contributions made by the participants (one third) and the Organization (two thirds) and from investment income.

The Organization accounts for after-service staff health insurance as a post-employment benefit. Actuarial gains and losses are recognized in the net assets/equity in accordance with IPSAS 39 (Employee Benefits).

Professional actuaries determined the 2016 defined benefit obligation for the Staff Health Insurance based on personnel data and payment experience provided by WHO. As at 31 December 2016, the unfunded defined benefit obligation amounted to US$ 1 186 million (US$ 1 069 million in 2015 restated). In accordance with IPSAS 39, the actuarial loss of US$ 90 million was charged directly to net assets/equity in 2016, US$ 23 million was charged by nature of expense in the Statement of Financial Performance (Statement II) (refer to note 5.2) and US$ 3 million was transferred from the African Programme for Onchocerciasis Control (APOC).

Further details on Staff Health Insurance liability can be found in the annual report of the Staff Health Insurance scheme.

Special Fund for Compensation

In the event of a death or disablement attributable to the performance of official duties of an eligible staff member, the Special Fund for Compensation covers all reasonable medical, hospital, and other directly related costs, as well as funeral expenses. In addition, the Fund provides compensation to disabled staff members (for the duration of the disability) or to the surviving family members.

WHO accounts for the Special Fund for Compensation as a post-employment benefit. Actuarial gains and losses are recognized in the net assets/equity, in accordance with IPSAS 39 (Employee Benefits).

As per the actuarial study, the total liability was US$ 14.2 million at 31 December 2016 (US$ 15.5 million as at 31 December 2015 restated). In accordance with IPSAS 39, the actuarial gain of US$ 2 million was charged directly to net assets/equity in 2016, US$0.6 million was charged by nature of expense in the Statement of Financial Performance (Statement II).

Accident and Illness Insurance

The Accident and Illness Insurance Fund was established to cover benefit payments in the event of death, permanent disability, loss of function and sick leave (SLIC) to staff members of WHO, PAHO, IARC, ICC, UNITAID and UNAIDS. It is funded by contributions from staff and their organizations.

Liabilities for these benefits are determined by professional consulting actuaries and recorded as other long-term benefits. Actuarial gains and losses are recognized by nature of expense, in the Statement of Financial Performance (Statement II).

As per the actuarial study, the total liability was US$ 2.4 million at 31 December 2016.

Actuarial summary of terminal payments, the Staff Health Insurance and the Special Fund for Compensation (US$ thousands)

Description	Terminal Payments (other than accrued leave)	Special Fund For Compensation	Accident and Illness Insurance	Staff Health Insurance
Reconciliation of Defined Benefit Obligation				
Defined Benefit Obligation as at 31 December 2015	67 373	15 547		1 678 014
Service cost	7 195	737		71 041
Interest cost	1 900	564		48 535
Actual Gross Benefit Payments for 2016	(8 389)	(693)		(35 853)
Actual Administrative Expenses				(2 179)
Actual contributions by participants				10 170
Plan Amendments				(1 258)
Actuarial (Gain) Loss	(475)	(1 984)	2 364	87 426
Defined Benefit Obligation as at 31 December 2016	**67 604**	**14 171**	**2 364**	**1 855 896**
Reconciliation of Assets				
Assets as at 31 December 2015				608 526
Actual Gross Benefit Payments for 2016	(8 387)	(694)		(57 901)
Actual Administrative Expenses				(3 647)
Organization Contributions during 2016	8 387	694		67 934
Participant Contributions during 2016				34 165
Net HQ Transfer to/from WHO-PAHO/PAHO for 2016				(6 720)
Assets Scheduled to Be Transferred from PAHO-Administered Fund				2 311
Increase/Decrease in 470.1 reserve				334
Interest on Net WHO-Administered SHI Assets for 2016				18 641
Gain/(Loss) on Plan Assets				6 742
Assets as at 31 December 2016				**670 385**
Reconciliation of Unfunded Status				
Defined Benefit Obligation				
Active	67 604	3 115		1 017 823
Inactive		11 056	2 364	838 073
Total defined benefit obligation	67 604	14 171	2 364	1 855 896
Plan Assets				
Gross Plan Assets				(690 901)
Offset for WHO 470.1 Reserve				20 516
Total plan assets				(670 385)
Net Liability (Asset) Recognized in Statement of Financial Position	67 604	14 171	2 364	1 185 511
(Gain)/Loss on Defined Benefit Obligation		(1 984)		
Current	**7 532**	**582**	**1 727**	
Non-current	60 072	13 589	637	1 185 511
Net Liability (Asset) Recognized in Statement of Financial Position	67 604	14 171	2 364	1 185 511
Annual Expense for 2016				
Service Cost	7 195	737		71 041
Interest Cost	1 900	564		29 894
Past Service (Credit)/Cost				(1 258)
Remeasurements	(475)		2 364	
Total Expense Recognized in Statement of Financial Performance	8 620	1 301	2 364	99 677
Acturial (Gain)/Loss recognized in Net Assets/Equity		**(1 984)**		**89 955**
Expected Contributions during 2017				
Contributions by WHO	7 637	591		23 186
Contributions by Participants				47 421
Total expected contributions for 2017	**7 637**	**591**		**70 607**

Staff health insurance sensitivity analysis

2016 discount rate	US$ (thousands)
Current discount rate assumption minus 1%	2 325 370
Current discount rate assumption	1 855 896
Current discount rate assumption plus 1%	1 510 402
31 December 2016 defined benefit obligation	**US$ (thousands)**
Current medical inflation assumption minus 1%	1 520 556
Current medical inflation assumption	1 855 896
Current medical inflation assumption plus 1%	2 298 637

Actuarial methods and assumptions

Each year the Organization identifies and selects assumptions and methods that will be used by the actuaries in the year-end valuation to determine the expense and contribution requirements for the Organization's employee benefits. Actuarial assumptions are required to be disclosed in the financial statements, in accordance with IPSAS 39 (Employee Benefits). In addition, each actuarial assumption is required to be disclosed in absolute terms.

The actuaries used the roll-forward method to estimate the liabilities in 2016. Normally, a full revaluation is done every three years.

Measurement date	
All plans:	31 December 2016
Discount rate	
Terminal payments (other than accrued leave):	The weighted-average discount rate used is 2.8% (decrease from 3.0% in the prior valuation). Based on the combined projected benefit payments with weights of 75% on the Aon Hewitt AA Bond Universe yield curve and 25% on the SIX Swiss Exchange yield curve. The resulting discount rate is rounded to the nearest 0.1%.
Staff health insurance:	Europe, 1.1% (decrease from 1.5% in prior valuation); the Americas, 4.3% (decrease from 4.5% in prior valuation); Other Countries, 4.6% (decrease from 4.8% in prior valuation. Discount rates are based on the yields of high-grade corporate bonds. WHO uses a yield curve approach, which reflects the expected cash flows and assumed currency exposure—specific to the ASHI—for each grouping of offices. The liability is assumed to be incurred in Swiss francs, euros, and U.S. dollars, based on the approximate liability mix for each grouping of offices and the following yield curves: Switzerland—SIX Swiss Exchange curve, Euro Zone—iBoxx Euro Zone curve, and the United States—Aon Hewitt AA Bond Universe The discount rates for the 31 December 2016 valuation are based on the geographic locations of the offices, as described in the "Regional groupings for all purposes except claims costs" below. The resulting rate is rounded to the nearest 0.1%.
Special Fund for Compensation:	The weighted-average discount rate used is 3.4% (decrease from 3.7% in the prior valuation). Based on the combined projected benefit payments with weights of 75% on the Aon Hewitt AA Bond Universe yield curve and 25% on the SIX Swiss Exchange yield curve. The resulting discount rate is rounded to the nearest 0.1%.
Accident and Illness Insurance	The weighted-average discount rate used is 0.6%. Based on the combined projected benefit payments with weights of 30% on the Aon Hewitt AA Bond Universe yield curve and 70% on the SIX Swiss Exchange yield curve. The resulting discount rate is rounded to the nearest 0.1%.

Annual general inflation	
Terminal payments (other than accrued leave):	The weighted-average inflation rate used is 2.2%. Outside of Switzerland, the 2.5% inflation rate is selected to be consistent with the 3.0% rate from the 31 December 2015 valuation of the United Nations Joint Staff Pension Fund (UNJSPF), adjusted downward by 0.5% to reflect the shorter time horizon of the plans. The inflation rate for Switzerland is based on Aon Hewitt's 30 September 2016 forecast of Swiss inflation over the next 10 years. The regional weightings used are 75% on non-Swiss rate and 25% on Swiss rate. Rounding of the resulting weighted-average inflation rates for each plan to the nearest 0.1%.
Staff health insurance:	Europe 1.4%, the Americas 2.5%, Other Countries 2.5%. The rate for Europe is based on Aon Hewitt's Q4 2016 10-year forecast of global capital market assumptions. Specifically, this rate is a weighted average of the rates for Switzerland (1.1%) and the rest of Europe (1.6%), with the result rounded to the nearest 0.1%. The rate for Other Countries and the Americas is selected to be consistent with the 31 December 2015 valuation of the United Nations Joint Staff Pension Fund (which used a 3.0% general inflation assumption), with the resulting rate adjusted downward by 0.5% to reflect the shorter time horizon of WHO's valuation.
Special Fund for Compensation:	The weighted-average inflation rate used is 2.2%. Outside of Switzerland, the 2.5% inflation rate is selected to be consistent with the 3.0% rate from the 31 December 2015 valuation of the United Nations Joint Staff Pension Fund (UNJSPF), adjusted downward by 0.5% to reflect the shorter time horizon of the plans. The inflation rate for Switzerland is based on Aon Hewitt's 30 September 2016 forecast of Swiss inflation over the next 10 years. The regional weightings used are 75% on non-Swiss rate and 25% on Swiss rate. Rounding of the resulting weighted-average inflation rates for each plan to the nearest 0.1%.
Accident and Illness Insurance	The weighted-average inflation rate used is 1.5%. Outside of Switzerland, the 2.5% inflation rate is selected to be consistent with the 3.0% rate from the 31 December 2015 valuation of the United Nations Joint Staff Pension Fund (UNJSPF), adjusted downward by 0.5% to reflect the shorter time horizon of the plans. The inflation rate for Switzerland is based on Aon Hewitt's 30 September 2016 forecast of Swiss inflation over the next 10 years. The regional weightings used are 30% on non-Swiss rate and 70% on Swiss rate. Rounding of the resulting weighted-average inflation rates for each plan to the nearest 0.1%.
Annual salary scale	
All plans:	General inflation, plus 0.5% per year productivity growth, plus merit component. Productivity and merit increases are set equal to those from the 31 December 2015 valuation of the UNJSPF.
Regional groupings for all purposes except claims costs	
Terminal payments (other than accrued leave):	Not applicable
Staff health insurance:	Based on: the Regional Office for Europe, headquarters, which are grouped as Europe; the Regional Office for the Americas constitutes the Americas; and the African Region, the Eastern Mediterranean Region, the South-East Asia Region, and the Western Pacific Region, which are grouped as Other Countries.
Special Fund for Compensation:	Not applicable
Accident and Illness Insurance	Not applicable
Repatriation travel and removal on repatriation	
Terminal payments (other than accrued leave):	Calculated using the projected unit credit method with service prorated, and an attribution period from the "entry on duty date" to separation.
Staff health insurance:	Not applicable
Special Fund for Compensation:	Not applicable
Accident and Illness Insurance	Not applicable
Repatriation grant, termination indemnity, and grant in case of death	
Terminal payments (other than accrued leave):	Using the projected unit credit method with accrual rate proration.

Staff health insurance:	Not applicable
Special Fund for Compensation:	Not applicable
Accident and Illness Insurance	Not applicable
Accrued leave	
Terminal payments (other than accrued leave):	The liability is set equal to the walk-away liability – that is, as if all staff separated immediately.
Staff health insurance:	Not applicable
Special Fund for Compensation:	Not applicable
Accident and Illness Insurance	Not applicable
Abolition of post, end-of-service grant, and separation by mutual agreement	
Terminal payments (other than accrued leave):	These benefits are considered termination benefits under IPSAS 39 and, therefore, are excluded from the valuation.
Staff health insurance:	Not applicable
Special Fund for Compensation:	Not applicable
Accident and Illness Insurance	Not applicable

United Nations Joint Staff Pension Fund

The Fund's Regulations state that the Pension Board shall have an actuarial valuation made of the Fund at least once every three years by the Consulting Actuary. The practice of the Pension Board has been to carry out an actuarial valuation every two years using the Open Group Aggregate Method. The primary purpose of the actuarial valuation is to determine whether the current and estimated future assets of the Pension Fund will be sufficient to meet its liabilities.

WHO's financial obligation to the UNJSPF consists of its mandated contribution, at the rate established by the United Nations General Assembly (currently at 7.9% for participants and 15.8% for member organizations) together with any share of any actuarial deficiency payments under Article 26 of the Regulations of the Fund. Such deficiency payments are only payable if and when the United Nations General Assembly has invoked the provision of Article 26, following determination that there is a requirement for deficiency payments based on an assessment of the actuarial sufficiency of the Fund as of the valuation date. Each member organization shall contribute to this deficiency an amount proportionate to the total contributions that each paid during the three years preceding the valuation date.

The actuarial valuation performed as of 31 December 2015 revealed an actuarial surplus of 0.16% (a deficit of 0.72% in the 2013 valuation) of pensionable remuneration, implying that the theoretical contribution rate required to achieve balance as of 31 December 2015 was 23.54% of pensionable remuneration, compared to the actual contribution rate of 23.70%. The next actuarial valuation will be conducted as of 31 December 2017.

At 31 December 2015, the funded ratio of actuarial assets to actuarial liabilities, assuming no future pension adjustments, was 141.15% (127.5% in the 2013 valuation). The funded ratio was 100.9% (91.2% in the 2013 valuation) when the current system of pension adjustments was taken into account.

After assessing the actuarial sufficiency of the Fund, the Consulting Actuary concluded that there was no requirement, as of 31 December 2015, for deficiency payments under Article 26 of the Regulations of the Fund as the actuarial value of assets exceeded the actuarial value of all accrued liabilities under the Fund. In addition, the market value of assets also exceeded the actuarial value of all accrued liabilities as of the valuation date. At the time of this report, the General Assembly has not invoked the provision of Article 26.

During 2016, WHO paid US$ 162.3 million (US$ 156.7 million in 2015) as a contribution to the UNJSPF. Expected contributions due in 2017 are US$ 160 million.

The United Nations Board of Auditors carries out an annual audit of the Pension Fund and reports to the Pension Fund Pension Board on the audit every year. The UNJSPF publishes quarterly reports on its investments and these can be viewed by visiting the UNJSPF website at www.unjspf.org.

4.13 Deferred revenue

Deferred revenue on voluntary contributions represents multi-year agreements signed in 2016 or prior years but for which the revenue recognition has been deferred to future financial periods. The balance on voluntary contributions is split into current and non-current deferred revenue, depending on when the funds are available to the Organization to spend. Further details of voluntary contributions by fund and by contributor is available on the WHO Programme Budget Web Portal and the WHO Internet.[1]

Deferred revenue on reimbursable procurement relates to revenue recognized where supplies or services have not been delivered to requesting parties at year end. As reimbursable procurement is an exchange transaction, revenue is recorded on an accrual basis. The entire amount of deferred revenue for reimbursable procurement is current.

Description	31 December 2016	31 December 2015
	US$ thousands	
Voluntary contributions	364 297	300 514
Reimbursable procurement	15 611	38 904
Total deferred revenue – current	379 908	339 418
Voluntary contributions	207 278	197 472
Total deferred revenue – non-current	207 278	197 472
Total deferred revenue	**587 186**	**536 890**

4.14 Other current liabilities

The total balance for other current liabilities as at 31 December 2016 was US$ 63.3 million (US$ 108.8 million as at 31 December 2015). The largest component is composed of the various year-end accruals totalling US$ 42.3 million.

Description	31 December 2016	31 December 2015
	US$ thousands	
Accrual for uninvoiced goods and services	21 269	62 551
Accrual for restructuring cost	661	3 188
Accrued staff liability	12 520	3 469
Accrual for refunds payable	7 890	3 376
Pension payable	775	2 067
Insurance payable	4 632	12 951
Foundations	3 505	3 530
Other liabilities	12 096	17 615
Total other current liabilities	**63 348**	**108 747**

The balance for foundations concerns funds that WHO holds in trust and for whose financial and administrative management the Organization is responsible. As at 31 December 2016, the foundations with funds in trust were as follows.

- Down Syndrome Research Prize Foundation in the Eastern Mediterranean Region
- Dr A.T. Shousha Foundation

[1] WHO Programme Budget Web Portal – http://extranet.who.int/programmebudget/ and details of voluntary contributions by fund and by contributor, 2016 (document A70/INF./4) on the WHO website – http://www.who.int/about/finances-accountability/reports/en/.

- Dr Comlan A.A. Quenum Prize for Public Health
- Ihsan Doğramacı Family Health Foundation
- Jacques Parisot Foundation
- Léon Bernard Foundation
- Francesco Pocchiari Fellowship
- Foundation for the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region
- State of Kuwait Health Promotion Foundation
- United Arab Emirates Health Foundation
- Dr Lee Jong-Wook Memorial Prize for Public Health

4.15 Inter-entity liabilities

WHO hosts a number of entities through administrative service agreements. As cash for all entities is managed by the Organization, liabilities exist with these entities for funds held on their behalf. The total amounts due per entity are as follows.

Description	31 December 2016	31 December 2015
	US$ thousands	
Staff Health Insurance (SHI)	53 953	60 341
International Computing Centre (ICC)	22 035	15 490
International Drug Purchase Facility (UNITAID)	791 148	783 021
African Programme for Onchocerciasis Control (APOC)		6 171
Trust Fund for the Joint United Nations Programme on HIV/AIDS (UNAIDS)	153 554	143 888
Total inter-entity liabilities	**1 020 690**	**1 008 911**

4.16 Long-term borrowings

Resolution WHA55.8 (2002) and resolution WHA56.13 (2003), authorized construction of a new building at headquarters for WHO and UNAIDS at an estimated cost of CHF 66 million, of which WHO's share was estimated at CHF 33 million. The Swiss Confederation agreed to provide an interest-free loan to WHO and UNAIDS of CHF 59.8 million, of which WHO's share is CHF 29.9 million. In the resolutions mentioned above, the World Health Assembly also approved the use of the Real Estate Fund for the repayment over a 50-year period of the Organization's share of the interest-free loan provided by the Swiss Confederation with effect from the first year of the completion of the building.

The outstanding amount of US$ 21.8 million for the UNAIDS building loan is reflected at an amortized cost using the effective interest rate of 0.35% (0.7% for 2015) applicable for Swiss Confederation 30-year bonds. Of the total amount outstanding on the loan, US$ 0.6 million will be due in the next 12 months and is shown as current liability, which is separately disclosed for the first time in 2016 .

In 2015, the Organization signed a new loan agreement of US$ 14 million, towards the planning phase of the updated renovation strategy for WHO buildings in Geneva (decision WHA 67(12)). A total of US$ 11.9 million had been received as of 31 December 2016.

The outstanding balance of the loan at 31 December 2016 was US$ 33.7 million (US$ 27.5 million at 31 December 2015) and is made up as follows:

Description	31 December 2016	31 December 2015
	US$ thousands	
Current liabilities		
WHO/UNAIDS building	583	
Total current liabilities	**583**	
Non-current liabilities		
WHO/UNAIDS building	21 234	21 592
WHO HQ building	11 905	5 885
Total non-current liabilities	**33 139**	**27 477**
Total long-term borrowings	**33 722**	**27 477**

5. Supporting information to the Statement of Financial Performance

5.1 Revenue

Assessed contributions

Assessed contributions for 2016 were US$ 470 million[1] (US$ 463 million for 2015).

Description	31 December 2016	31 December 2015
	US$ thousands	
Assessed contributions	467 725	467 499
Decrease/(Increase) in allowance for doubtful accounts	2 311	(4 848)
Assessed contributions net of allowance	**470 036**	**462 651**

In May 2015, the Sixty-eighth World Health Assembly adopted the resolution for the financial period 2016–2017,[2] in which it approved a total effective budget of US$ 4385 million which was later revised to US$ 4545 through the adoption of decision WHA69(9) (2016). In resolution WHA68.1, the Health Assembly further resolved that the total assessment on Member States in respect of the financial period 2016–2017 would be US$ 929 million.

Following resolution WHA66.16 (2013), since 2014 the assessed contributions have been invoiced in Swiss francs and United States dollars. Where the total annual assessed contribution for a Member State is US$ 200 000 or more, the contribution is assessed half in United States dollars and half in Swiss francs. Where the annual assessed contribution for a Member State is less than US$ 200 000, the contribution is assessed in United States dollars only. The annual assessment for 2016 amounted to US$ 478 million or US$ 241 million and CHF 224 million per year using the May 2015 exchange rate. Contributions are due from 1 January so the Swiss franc portion of the assessment was recorded at the January 2016 exchange rate, which resulted in an exchange loss on recording of US$ 10 million. As a result, the total accounted assessed contributions were US$ 468 million.

[1] See document A70/41 for details of the status of collection of assessed contributions.

[2] Resolution WHA68.1

Voluntary contributions

Voluntary contributions for 2016 were US$ 1752 million (US$ 1838 million for 2015).

Description	31 December 2016	31 December 2015
	US$ thousands	
Voluntary contributions	1 751 639	1 839 094
Decrease/(increase) in allowance for doubtful debts	172	(651)
Voluntary contributions net of allowance	**1 751 811**	**1 838 443**

Voluntary contributions represent revenue recognized from governments, intergovernmental organizations, institutions, other United Nations organizations as well as non-government organizations. Much of the revenue reported in 2016 relates to agreements that continue in future years. Further details of voluntary contributions by fund and by contributor are contained in the Annex to the Financial Report.[1]

The figure for total voluntary contributions reported of US$ 1752 million is after the deduction of (i) refunds to contributors – these amounted to US$ 17.8 million (US$ 33.9 million for 2015); (ii) reductions in revenue recognized in prior years due to evidence arising in the current year that amounts will no longer be collected – these amounted to US$ 11.8 million (US$ 19.5 million for 2015); and (iii) the adjustment of payment terms with the effect of increasing deferred revenue and decreasing current revenue for revenue recognized in previous years – these amounted to US$ 13.6 million (US$ 1.0 million for 2015).

Voluntary contributions in-kind and in-service

WHO receives non-cash contributions from Member States and other contributors. In 2016, the Organization received in-kind and in-service contributions amounting to US$ 87.7 million (US$ 129.9 million as at 31 December 2015).[2] Further details of in-kind and in-service contributions is available on the WHO Programme Budget Web Portal and on the WHO Internet.[3]

In 2016, the in-kind and in-service expense was US$ 87.6 million (see Statement V). In-kind contributions of cholera, meningitis and yellow fever vaccines for US$ 0.1 million (US$ 3.7 million for 2015) received from the International Coordinating Group account for the difference between the in-kind revenue and expense. This in-kind contribution was charged to donor activities so that funds would be available under the Outbreak and Crisis Response Fund, Voluntary Fund for the future purchases of vaccines.

Description	31 December 2016	31 December 2015
	US$ thousands	
In-kind – Medical supplies and materials	62 127	96 678
In-kind – Office space	9 090	13 466
In-service	16 532	19 769
Total voluntary contributions in-kind and in-service	**87 749**	**129 913**

In addition, WHO also benefits from land made available from the host governments either at no cost or at a token rent. As the title to the land remains with the government, the use of the land is not recognized in the financial statements. The table below indicates the locations where land has been made available to WHO to construct or purchase premises.

[1] WHO Programme Budget Web Portal – http://extranet.who.int/programmebudget/ and details of voluntary contributions by fund and by contributor, 2016 (document A70/INF./4) on the WHO website – http://www.who.int/about/finances-accountability/reports/en/.

[2] Further details of in-kind and in-service contributions is available on the WHO Programme Budget Web Portal and on the WHO Internet: http://www.who.int/about/finances-accountability/funding/voluntary-contributions/en/.

[3] See http://www.who.int/about/finances-accountability/funding/voluntary-contributions/en/.

Region	Country	City
HQ	Switzerland	Geneva
AFRO	Equatorial Guinea	Malabo
AFRO	Republic of South Sudan	Juba
EMRO	Egypt	Cairo
EMRO	Afghanistan	Kabul
EMRO	Pakistan	Islamabad
EMRO	Jordan	Amman
EMRO	Tunisia	Tunis
EMRO	Somalia	Garowe
SEARO	India	New Delhi
WPRO	Philippines	Manila

Reimbursable procurement

WHO procures medicines, vaccines, equipment and other supplies on behalf of Member States and other United Nations agencies. The total revenue and expenses recognized for 2016 for reimbursable procurement was US$ 25.3 million (US$ 26.2 million for 2015) after the deduction of refunds to contributors of US$ 2.7 million (US$ 4.1 million for 2015). The balance of funds received in advance for reimbursable procurement is reported as deferred revenue. The revenue and expenses related to reimbursable procurement form part of the Enterprise Fund and are not reported against the programme budget.

Other operating revenue

In 2016, other operating revenue totalled US$ 29.1 million (US$ 18 million as at 31 December 2015). This mainly represents earnings generated for hosting entities such as UNAIDS UNITAID, and International Computing Centre and staff contributions for accident and illness insurance. Other sources of earnings also included the sale of publications and royalties.

5.2 Expenses

Staff costs

Staff and other personnel costs reflect the total cost of employing staff at all locations and include charges for base salary, post adjustment and any other types of entitlements (e.g. pensions and insurances) paid by the Organization. Staff costs also include the movement in the staff health insurance actuarial liability that is recognized in the Statement of Financial Performance (Statement II).

Description	31 December 2016	31 December 2015 (restated)[1]
	US$ thousands	
Salary cost	811 855	808 186
Actuarial cost	23 067	36 644
Other personnel costs	75 869	65 632
Total staff costs	**910 791**	**910 462**

[1] Refer to note 3.

Medical supplies and materials

Medical supplies and materials are mainly purchased and distributed by WHO to support programmatic activities in countries. These include hospital supplies, vaccines, medicines as well as related shipping costs. The

medical supplies expense includes the cost of reimbursable procurement – refer to note 5.1 (Reimbursable procurement).

Description	31 December 2016	31 December 2015
	US$ thousands	
Medical supplies	182 805	184 980
Medical supplies – in-kind	61 657	80 501
Total medical supplies and materials	**244 462**	**265 481**

Contractual services

Contractual services represent expenses incurred for suppliers engaged by WHO to provide services in support of the Organization's programmatic activities. The main components within contractual services are direct implementation (implemented by WHO e.g. vaccination campaigns directly in collaboration with national governments), agreements for performance of work, consulting contracts including special service agreements given to individuals to perform activities on behalf of the Organization. Medical research activities, costs for fellowships, and security expenses are also included in contractual services.

Description	31 December 2016	31 December 2015
	US$ thousands	
Direct implementation	233 042	220 899
Contractual services	361 627	433 458
Fellowships and SSA	61 182	70 811
Security and other costs	19 869	18 928
Total contractual services	**675 720**	**744 096**

Transfers and grants

Transfers and grants to counterparts include non-exchange contracts signed with national counterparts (mainly health ministries) and letters of agreement signed with other counterparts to perform activities that are in line with the Organization's objectives. Transfers and grants to government ministries are referred to as "direct financial cooperation" (DFCs). Funds are normally expensed at the time of transfer to the contractual partner. Counterparts are required to report back on the use of funds to ensure that they are used according to the agreement, and WHO performs on-site monitoring and spot checks of ongoing activities on DFCs and post-facto review of selected DFCs based on risk assessments. WHO may withhold further funding to recipients of transfers and grants on the basis of performed assurance activities if the requirements of the agreement have not been met.

Description	31 December 2016	31 December 2015
	US$ thousands	
Direct financial cooperation	203 695	243 532
Grant letters of agreement	45 515	68 185
Total transfer and grants	**249 210**	**311 717**

Travel

The cost of travel for WHO staff, non-staff participants in meetings, consultants and representatives of Member States paid by the Organization is included in the balance total for travel expenses. Travel expenses include airfare, per diem and other travel-related costs. This amount does not include the statutory travel for home leave or education grant, which is accounted for within staff and other personnel costs.

Description	31 December 2016	31 December 2015
	US$ thousands	
Travel	200 331	233 539
Total travel	**200 331**	**233 539**

General operating expenses

General operating expenses reflect the cost of general running costs incurred to maintain country offices, regional offices and headquarters including utilities, telecommunications (fixed telephone, mobile phone, Internet and global network expenses), office rents etc. Hospitality and courtesy expenses that are mainly incurred during workshops, meetings and training are included here, as well as the catastrophic accident and illness insurance premium.

"Other in-kind" pertains to the computers, vehicles, office rent, supplies and other items that were received as in-kind contributions.

Description	31 December 2016	31 December 2015[1]
	US$ thousands	
General operating costs	118 668	163 439
Hospitality and courtesy costs	3 652	2 384
Other in-kind	9 465	25 892
Total general operating expenses	**131 785**	**191 715**

[1] Refer to note 3.

Equipment, vehicles and furniture

As WHO opted to use the transitional provision under IPSAS 17 (Property, Plant, and Equipment), the Organization currently expenses the full cost of equipment, vehicles and furniture at the point of delivery, excluding owned land and buildings. Total expenses for 2016 were US$ 55.8 million (US$ 67.7 million as at 31 December 2015).

Depreciation and amortization

Depreciation is the expense resulting from the systematic allocation of the depreciable amounts of property, plant and equipment over their useful lives. As of 2016, it relates to all the Organization's buildings.

Amortization is the expense resulting from the systematic allocation of the amortizable amount of intangible assets over their useful lives. As of 2016, it relates to purchased software.

Description	31 December 2016	31 December 2015
	US$ thousands	
Depreciation	2 204	2 110
Amortization	632	323
Total depreciation and amortization	**2 836**	**2 433**

5.3 Finance revenue

Finance revenue includes the following:

Description	31 December 2016	31 December 2015 (restated)[1]
	US$ thousands	
Investment revenue	34 308	20 820
Bank charges and investment management fees	(3 279)	(3 083)
Net realized foreign exchange gains or (losses)[2]	50 056	284
Net unrealized foreign exchange gains or (losses)	(4 120)	9 020
Actuarial revaluation gains or (losses) on Terminal Payments Fund and Accident and Illness Insurance Fund	(1 889)	3 847
Actuarial interest cost related to valuation of Terminal Payments Fund, Special Fund for Compensation and Accident and Illness Insurance Fund	(2 465)	(2 213)
Net total finance revenue	**72 611**	**28 675**
Investment revenue and foreign exchange gains and losses apportioned to other entities	(9 929)	(7 633)
Total net finance revenue	**62 682**	**21 042**

[1] Refer to note 3.

[2] Includes differences due to rounding of the financial statement to the nearest thousand US dollars.

Total finance revenue includes amounts related to funds administered by WHO on behalf of other entities (refer to Note 4.15). The investment income relating to other entities is allocated to those entities. Certain funds earned investment income; in addition, interest is apportioned based on average fund balance and reported as finance revenue for the fund.

6. Supporting information to the Statement of Changes in Net Assets/Equity

6.1 General Fund

The accounts under this fund are part of the programme budget. The summary of the General Fund is as follows.

Description	31 December 2016	31 December 2015
	US$ thousands	
Regular Budget	3 838	43 176
Voluntary Funds	2 164 343	2 166 155
Total General Fund	**2 168 181**	**2 209 331**

6.1.a Regular budget

This note provides details of financing and revenue for assessed contributions, along with the transfer made to the Tax Equalization Fund for the year 2016 (as resolved by the Health Assembly, inter alia, in resolution WHA68.1 (2015)). The status of the funds available (as shown in the table below) highlights the net surplus/ (deficit) of the Regular budget.

Description	Member States AC Fund	Tax Equalization Fund	Working Capital Fund	Total
	US$ thousands			
Balance as at 1 January 2016	**17 738**	**(5 562)**	**31 000**	**43 176**
Programmatic revenue and expenses				
Net Member States' assessed contributions	470 036			470 036
Tax equalization appropriations	(13 489)	13 489		–
Finance revenue	(665)			(665)
Miscellaneous revenue	2 307			2 307
Programmatic expenses	(494 276)			(494 276)
Tax reimbursements to staff members		(16 740)		(16 740)
Balance as at 31 December 2016	**(18 349)**	**(8 813)**	**31 000**	**3 838**

For details regarding assessed contributions revenue, see Note 5.1

In line with resolution WHA68.1, US$ 13.5 million was transferred to the Tax Equalization Fund.

In resolution WHA68.1, the Health Assembly decided that the Working Capital Fund should be maintained at its existing level of US$ 31 million.

6.1.b Voluntary Funds

This note provides details of the core, specified and partnerships under the Voluntary Fund, the revenues and expenditures for which are reported as implementation of the programme budget. The summary of the Voluntary Fund is as follows:

Description	Notes	31-December-2016	31-December-2015
		US$ thousands	
Voluntary Contributions Core Fund		190 285	154 376
Voluntary Contributions Specified Fund		1 145 431	1 118 132
Special Programme for Research and Training in Tropical Diseases (TDR Trust Fund)		19 277	20 890
Special Programme of Research, Development and Research Training in Human Reproduction (HRP Trust Fund)		44 291	40 146
Special Programmes and Collaborative Arrangements Fund		193 359	334 162
Special Account for Servicing Costs Fund	6.1.b.i	415 062	302 775
Outbreak and Crisis Response Fund		139 561	181 409
Contingency Fund for Emergencies	6.1.b.ii	17 077	14 265
Total voluntary funds		**2 164 343**	**2 166 155**

6.1.b.i Special Account for Servicing Costs Fund

The Special Account for Servicing Costs Fund was established in order to support the costs of servicing activities financed from sources other than the assessed contribution budget (i.e. from voluntary contributions).

The Fund is credited with revenue from the following sources:

- under resolution WHA34.17 (1981), funds are received for programme support costs from voluntary sources and are calculated by applying a fixed percentage rate to total expenses
- administrative service agreements with other entities
- interest earned on voluntary funds as described in document EB122/3

A summary of the Fund is provided below.

Description	31 December 2016	31 December 2015
	US$ thousands	
Balance as at 1 January	**302 775**	**264 447**
Revenue		
Programme support costs	148 667	169 244
Finance revenue	67 134	7 455
Administrative service agreements with other entities	6 144	6 041
Other revenue	1 310	
Total revenue	**223 255**	**182 740**
Expenses		
Staff and other personnel costs	68 487	80 554
Medical supplies and materials	289	642
Contractual services	19 841	16 065
Transfers and grants to counterparts	(38)	726
Travel	2 676	4 281
General operating expenses	16 711	33 039
Equipment, vehicles and furniture	3 174	8 454
Total expenses	**111 140**	**143 761**
Less:		
Increase/(decrease) in allowance for doubtful accounts receivables – voluntary contributions[a]	(172)	651
Balance as at 31 December	**415 062**	**302 775**

(a): In 2016, there is a decrease in the allowance for doubtful accounts receivables under voluntary contributions, refer to Note 4.3.

Expenses under the Fund by major office are as follows.

Expenses by major office	31 December 2016	31 December 2015
	US$ thousands	
Global and interregional activities	44 140	54 123
Regional Office for Africa	20 811	30 245
Regional Office for the Americas	9 043	5 756
Regional Office for the Eastern Mediterranean	14 047	15 485
Regional Office for Europe	6 219	10 718
Regional Office for South-East Asia	9 414	14 848
Regional Office for the Western Pacific	7 466	12 586
Total expenses by major office	**111 140**	**143 761**

6.1.b.ii Contingency Fund for Emergencies

This fund was established by the Sixty-eighth World Health Assembly in decision WHA68(10) (2015). The purpose of the fund is to provide temporary financing for the emergency field operations with a target capitalization of US$ 100 million. It will be funded by voluntary contributions. A summary of the fund is as follows.

Description	31 December 2016	31 December 2015
	US$ thousands	
Balance as at 1 January	**14 265**	
Revenue		
Contributions	18 090	14 296
Total revenue	**18 090**	**14 296**
Expenses		
Staff costs	867	
Medical supplies and materials	1 556	
Contractual services	3 615	
Transfers and grants	565	
Travel	5 517	31
General operating expenses	2 795	
Equipment, vehicles and furniture	363	
Total expenses	**15 278**	**31**
Balance as at 31 December	**17 077**	**14 265**

6.2 Member States - other

The accounts under this fund are outside the programme budget. The summary of the Member States - other is as follows.

Description	31 December 2016	31 December 2015 (restated)
	US$ thousands	
Common Fund	86 022	103 014
Enterprise Fund (refer to note 6.2.a)	17 483	9 365
Special Purpose Fund (refer to note 6.2.b)	(998 265)	(915 960)
Total Member States – other	**(894 760)**	**(803 581)**

6.2.a Enterprise Fund

This fund contains accounts for self-sustaining activities. The revenue and expenses under this fund are not included in the reporting of the programme budget. The summary of the Enterprise Fund is as follows.

Description	31 December 2016	31 December 2015
	US$ thousands	
Enterprise Fund		
Revolving Sales Fund	3 848	3 526
Concessions Fund	3 724	2 981
Insurance Policies Fund	1 063	859
Garage Rental Fund	2 873	1 999
Accident and Illness Insurance Fund (refer to note 6.4)	5 975	
Total Enterprise Fund	**17 483**	**9 365**

6.2.b Special Purpose Fund

The accounts contained under this fund are used for specific purpose. The revenue and expenses are not included in the reporting of the programme budget. The summary of the Special Purpose Fund is as follows.

Description	31 December 2016	31 December 2015 (restated)
	US$ thousands	
Special Purpose Fund		
Real Estate Fund	95 725	90 980
Building Loan Fund	(7 891)	(2 525)
Security Fund	2 794	2 921
Information Technology Fund	4 141	12 009
Special Fund for Compensation[a]	(4 859)	(8 223)
Terminal Payments Fund	6 479	(3 904)
Non-Payroll Staff Entitlements Fund	16 624	20 756
Post Occupancy Charge Fund	26 243	8 150
Mobility Fund	10 073	
Internal Service Cost Recovery Fund	4 413	3 884
Staff Health Insurance Fund[a]	(1 182 510)	(1 069 488)
Stockpiles Replenishment Fund	10 503	9 480
Polio Staff Fund	20 000	20 000
Total Special Purpose Fund	**(998 265)**	**(915 960)**

[a] Following the adoption of IPSAS 39, 2016 opening balance was restated, refer to note 3.

6.2.b.1 Real Estate Fund

This fund was established by the Health Assembly in resolution WHA23.14 (1970). The Fund is used to meet the costs of: the construction of buildings or extensions to existing buildings; the acquisition of land that may be required; and major repairs and alterations to WHO's existing office buildings and to residences leased to staff by the Organization. Specific Health Assembly authorization is required for the acquisition of land and the construction of buildings or extensions to existing buildings.

The summary of the fund is as follows.

Description	31 December 2016	31 December 2015
	US$ thousands	
Balance as at 1 January	**90 980**	**64 766**
Revenue		
Appropriation received in accordance with resolution WHA63.7 (2010)		10 000
Transfer for special projects[a]		7 141
Sale proceeds		4 327
Rents collected	2 073	2 253
Other revenue	8 886	8 282
Total revenue	**10 959**	**32 003**
Expenses		
Staff and other personnel costs	9	94
Medical supplies and materials	22	51
Contractual services	4 173	1 201
Transfers and grants		26
Travel	34	10
General operating expenses	1 063	3 390
Equipment, vehicles and furniture	913	1 017
Total expenses	**6 214**	**5 789**
Balance as at 31 December	**95 725**	**90 980**

[a] In 2016, US$ 5.2 million by AFRO and US$ 1.9 million by SEARO was transferred to the Real Estate Fund

Expenses under the Real Estate Fund are as follows.

Description	31 December 2016	31 December 2015
	US$ thousands	
Expenses by major office		
Headquarters	1 692	2 126
Regional Office for Africa	3 825	956
Regional Office for the Americas		203
Regional Office for the Eastern Mediterranean	326	1 626
Regional Office for Europe		163
Regional Office for South-East Asia		231
Regional Office for the Western Pacific	371	484
Total expenses	**6 214**	**5 789**

6.3 Fiduciary Fund

This fund accounts for assets that are held by WHO in a trustee or agent capacity for others and that cannot be used to support the Organization's own programmes. The Fund includes the assets of the partnerships that are administered by the Organization and whose budgets are not approved by the Health Assembly. The summary of the Fiduciary Fund is as follows.

Description	31 December 2016	31 December 2015
	US$ thousands	
Fiduciary Fund		
WHO Framework Convention on Tobacco Control	10 707	7 226
Roll Back Malaria Partnership Fund (refer to note 6.4)	964	4 540
Partnership for Maternal, Newborn and Child Health Fund	2 255	4 343
United Nations System Standing Committee on Nutrition Fund (refer to note 6.4)		305
Alliance for Health Policy and System Research Fund	14 851	15 779
Global Health Workforce Alliance Fund	1 515	2 205
Stop TB Partnership (refer to note 6.4)		2 298
European Observatory on health systems and policies	5 074	5 417
ESPEN Fund	7 727	761
Total Fiduciary Fund	**43 093**	**42 874**

6.4 Changes to funds under Statement III (Statement of Changes in Net Assets/Equity)

As at 31 December 2016, the following new funds were established or in the process of closing:

- **Accident and Illness Insurance Fund** – A new fund was created in 2016 to record and report contributions and benefits for staff members in case of accident and illness.
- **Roll Back Malaria Partnership Fund** – Roll Back Malaria operations closed at 31 December 2015. Administrative closure of the fund will be finalized in 2017.
- **United Nations System Standing Committee on Nutrition Fund** – UNSSC operations closed at 31 December 2015. The final balance due was paid in 2016.
- **Stop TB Partnership** – Effective from 1 January 2016, the administration of Stop TB Partnership has moved to the United Nations Office for Project Services. The final balance due was paid in 2016.

7. Supporting information to the Statement of Comparison of Budget and Actual Amounts

In May 2015, the Health Assembly adopted resolution WHA68.1 on the Programme budget 2016–2017, in which it approved the budget for the financial period 2016–2017, under all sources of funds, namely, assessed and voluntary contributions of US$ 4385 million. WHO's budget is adopted on a biennial basis by the Health Assembly. In May 2016, the Health Assembly adopted decision WHA69(9) to revise the Programme budget 2016-2017 to US$ 4545 million (an increase of US$ 160 million compared to the figure

originally approved). Further, the programme budget for Polio, Outbreak and Crisis Response and Special Programmes (TDR and HRP) has been increased due to the event-driven nature and financing of these programmes from the Health Assembly approved amount of US$ 1191 million to US$ 2317 million as per the Director-General's delegated authority under resolution WHA68.1. The total revised budget is US$ 5671 million. As the Organization's methodology is based on a results-based framework, the approved programme budget is measured on expenses incurred during the programme budget period.

WHO's budget and financial statements are prepared using a different accounting basis. The Statement of Financial Position (Statement I), Statement of Financial Performance (Statement II), Statement of Changes in Net Assets/Equity (Statement III), and Statement of Cash Flow (Statement IV) are prepared on a full accrual basis, whereas the Statement of Comparison of Budget and Actual Amounts (Statement V) is established on a modified cash basis (i.e. actual expenses are used to measure the budget utilization).

As per the requirements of IPSAS 24 (Presentation of Budget Information in Financial Statements), the actual amounts presented on a comparable basis to the budget shall, where the financial statements and the budget are not prepared on a comparable basis, be reconciled to the actual amounts presented in the financial statements, identifying separately any differences in terms of basis, timing, entity and presentation. The General Fund, as per Note 2.17, represents the programme budget results, except for the Tax Equalization Fund expenses, other non-programme budget utilization and all in-kind/in-service expenses which are not included in the programme budget results.

Explanations of material differences between the final budget and the actual amounts by Category and Programme Area are available in section 1 of this document.

As required by IPSAS 24 (Presentation of Budget Information in Financial Statements), reconciliation is provided on a comparable basis between the actual amounts as presented in Statement V and the actual amounts in the financial accounts identifying separately any basis, timing, entity and presentation differences.

Basis differences occur when the components of the approved programme budget are used for activities other than the implementation of technical programmes. Examples of this include Tax Equalization Fund expenses, other non-programme budget utilization and special arrangements.

Timing differences represent the inclusion in WHO's financial accounts of programme budget expenses in other financial periods.

Entity differences represent the inclusion in WHO's financial accounts of the amounts against two funds: Member States – other and the Fiduciary Fund. These funds do not form part of the Organization's programme budget.

Presentation differences concern differences in the format and classification schemes in the Statement of Cash Flow (Statement IV) and the Statement of Comparison of Budget and Actual Amounts (Statement V).

A reconciliation between the actual amounts on a comparable basis in Statement V and the actual amounts in Statement IV for December 2016 is presented below.

Description	2016			
	Operating	Investing	Financing	Total
	US$ thousands			
Actual amount on a comparable basis (Statement V)	(2 182 185)			(2 182 185)
Basis differences	47 920	9 646	5 437	63 003
Timing differences	80 275			80 275
Entity differences	160 517	(1 932)		158 585
Presentation differences	1 896 552	(10 658)		1 885 894
Actual amount in the Statement of Cash Flow (Statement IV)	**3 079**	**(2 944)**	**5 437**	**5 572**

8. Segment reporting

8.1 Statement of Financial Position by segments

As at 31 December 2016 (In thousands of US dollars)

Description	Headquarters	Regional Office for Africa	Regional Office for the Americas	Regional Office for the Eastern Mediterranean	Regional Office for Europe	Regional Office for South-East Asia	Regional Office for the Western Pacific	Total
ASSETS								
Current assets								
Cash and cash equivalents	390 222	26 108		12 015	1 489	3 163	3 893	436 890
Short-term investments	2 717 079							2 717 079
Receivables - current	1 381 588	964	(511 543)	84	263	355	97	871 808
Staff receivables	5 166	2 088		593	363	864	1 169	10 243
Inventories	15 065	1 515		21 461		917	596	39 554
Prepayments and deposits	8 082	135		47	981	135	235	9 615
Other current assets								
Total current assets	**4 517 202**	**30 810**	**(511 543)**	**34 200**	**3 096**	**5 434**	**5 990**	**4 085 189**
Non-current assets								
Receivables - non-current	207 278							207 278
Long-term investments	95 846							95 846
Property, plant and equipment	45 034	5 415		19 500		144	871	70 964
Intangibles	4 788							4 788
Total non-current assets	**352 946**	**5 415**		**19 500**		**144**	**871**	**378 876**
TOTAL ASSETS	**4 870 148**	**36 225**	**(511 543)**	**53 700**	**3 096**	**5 578**	**6 861**	**4 464 065**
LIABILITIES								
Current liabilities								
Contributions received in advance	68 346							68 346
Accounts payable	12 048	9 244		11 547	2 311	3 905	2 074	41 129
Staff payable	719	654		372	31	139	90	2 005
Accrued staff benefits - current	22 189	11 572		3 935	2 935	2 953	3 064	46 648
Deferred revenue	379 908							379 908
Financial liabilities	24 668							24 668
Other current liabilities	(12 187 445)	5 414 632	131 329	3 020 747	961 280	1 559 955	1 162 850	63 348
Inter-entity liabilities	1 020 690							1 020 690
Long-term borrowings - current	583							583
Total current liabilities	**(10 658 294)**	**5 436 102**	**131 329**	**3 036 601**	**966 557**	**1 566 952**	**1 168 078**	**1 647 325**
Non-current liabilities								
Long-term borrowings - non-current	33 139							33 139
Accrued staff benefits - non-current	801 014	197 926		59 947	81 779	70 171	48 972	1 259 809
Deferred revenue - non-current	207 278							207 278
Total non-current liabilities	**1 041 431**	**197 926**		**59 947**	**81 779**	**70 171**	**48 972**	**1 500 226**
TOTAL LIABILITIES	**(9 616 863)**	**5 634 028**	**131 329**	**3 096 548**	**1 048 336**	**1 637 123**	**1 217 050**	**3 147 551**
NET ASSETS/EQUITY								
General Fund	14 612 344	(5 363 011)	(628 232)	(2 850 799)	(932 228)	(1 551 245)	(1 118 648)	2 168 181
Member States - other	(183 444)	(233 926)	(14 427)	(191 874)	(99 705)	(79 996)	(91 388)	(894 760)
Fiduciary funds	58 111	(866)	(213)	(175)	(13 307)	(304)	(153)	43 093
TOTAL NET ASSETS/EQUITY[a]	**14 487 011**	**(5 597 803)**	**(642 872)**	**(3 042 848)**	**(1 045 240)**	**(1 631 545)**	**(1 210 189)**	**1 316 514**
TOTAL LIABILITIES AND NET ASSETS/EQUITY	**4 870 148**	**36 225**	**(511 543)**	**53 700**	**3 096**	**5 578**	**6 861**	**4 464 065**

Note a. Under other current liabilities, the high balances between offices are mainly due to inter-office accounting, which nets to zero across offices; under net assets/equity, the high balances are due to centralized accounting for revenue and decentralized accounting for expenses.

8.2 Statement of Financial Performance by segments

For the year ended 31 December 2016 (In thousands of US dollars)

Description	Headquarters	Regional Office for Africa	Regional Office for the Americas	Regional Office for the Eastern Mediterranean	Regional Office for Europe	Regional Office for South-East Asia	Regional Office for the Western Pacific	Total
Revenue								
Assessed contributions	470 036							470 036
Voluntary contributions	1 750 721	1 038			52			1 751 811
Voluntary contributions in-kind and in-service	22 752	33 343		3 973	4 813	18 822	4 046	87 749
Reimbursable procurement	25 294							25 294
Other revenue	35 097	(3 157)		879	(2 150)	(796)	(687)	29 186
Total revenue	**2 303 900**	**31 224**		**4 852**	**2 715**	**18 026**	**3 359**	**2 364 076**
Expenses								
Staff costs	427 422	200 257	30 468	81 600	63 449	51 901	55 694	910 791
Medical supplies and materials	48 662	62 880	1 248	85 145	5 189	32 300	9 038	244 462
Contractual services	165 175	214 864	10 593	182 885	28 005	52 903	21 295	675 720
Transfers and grants	14 261	127 451	3 611	62 885	798	21 625	18 579	249 210
Travel	87 854	55 881	10 996	14 753	11 533	10 189	9 125	200 331
General operating expenses	27 117	46 307	6 103	23 819	9 406	12 686	6 347	131 785
Equipment, vehicles and furniture	7 749	24 948		15 457	1 326	3 886	2 396	55 762
Depreciation and amortization	1 697	227		403		74	435	2 836
Total expenses	**779 937**	**732 815**	**63 019**	**466 947**	**119 706**	**185 564**	**122 909**	**2 470 897**
Finance revenue	**64 084**	**(1 693)**		**494**	**(387)**	**(144)**	**328**	**62 682**
TOTAL (DEFICIT)/SURPLUS FOR THE YEAR[a]	**1 588 047**	**(703 284)**	**(63 019)**	**(461 601)**	**(117 378)**	**(167 682)**	**(119 222)**	**(44 139)**

Note a. The revenue balance shows a high surplus for headquarters and deficits for other offices. This is a consequence of the policy of centralized accounting for revenue and decentralized accounting for expenses.

9. Amounts written-off and ex-gratia payments

During 2016, a total of US$ 328 434 was approved as write-off (nil in 2015). This amount is comprised of (i) US$ 300 828 for salary advances, travel advances and missing pension contributions mainly from former staff members where recovery was deemed impossible; and (ii) US$ 27 606 relates to supplier advances and credit memos where the balance was deemed impossible to recover.

During 2016, no ex-gratia payment was approved (US$ 84 435 in 2015).

10. Related party and other senior management disclosures

Staff members considered to be "key management personnel" are the Director-General, regional directors and all other ungraded staff.

The number of key management personnel who held these positions over the course of the year was 18. The table below details their aggregate remuneration.

Description	US$ thousands
Compensation and post adjustment	3 990
Entitlements	138
Pension and health plans	1 076
Total remuneration	**5 204**
Outstanding advances against entitlements	**20**
Outstanding loans (in addition to normal entitlements, if any)	**–**

The aggregate remuneration of key management personnel includes: net salaries, post adjustment, entitlements such as representation allowance and other allowances, assignment and other grants, rental subsidy, personal effect shipment costs, and employer pension and current health insurance contributions.

Key management personnel are also qualified for post-employment benefits at the same level as other employees. These benefits cannot be reliably quantified. Key management personnel are ordinary members of the UNJSPF.

The Regional Director for the Americas is included among the key management personnel. However, as the Regional Director is receiving all entitlements and benefits from PAHO, the entitlements and benefits concerned are disclosed in PAHO's financial statements and not in WHO's financial statements.

During the year, no loans were granted to key management personnel beyond those widely available to staff outside this grouping.

11. Events after the reporting date

WHO's reporting date is 31 December 2016. On the date of the signing of these accounts, no material events, favourable or unfavourable, had arisen between the balance sheet date and the date when the financial statements were authorized for issue that would have had an impact on the financial statements.

12. Contingent liabilities, commitments and contingent assets

Contingent liabilities

As at 31 December 2016, WHO had a number of legal cases pending. Most involve disputes that are not recorded because the likelihood of repayment has been determined to be remote. However, there are four cases involving contractual disputes that are to be considered contingent liabilities. The total potential cost to the Organization is estimated at US$ 16 150 (US$ 24 040 as at 31 December 2015).

Operating leases commitments

WHO enters into operating lease arrangements for renting office space in various country offices. Future minimum lease rental payments for the following periods are as follows.

Description	Total	
	US$ thousands	
	Year 2016	**Year 2015**
Under 1 Year	7 139	6 015
1 to 5 years	9 046	7 705
5 years +	1 107	1 260
Total lease commitments	**17 292**	**14 980**

The Organization has no outstanding leases qualifying as finance leases at the reporting date.

WHO leased office space to six tenants. As at 31 December 2016, total revenue from the leasing activities was US$ 0.8 million (US$ 1.0 million as at 31 December 2015).

Contingent assets

In accordance with IPSAS 19 (Provisions, Contingent Liabilities and Contingent Assets), contingent assets will be disclosed for cases where an event will give rise to a probable inflow of economic benefits. As at 31 December 2016, there are no material contingent assets to disclose.

Schedule I. Statement of Financial Performance by major funds

For the year ended 31 December 2016
(In thousands of US dollars)

Description	General Fund				Member States -other			Fidicicary Fund	Subtotal	Eliminations	Total	Percentage
	Regular budget	Voluntary funds	Eliminations	Subtotal	Common Fund	Enterprise Fund	Special Purpose Fund					
Revenue												
Assessed contributions	470 036			470 036							470 036	20%
Voluntary contributions		1 717 391		1 717 391				35 023	35 023	(603)	1 751 811	74%
Voluntary contributions in-kind and in-service		100		100		87 649			87 649		87 749	4%
Reimbursable procurement						25 294			25 294		25 294	1%
Other revenue	2 307	156 828	(144 374)	14 761		15 024	179 537	(707)	193 854	(179 429)	29 186	1%
Total operating revenue	**472 343**	**1 874 319**	**(144 374)**	**2 202 288**		**127 967**	**179 537**	**34 316**	**341 820**	**(180 032)**	**2 364 076**	**100%**
Expenses												
Staff costs	389 963	529 573		919 536		19 542	121 669	13 985	155 196	(163 941)	910 791	37%
Medical supplies and materials	9 608	139 678		149 286	11 376	83 586	5 801	(1)	100 762	(5 586)	244 462	10%
Contractual services	43 622	595 314		638 936	(1 230)	684	35 295	8 476	43 225	(6 441)	675 720	27%
Transfers and grants	14 558	232 380		246 938				2 875	2 875	(603)	249 210	10%
Travel	28 375	167 053		195 428		148	1 185	3 713	5 046	(143)	200 331	8%
General operating expenses	19 861	234 169	(144 374)	109 656	466	11 416	5 822	4 993	22 697	(568)	131 785	5%
Equipment, vehicles and furniture	5 029	45 571		50 600	(107)	2 115	5 850	55	7 913	(2 751)	55 762	2%
Depreciation and amortization					2 836				2 836		2 836	0%
Total expenses	**511 016**	**1 943 738**	**(144 374)**	**2 310 380**	**13 341**	**117 491**	**175 622**	**34 096**	**340 550**	**(180 033)**	**2 470 897**	**100%**
Finance revenue	**(665)**	**67 607**		**66 942**	**(3 651)**	**(2 358)**	**1 751**	**(1)**	**(4 259)**	**(1)**	**62 682**	
TOTAL SURPLUS/(DEFICIT) FOR THE YEAR	**(39 338)**	**(1 812)**		**(41 150)**	**(16 992)**	**8 118**	**5 666**	**219**	**(2 989)**		**(44 139)**	
Fund balance – 1 January 2016	**43 176**	**2 166 155**		**2 209 331**	**103 014**	**9 365**	**(915 960)**	**42 874**	**(760 707)**		**1 448 624**	
Direct adjustments to net assets/equity							**(87 971)**		**(87 971)**		**(87 971)**	
Fund balance – 31 December 2016	**3 838**	**2 164 343**		**2 168 181**	**86 022**	**17 483**	**(998 265)**	**43 093**	**(763 696)**		**1 316 514**	

Note (a). Eliminations as reported in the "Statement of financial performance by major fund (Schedule 1)" are accounting adjustments made to remove the effect of inter-fund transfers that would otherwise overstate revenue and expenses of the Organization. These accounting adjustments are done through a separate elimination fund established for this purpose.

Schedule II. Expenses by major office – General Fund only

For the year ended 31 December 2016
(In thousands of US dollars)

Description	Headquarters	Regional Office for Africa	Regional Office for the Americas	Regional Office for the Eastern Mediterranean	Regional Office for Europe	Regional Office for South-East Asia	Regional Office for the Western Pacific	Total
Expenses								
Staff costs	428 446	215 207	30 468	83 629	54 461	52 254	55 071	919 536
Medical supplies and materials	32 434	29 627	1 248	62 204	6 253	13 633	3 887	149 286
Contractual services	136 357	209 175	10 593	181 167	26 948	54 374	20 322	638 936
Transfers and grants	12 113	127 327	3 611	62 885	798	21 625	18 579	246 938
Travel	84 496	54 588	10 996	14 706	11 299	10 189	9 154	195 428
General operating expenses	14 794	43 747	6 103	22 548	4 793	12 425	5 246	109 656
Equipment, vehicles and furniture	4 455	22 609		16 751	1 323	3 814	1 648	50 600
Total expenses	**713 095**	**702 280**	**63 019**	**443 890**	**105 875**	**168 314**	**113 907**	**2 310 380**
Percentage of expenses by expense type across major office								
Staff and other personnel costs	47%	23%	3%	9%	6%	6%	6%	100%
Medical supplies and materials	22%	20%	1%	42%	4%	9%	3%	100%
Contractual services	21%	33%	2%	28%	4%	9%	3%	100%
Transfers and grants to counterparts	5%	52%	1%	25%	0%	9%	8%	100%
Travel	43%	28%	6%	8%	6%	5%	5%	100%
General operating expenses	13%	40%	6%	21%	4%	11%	5%	100%
Equipment, vehicles and furniture	9%	45%	0%	33%	3%	8%	3%	100%
Total percentage	**31%**	**30%**	**3%**	**19%**	**5%**	**7%**	**5%**	**100%**
Percentage of expenses by expense type within each major office								
Staff and other personnel costs	60%	31%	48%	19%	51%	31%	48%	40%
Medical supplies and materials	5%	4%	2%	14%	6%	8%	3%	6%
Contractual services	19%	30%	17%	41%	25%	32%	18%	28%
Transfers and grants to counterparts	2%	18%	6%	14%	1%	13%	16%	11%
Travel	12%	8%	17%	3%	11%	6%	8%	8%
General operating expenses	2%	6%	10%	5%	5%	7%	5%	5%
Equipment, vehicles and furniture	1%	3%	0%	4%	1%	2%	1%	2%
Total percentage	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

ANNEXES

ANNEX 1

2016 FINANCIAL OVERVIEW – REVENUE AND EXPENDITURE

(a) Financial overview

In 2016, total expenditure exceeded total revenue by US$ 44 million (for 2015, US$ 231 million, restated). The below table provides a summary of 2016 and 2015 revenue and expense.

Financial overview – all funds, 2016 and 2015 (US$ million)

	Total 2016	Total 2015
Assessed contributions	470	463
Voluntary contributions – programme budget	1 717	1 837
Total contributions – programme budget	**2 187**	**2 300**
Non-programme budget revenue	89	45
Voluntary contributions in-kind and in-service	88	130
Total revenue (all sources)	**2 364**	**2 475**
Expenses – programme budget	2 182	2 466
Expenses – in-kind and in-service	88	126
Expenses – non-programme budget and other	201	135
Total expenses (all sources)	**2 471**	**2 727**
Finance revenue	**63**	**21**
Net	**(44)**	**(231)**

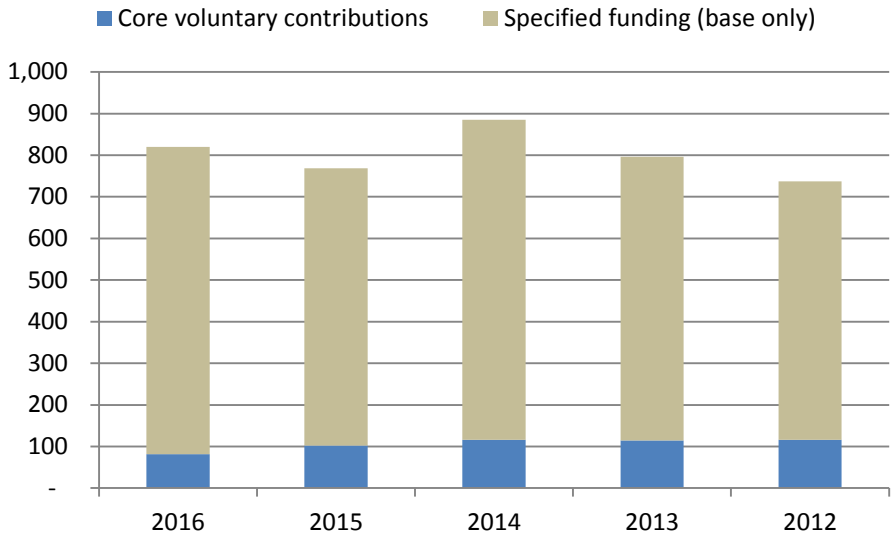
Revenue

Total revenue received for the Programme budget 2016–2017 in 2016 was US$ 2187 million, comprising assessed contributions from Member States of US$ 470 million and voluntary contributions of US$ 1717 million. Non-Programme budget revenue was US$ 89 million in 2016, which is an increase from the prior year and reflects steady income from the hosted partnerships. Voluntary contributions in-kind and in-service represent donations of medical supplies, office rentals and staff costs. A full list of all voluntary contributions, by donor and by fund, is available on the WHO programme budget web portal and WHO website.[1]

In total, voluntary contribution revenue in 2016 to the Programme budget 2016–2017 shows a decrease of US$ 120 million or 7% compared to the comparable figure for 2015. The main decreases were under the Outbreak and crisis response segment and the Special Partnership Arrangements, which fell by 26% and 11% respectively compared to 2015. Voluntary contributions for the base programme show an overall increase of 8%. Many of the specified voluntary contributions were highly earmarked and related to individual projects with differing reporting requirements within the framework of the planned results of the Programme budget. The table below summarizes the base revenue for the Programme budget by specified and core voluntary contributions.

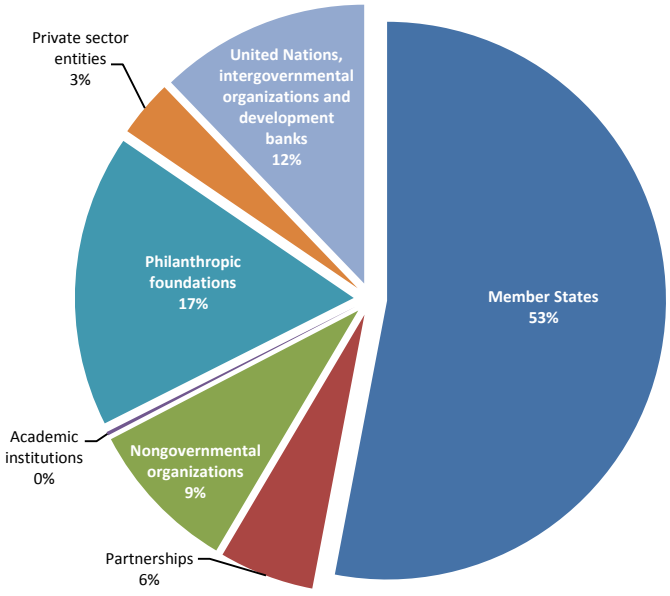
[1] WHO Programme budget web portal, http://extranet.who.int/programmebudget/ and details of voluntary contributions by fund and by contributor, 2016 (A70/INF./4) on the WHO website, http://www.who.int/about/finances-accountability/reports/en/

Programme budget (base) revenue 2012 to 2016 (US$ million)



Member States continue to be the largest source of voluntary contributions contributing 53% of the total non-assessed (voluntary) contributions in 2016 and 2015. The updating of categories of contributors during 2016 to be consistent with the web portal presentation has resulted in some variations compared to 2015 and prior published figures. Comparison on a consistent basis shows that the largest change is an increase in philanthropic foundations due to higher contributions to the Global Polio Eradication Initiative.

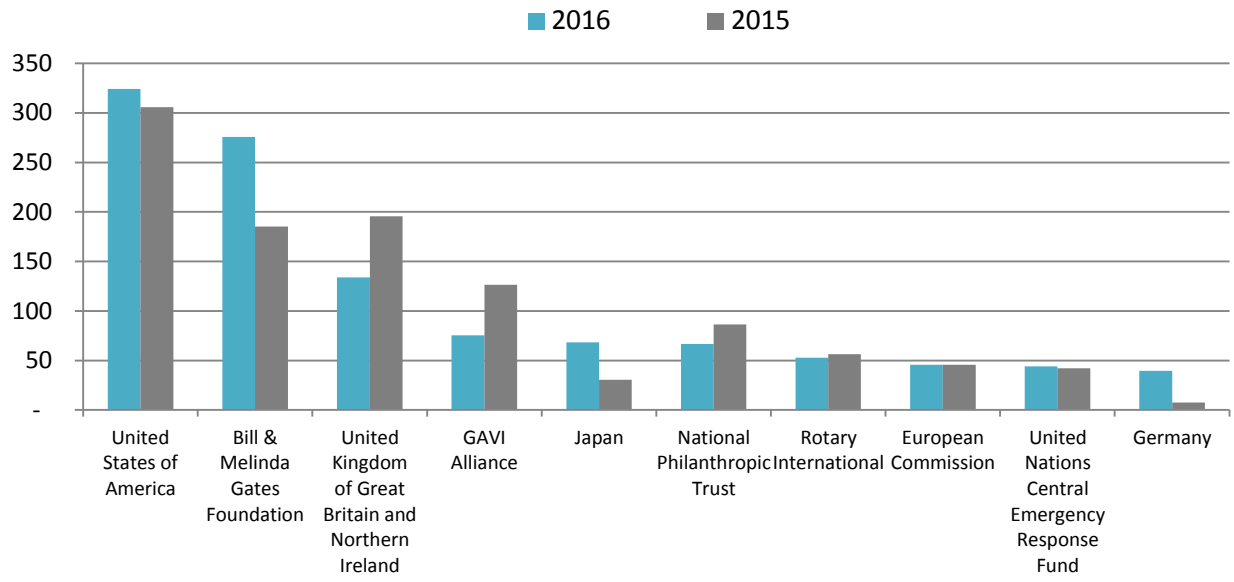
Revenue from voluntary contributions for 2016, by source



Total contributions by Member States to the Programme budget 2016–2017 (voluntary contributions and assessed contributions) for 2016 were US$ 1371 million compared to US$ 1473 million for 2015. For 2016, this represents 63% of total voluntary and assessed contributions.

The top voluntary contributors for 2016 are summarized below with a comparison against 2015. This includes both Member States and other contributors. The top 10 voluntary contributors represent 66% of the total voluntary contributions under the Programme budget.

Top 10 voluntary contributors to the Programme budget in 2016 and 2015 (US$ million)

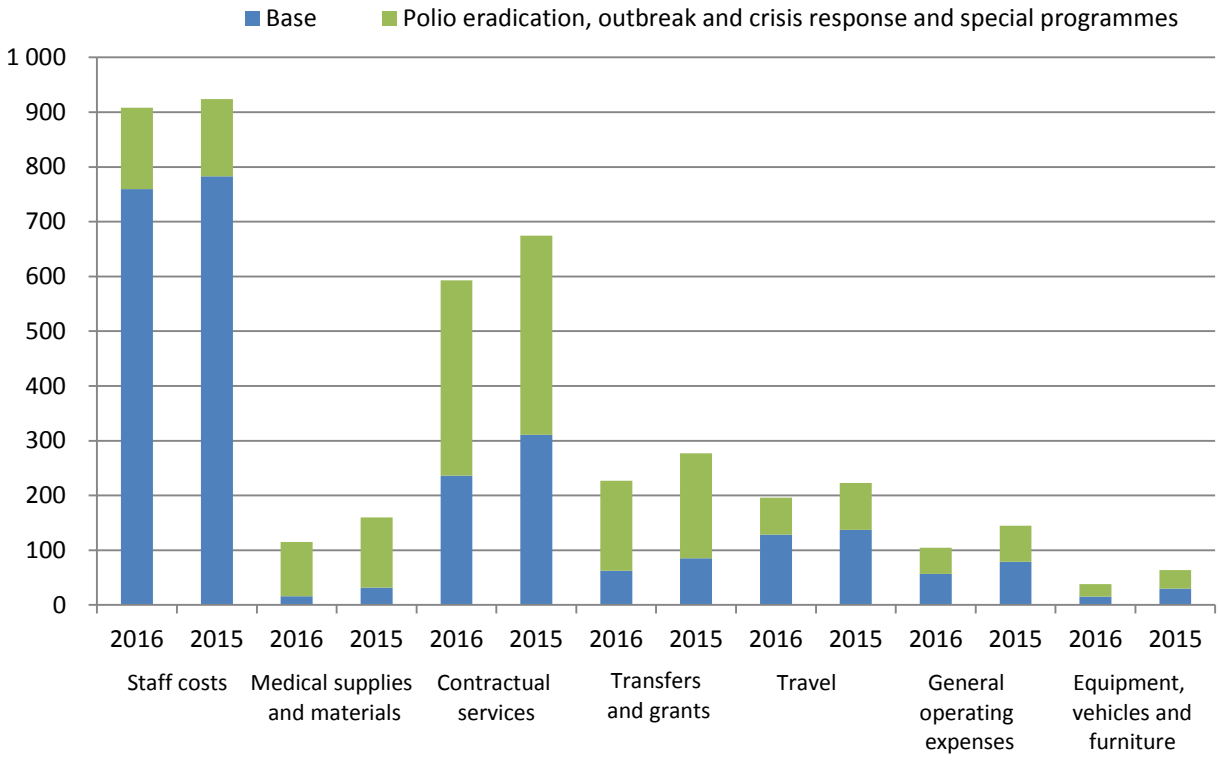


(b) Expenses

Total expenses[1] for 2016 for the implementation of the Programme budget 2016–2017 were US$ 2182 million, representing a decrease of 11%, from 2015 and an increase of 15% from 2014 (same time in the biennium 2014–2015).

The figure below provides a summary of Programme budget expenses by expense type for 2016 and 2015.

Programme budget expenses by type in 2016 and 2015 (US$ million)



[1] Expenses are recognized when goods and services are received and not when commitments or payments are made.

Staff costs represents the total cost of employing staff, including charges for base salary, post adjustment and any other types of entitlements paid by the Organization (for instance, pensions and insurances). Total staff costs fell by US$ 16 million from 2015 to 2016, from US$ 924 million to US$ 908 million and represented 42% of the total expenses incurred for the Programme budget in 2016 (37% in 2015). Across segments, base staff costs have reduced from US$ 783 million in 2015 to US$ 760 million in 2016. Staff costs for Polio and Outbreak and crisis response and Special programmes have increased by 6% between 2016 and 2015.

Contractual services represented 28% of overall expenses in 2016 and were the second largest group of expenses. Contractual services represent the cost of contracts given to experts and service providers to support the Organization in achieving its planned objectives. Contractual services expenses decreased overall by 7% from 2015 to 2016, mainly under base programmes following the trend of reduced expenditure in 2016. Expenses increased, however, in the Eastern Mediterranean Region owing to the emergency responses, mainly in the Syrian Arab Republic and Yemen. Contractual services decreased most in the African Region because of the scaling down of the response to the Ebola virus disease outbreak that had increased spending substantially in 2015. The largest component of Contractual services is Direct implementation, relating mainly to large-scale immunization campaigns within the Polio eradication programme, in particular in Afghanistan, Nigeria, Pakistan and Somalia. In addition to Direct implementation, the other large component of this group of expenses comprises consultant contracts and agreements for performance of work.

Transfers and grants to counterparts represented 10% of overall expenses and were highest in the African Region followed by the Eastern Mediterranean Region. These expenses were mainly for contracts signed with national counterparts, primarily health ministries (direct financial cooperation) and to a lesser degree for contracts with other implementing partners such as other United Nations organizations and non-State actors to perform activities in line with the Programme budget. Overall, 2016 expenditure for transfers and grants was 16% lower than in 2015. From the total direct financial cooperation expenses in 2016, 63% were related to the Global Polio Eradication Initiative in 2016, compared to 48% in 2015. The policies and procedures surrounding the use of direct financial cooperation arrangements have been strengthened during the past three years and following the changes transparency and accountability for the use of these transfers have improved significantly.

General operating expenses represent general expenses to support maintenance of offices and operational running costs, utilities and other office costs including rent. These are incurred mainly at the local level and represented 5% of total expenses under the Programme budget 2016–2017 in 2016, a slight decrease from 2015 when they represented 6% of all costs. General operating costs were the highest in the African Region, followed by the Eastern Mediterranean Region and then headquarters. This reflects the number and size of offices maintained and staff working in these regions. The large variances in average general operating costs from one location to another owe to differences in rental and other costs between duty stations.

Travel constituted 8% of the Organization's total expenses for the Programme budget 2016–2017 in 2016, compared to 9% in 2015. Travel expenses include airfare, per diem and other travel-related costs for staff and non-staff. Total travel costs decreased by 14% in 2016 from 2015. There are two reasons for the decrease: the reduction in travel related to the Ebola response and efficiency measures. The average cost per trip undertaken has decreased with ticket prices in 2016 being lower than in 2015 or 2014. Also, the duration of trips has shortened, resulting in lower per diem costs per travel. The staff/non-staff ratio within travel expenses has evolved over the past three years from 45%/55% in 2014 to 40%/60% in 2016, reflecting the fact that staff travel has been consciously reduced through the revised travel policy compared to non-staff travel, of which meeting participants make up the largest group.

The expenses for **medical supplies and materials** relate primarily to medical supplies purchased and distributed by the Organization for programme implementation. These accounted for 6% of total expenses in 2016 (6% in 2015). Total expenses for medical supplies and materials fell by 9% from 2015. Total expenses decreased, but there were increases in the Eastern Mediterranean Region mainly because of the emergencies in the Syrian Arab Republic and Yemen and also in the European Region because of support to the Syrian emergency being carried out from Turkey and reflected in its country operation.

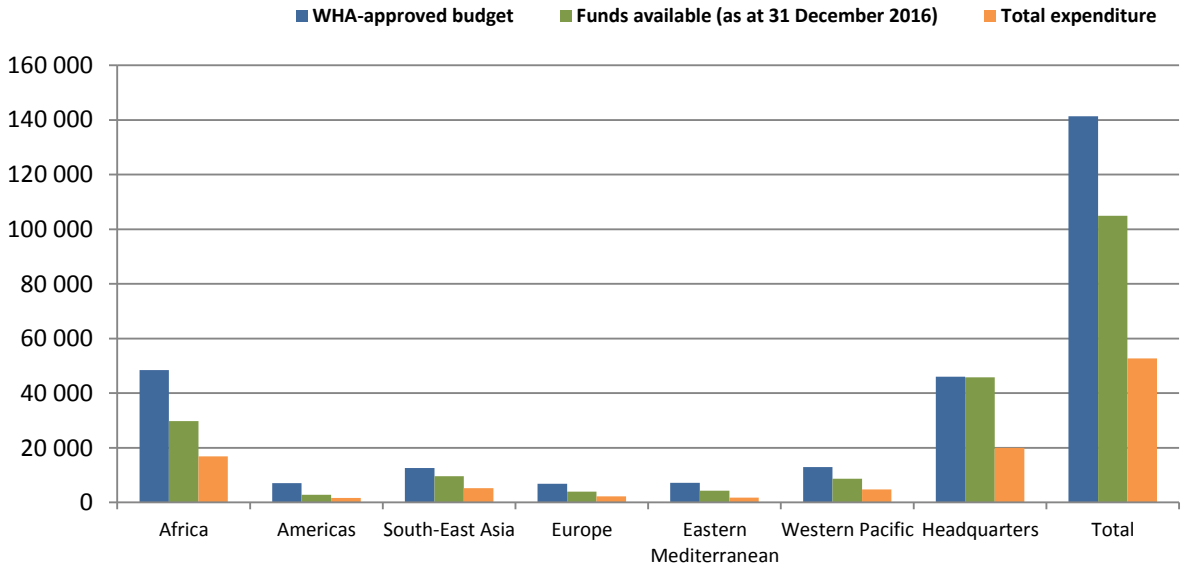
ANNEX 2

OUTPUT RATINGS AND FINANCIAL INFORMATION BY PROGRAMME

1.1 HIV and hepatitis

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
1.1.1. Increased capacity of countries to deliver key HIV interventions through active engagement in policy dialogue, development of normative guidance and tools, dissemination of strategic information, and provision of technical support	✓	✓	✓	✓	✓	✓	✓
1.1.2. Increased capacity of countries to deliver key hepatitis interventions through active engagement in policy dialogue, development of normative guidance and tools, dissemination of strategic information, and provision of technical support	✓	✓	✓	✓	✓	✓	✓

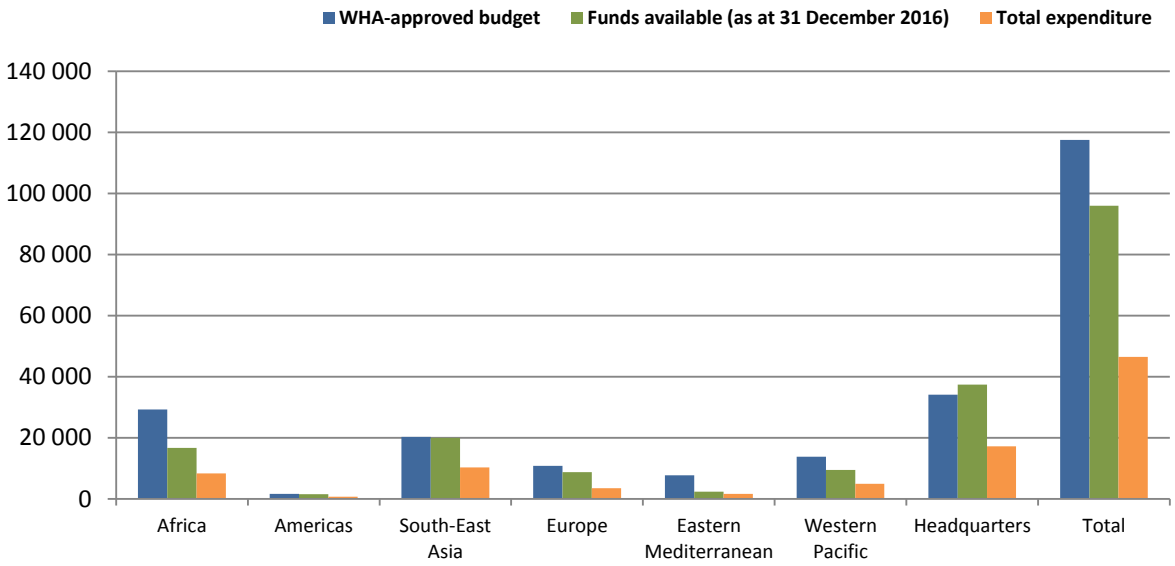


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	48 500	7 100	12 600	6 900	7 200	13 000	46 000	141 300
Funds available (as at 31 Dec 2016)								
Flexible funds	8 865	1 920	2 702	1 101	3 094	3 528	5 432	26 642
Voluntary contributions – specified	20 938	884	6 861	2 827	1 180	5 220	40 380	78 290
Total	**29 803**	**2 804**	**9 563**	**3 928**	**4 274**	**8 748**	**45 812**	**104 932**
Funds available as a % of budget	61%	39%	76%	57%	59%	67%	100%	74%
Staff costs	9 466	1 005	2 261	1 630	930	3 304	12 091	30 687
Activity costs	7 454	695	3 018	589	880	1 503	7 851	21 990
Total expenditure	**16 920**	**1 700**	**5 279**	**2 219**	**1 810**	**4 807**	**19 942**	**52 677**
Expenditure as a % of approved budget	35%	24%	42%	32%	25%	37%	43%	37%
Expenditure as a % of funds available	57%	61%	55%	56%	42%	55%	44%	50%
Staff expenditure by major office	31%	3%	7%	5%	3%	11%	39%	100%

1.2 Tuberculosis

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
1.2.1. Worldwide adaptation and implementation of the global strategy and targets for tuberculosis prevention, care and control after 2015 as adopted in resolution WHA67.1	✓	✓	✓	✓	✓	✓	✓
1.2.2. Updated policy guidelines and technical tools to support the adoption and implementation of the global strategy and targets for tuberculosis prevention, care and control after 2015, covering the three pillars: (1) integrated, patient-centred care and prevention; (2) bold policies and supportive systems; and (3) intensified research and innovation	✓	✓	✓	✓	✓	✓	✓

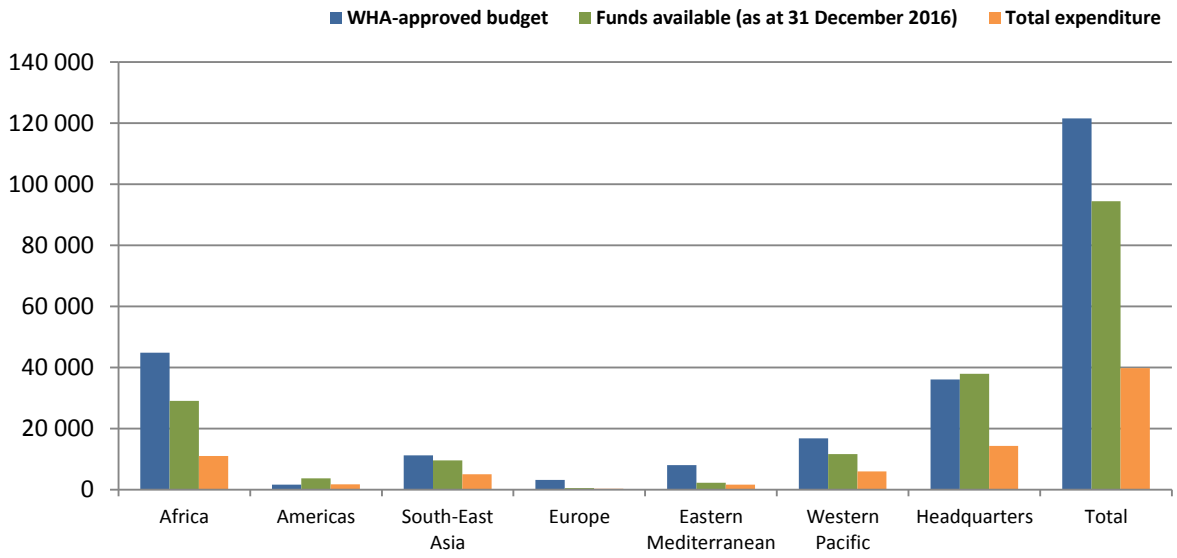


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	29 200	1 600	20 300	10 800	7 700	13 800	34 100	117 500
Funds available (as at 31 Dec 2016)								
Flexible funds	4 887	1 031	4 769	495	1 291	1 712	3 850	18 035
Voluntary contributions – specified	11 782	445	15 190	8 212	1 043	7 685	33 565	77 922
Total	**16 669**	**1 476**	**19 959**	**8 707**	**2 334**	**9 397**	**37 415**	**95 957**
Funds available as a % of budget	57%	92%	98%	81%	30%	68%	110%	82%
Staff costs	5 037	255	2 836	1 822	807	3 078	12 022	25 857
Activity costs	3 232	444	7 464	1 676	750	1 868	5 204	20 638
Total expenditure	**8 269**	**699**	**10 300**	**3 498**	**1 557**	**4 946**	**17 226**	**46 495**
Expenditure as a % of approved budget	28%	44%	51%	32%	20%	36%	51%	40%
Expenditure as a % of funds available	50%	47%	52%	40%	67%	53%	46%	48%
Staff expenditure by major office	19%	1%	11%	7%	3%	12%	46%	100%

1.3 Malaria

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
1.3.1. Countries enabled to implement evidence-based malaria strategic plans, with focus on effective coverage of vector control interventions and diagnostic testing and treatment, therapeutic efficacy and insecticide resistance monitoring and surveillance through capacity strengthening for enhanced malaria reduction	✓	✓	✓	!	!	✓	✓
1.3.2. Updated policy recommendations, strategic and technical guidelines on vector control, diagnostic testing, antimalarial treatment, integrated management of febrile illness, surveillance, epidemic detection and response for accelerated malaria reduction and elimination	✓	✓	✓	✓	✓	✓	✓

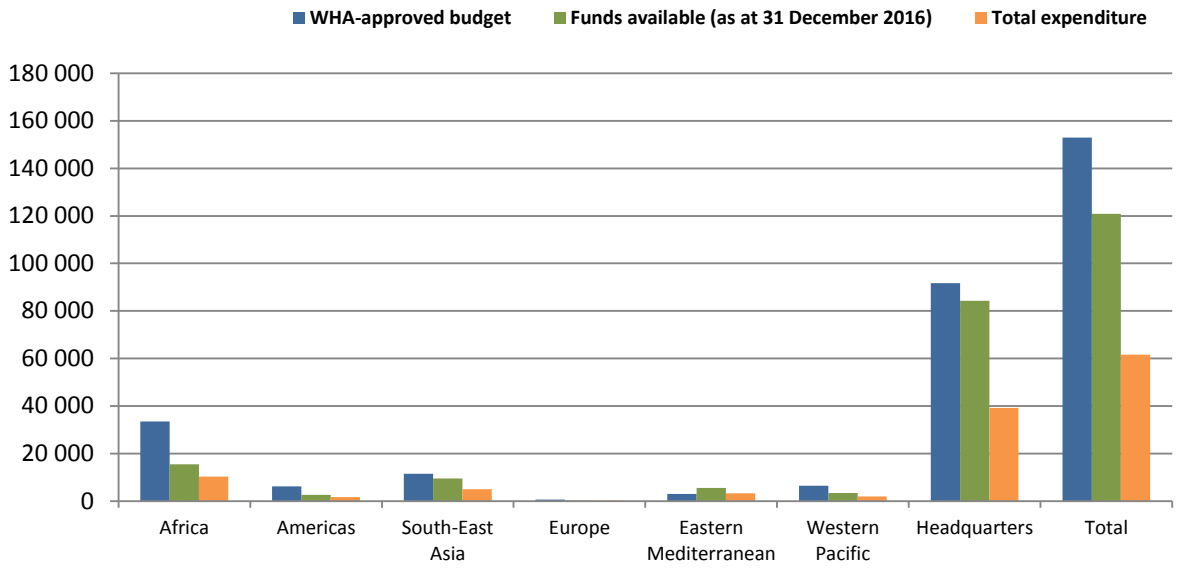


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	44 800	1 600	11 200	3 100	8 000	16 800	36 000	121 500
Funds available (as at 31 Dec 2016)								
Flexible funds	4 458	2 802	2 868	252	1 738	1 433	4 812	18 363
Voluntary contributions – specified	24 621	873	6 668	227	512	10 131	33 074	76 106
Total	**29 079**	**3 675**	**9 536**	**479**	**2 250**	**11 564**	**37 886**	**94 469**
Funds available as a % of budget	65%	230%	85%	15%	28%	69%	105%	78%
Staff costs	6 815	1 215	2 359	108	865	3 444	10 399	25 205
Activity costs	4 141	530	2 668	154	719	2 443	3 870	14 525
Total expenditure	**10 956**	**1 745**	**5 027**	**262**	**1 584**	**5 887**	**14 269**	**39 730**
Expenditure as a % of approved budget	24%	109%	45%	8%	20%	35%	40%	33%
Expenditure as a % of funds available	38%	47%	53%	55%	70%	51%	38%	42%
Staff expenditure by major office	27%	5%	9%	0%	3%	14%	41%	100%

1.4 Neglected tropical diseases

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
1.4.1. Implementation and monitoring of the WHO road map for neglected tropical diseases facilitated	✓	✓	✓	✓	✓	✓	✓
1.4.2. Implementation and monitoring of neglected tropical disease control interventions facilitated by evidence-based technical guidelines and technical support	✓	✓	✓	✓	✓	✓	✓
1.4.3. New knowledge, solutions and implementation strategies that respond to the health needs of disease-endemic countries developed	N/A	N/A	N/A	N/A	N/A	N/A	✓

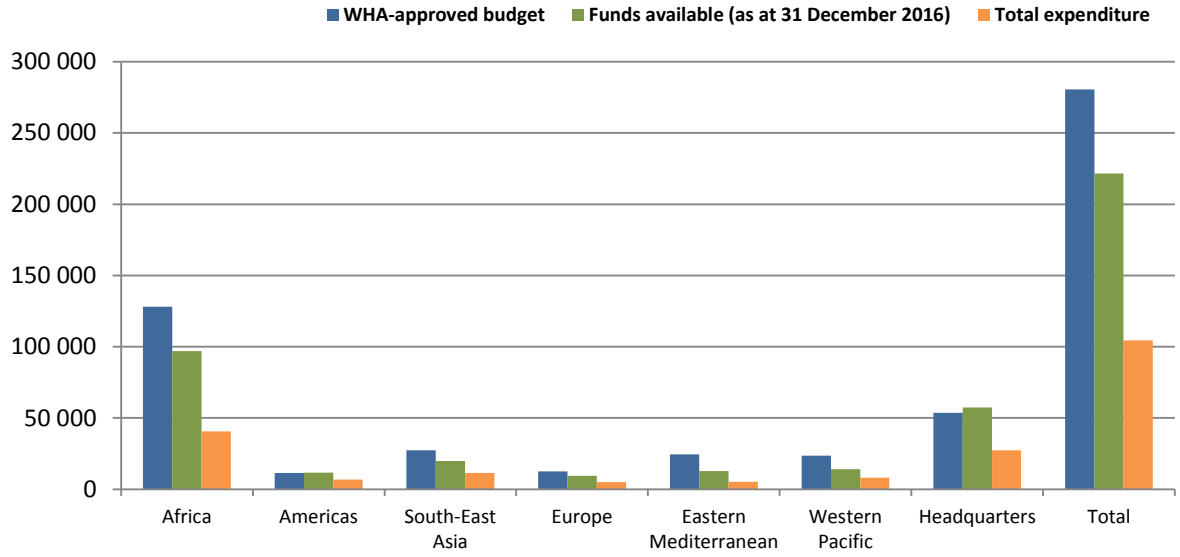


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	33 500	6 200	11 500	600	3 000	6 400	91 700	152 900
Funds available (as at 31 Dec 2016)								
Flexible funds	3 260	1 202	4 946	14	1 202	1 230	11 001	22 855
Voluntary contributions – specified	12 233	1 428	4 507	225	4 253	2 122	73 238	98 006
Total	**15 493**	**2 630**	**9 453**	**239**	**5 455**	**3 352**	**84 239**	**120 861**
Funds available as a % of budget	46%	42%	82%	40%	182%	52%	92%	79%
Staff costs	4 077	613	2 144	0	497	728	20 661	28 720
Activity costs	6 239	1 053	2 861	164	2 724	1 262	18 512	32 815
Total expenditure	10 316	1 666	5 005	164	3 221	1 990	39 173	61 535
Expenditure as a % of approved budget	31%	27%	44%	27%	107%	31%	43%	40%
Expenditure as a % of funds available	67%	63%	53%	69%	59%	59%	47%	51%
Staff expenditure by major office	14%	2%	7%	0%	2%	3%	72%	100%

1.5 Vaccine-preventable diseases

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
1.5.1. Implementation and monitoring of the global vaccine action plan, with emphasis on strengthening service delivery and immunization monitoring in order to achieve the goals for the Decade of Vaccines	✓	✓	✓	✓	✓	✓	✓
1.5.2. Intensified implementation and monitoring of measles and rubella elimination strategies facilitated	✓	✓	✓	✓	✓	!	!
1.5.3. Target product profiles for new vaccines and other immunization-related technologies, as well as research priorities, defined and agreed, in order to develop vaccines of public health importance and overcome barriers to immunization	✓	✓	✓	✓	✓	✓	✓

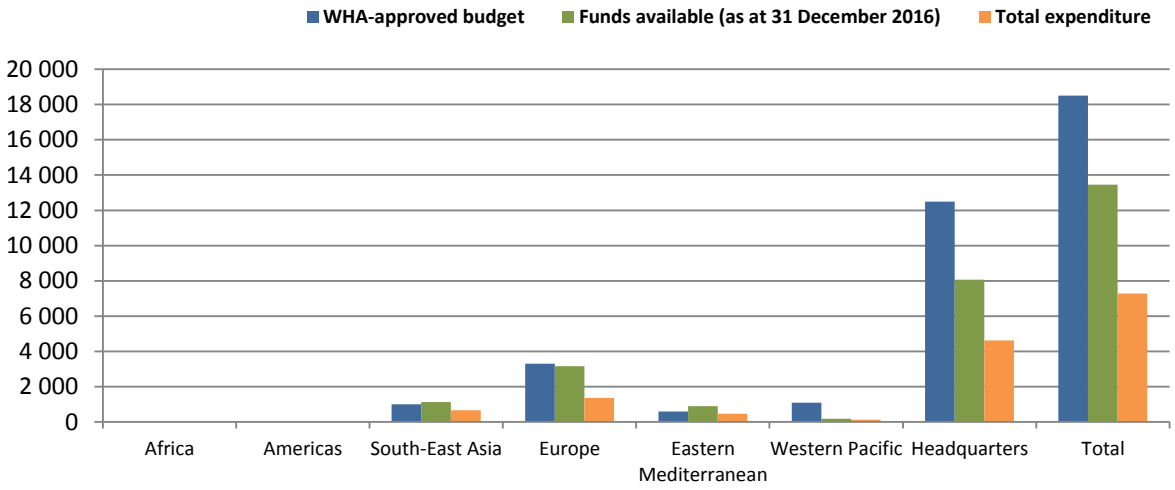


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	128 000	11 300	27 200	12 400	24 400	23 600	53 600	280 500
Funds available (as at 31 Dec 2016)								
Flexible funds	6 194	5 280	2 970	723	2 414	1 793	5 430	24 804
Voluntary contributions – specified	90 743	6 257	16 745	8 605	10 322	12 204	51 858	196 734
Total	**96 937**	**11 537**	**19 715**	**9 328**	**12 736**	**13 997**	**57 288**	**221 538**
Funds available as a % of budget	76%	102%	72%	75%	52%	59%	107%	79%
Staff costs	11 420	2 609	2 946	2 679	2 342	3 469	15 911	41 376
Activity costs	29 124	4 166	8 510	2 252	2 957	4 542	11 441	62 992
Total expenditure	**40 544**	**6 775**	**11 456**	**4 931**	**5 299**	**8 011**	**27 352**	**104 368**
Expenditure as a % of approved budget	32%	60%	42%	40%	22%	34%	51%	37%
Expenditure as a % of funds available	42%	59%	58%	53%	42%	57%	48%	47%
Staff expenditure by major office	28%	6%	7%	6%	6%	8%	38%	100%

1.6 Antimicrobial resistance

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
1.6.1. Implementation oversight of the draft action plan on antimicrobial resistance, including surveillance and development of national and regional plans	✓	✓	✓	✓	!	✓	✓

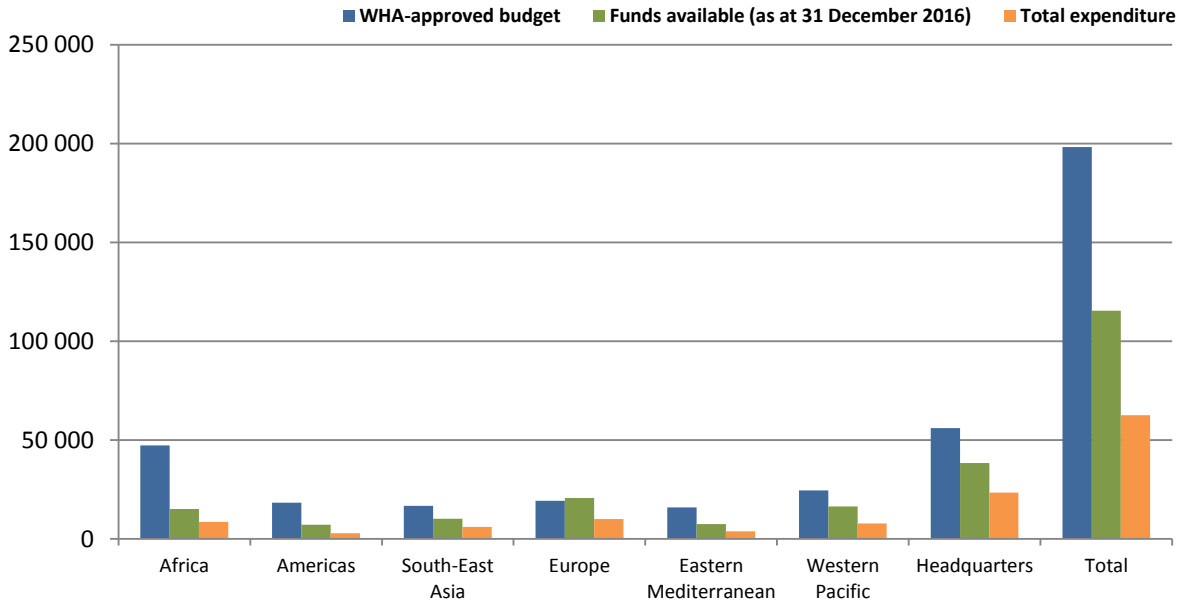


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	0	0	1 000	3 300	600	1 100	12 500	18 500
Funds available (as at 31 Dec 2016)								
Flexible funds	0	0	431	676	170	54	2 518	3 849
Voluntary contributions – specified	8	0	698	2 483	732	139	5 545	9 605
Total	**8**	**0**	**1 129**	**3 159**	**902**	**193**	**8 063**	**13 454**
Funds available as a % of budget	_	_	113%	96%	150%	18%	65%	73%
Staff costs	0	0	86	677	203	102	3 564	4 632
Activity costs	8	0	584	691	270	37	1 057	2 647
Total expenditure	**8**	**0**	**670**	**1 368**	**473**	**139**	**4 621**	**7 279**
Expenditure as a % of approved budget	_	_	67%	41%	79%	13%	37%	39%
Expenditure as a % of funds available	100%	_	59%	43%	52%	72%	57%	54%
Staff expenditure by major office	0%	0%	2%	15%	4%	2%	77%	100%

2.1 Noncommunicable diseases

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
2.1.1. Development and/or implementation of national multisectoral policies and plans to prevent and control noncommunicable diseases accelerated	✓	✓	✓	✓	✓	✓	✓
2.1.2. Countries enabled to implement strategies to reduce modifiable risk factors for noncommunicable diseases (tobacco use, diet, physical inactivity and harmful use of alcohol), including the underlying social determinants	✓	✓	✓	✓	✓	✓	✓
2.1.3. Countries enabled to improve health care coverage for the management of cardiovascular diseases, cancer, diabetes and chronic respiratory diseases and their risk factors through strengthening health systems	✓	✓	✓	✓	✓	✓	✓
2.1.4. Monitoring framework implemented to report on the progress made on the commitments contained in the Political Declaration of the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases and in the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020	✓	✓	✓	✓	✓	✓	✓

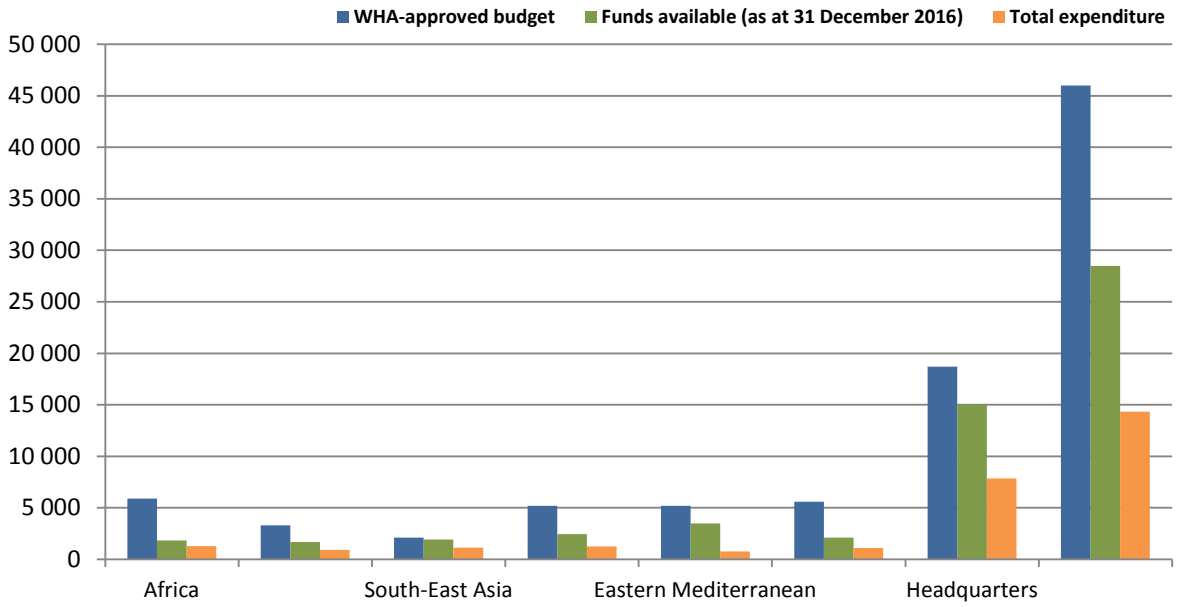


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	47 300	18 300	16 800	19 200	16 000	24 600	56 100	198 300
Funds available (as at 31 Dec 2016)								
Flexible funds	9 734	6 198	7 567	3 423	6 432	8 270	21 774	63 398
Voluntary contributions – specified	5 335	1 019	2 635	17 359	1 015	8 128	16 577	52 068
Total	**15 069**	**7 217**	**10 202**	**20 782**	**7 447**	**16 398**	**38 351**	**115 466**
Funds available as a % of budget	32%	39%	61%	108%	47%	67%	68%	58%
Staff costs	5 267	1 864	2 453	3 150	2 086	3 733	16 911	35 464
Activity costs	3 352	936	3 593	6 827	1 770	4 139	6 426	27 043
Total expenditure	8 619	2 800	6 046	9 977	3 856	7 872	23 337	62 507
Expenditure as a % of approved budget	18%	15%	36%	52%	24%	32%	42%	32%
Expenditure as a % of funds available	57%	39%	59%	48%	52%	48%	61%	54%
Staff expenditure by major office	15%	5%	7%	9%	6%	11%	48%	100%

2.2 Mental health and substance abuse

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
2.2.1. Countries' capacity strengthened to develop and implement national policies, plans and information systems in line with the comprehensive mental health action plan 2013–2020	✓	✓	✓	✓	✓	✓	✓
2.2.2. Countries with technical capacity to develop integrated mental health services across the continuum of promotion, prevention, treatment and recovery	✓	✓	✓	✓	✓	✓	!
2.2.3. Expansion and strengthening of country strategies, systems and interventions for disorders caused by alcohol and other psychoactive substance use enabled	!	✓	✓	✓	✓	✓	!

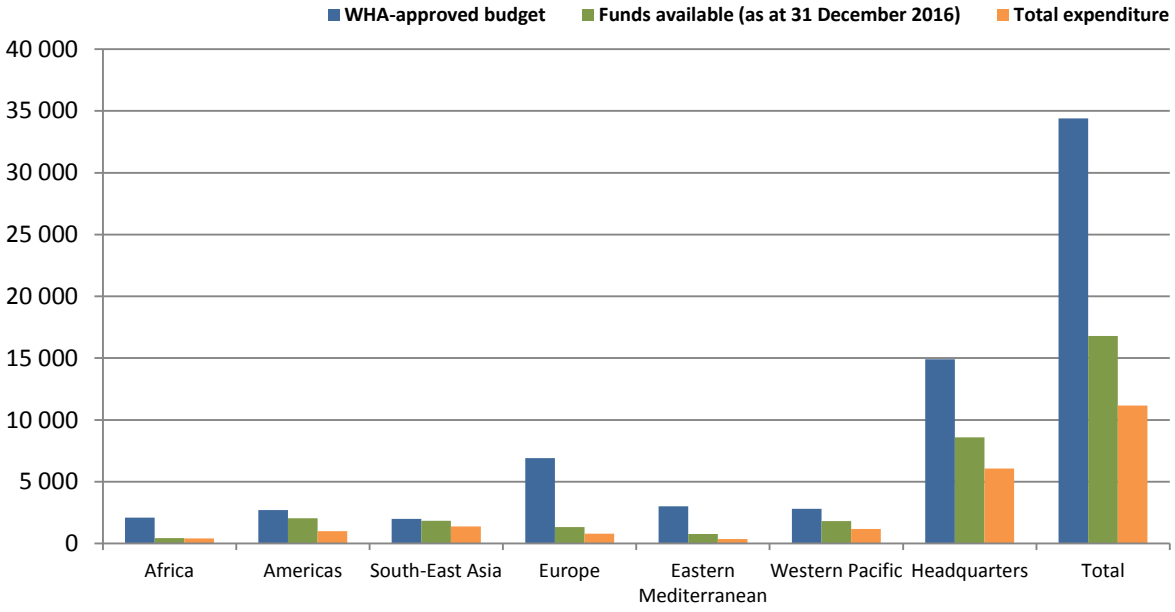


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	5,900	3,300	2,100	5,200	5,200	5,600	18,700	46,000
Funds available (as at 31 Dec 2016)								
Flexible funds	828	1 686	1 572	1 828	1 315	1 329	2 928	11 486
Voluntary contributions – specified	1 013	0	350	610	2 181	780	12 077	17 011
Total	**1 841**	**1 686**	**1 922**	**2 438**	**3 496**	**2 109**	**15 005**	**28 497**
Funds available as a % of budget	31%	51%	92%	47%	67%	38%	80%	62%
Staff costs	333	685	452	947	381	395	5 183	8 376
Activity costs	935	240	679	304	396	718	2 671	5 943
Total expenditure	**1 268**	**925**	**1 131**	**1 251**	**777**	**1 113**	**7 854**	**14 319**
Expenditure as a % of approved budget	21%	28%	54%	24%	15%	20%	42%	31%
Expenditure as a % of funds available	69%	55%	59%	51%	22%	53%	52%	50%
Staff expenditure by major office	4%	8%	5%	11%	5%	5%	62%	100%

2.3 Violence and injuries

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
2.3.1. Development and implementation of multisectoral plans and programmes to prevent injuries, with a focus on achieving the targets set under the United Nations Decade of Action for Road Safety 2011–2020	!	✓	✓	✓	✓	!	✓
2.3.2. Countries and partners enabled to develop and implement programmes and plans to prevent child injuries	!	✓	✓	✓	✓	X	✓
2.3.3. Development and implementation of policies and programmes to address violence against women, youth and children facilitated	X	✓	✓	✓	✓	X	✓

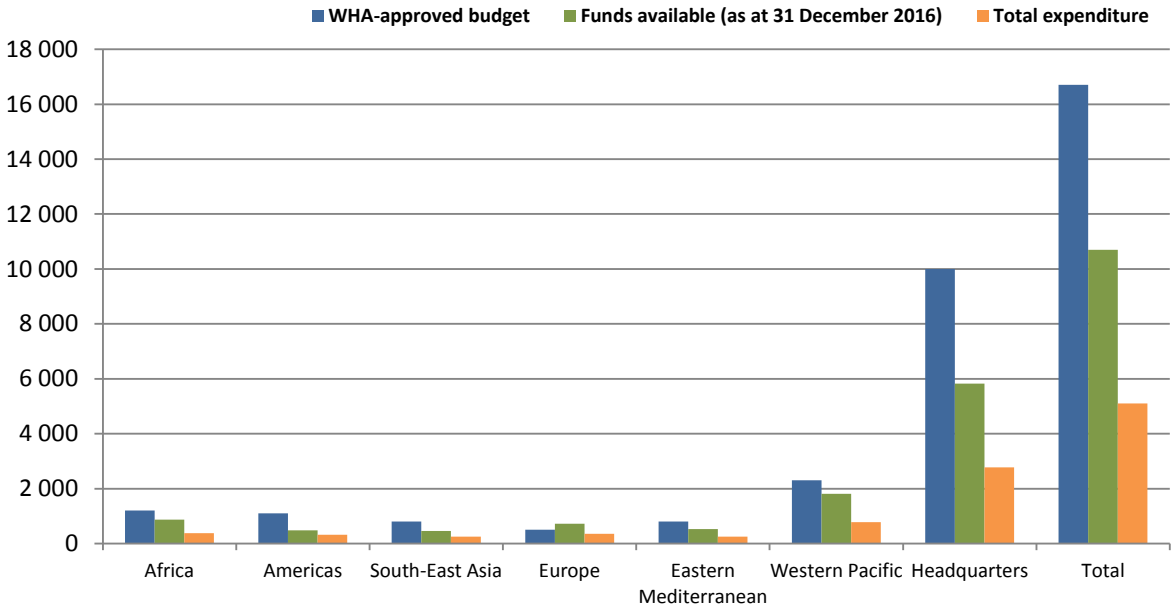


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	2 100	2 700	2 000	6 900	3 000	2 800	14 900	34 400
Funds available (as at 31 Dec 2016)								
Flexible funds	114	1 864	1 435	995	720	572	3 246	8 946
Voluntary contributions – specified	332	170	397	323	50	1 235	5 334	7 841
Total	**446**	**2 034**	**1 832**	**1 318**	**770**	**1 807**	**8 580**	**16 787**
Funds available as a % of budget	21%	75%	92%	19%	26%	65%	58%	49%
Staff costs	0	858	788	598	174	545	4 442	7 405
Activity costs	398	149	598	186	191	624	1 615	3 761
Total expenditure	**398**	**1 007**	**1 386**	**784**	**365**	**1 169**	**6 057**	**11 166**
Expenditure as a % of approved budget	19%	37%	69%	11%	12%	42%	41%	32%
Expenditure as a % of funds available	89%	50%	76%	59%	47%	65%	71%	67%
Staff expenditure by major office	0%	12%	11%	8%	2%	7%	60%	100%

2.4 Disabilities and rehabilitation

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
2.4.1. Implementation of the WHO global disability action plan 2014–2021: better health for all people with disability, in accordance with national priorities	!	✓	✓	✓	✓	✓	✓
2.4.2. Countries enabled to strengthen prevention and management of eye and ear diseases in the framework of health systems	!	✓	✓	✓	✓	✓	✓

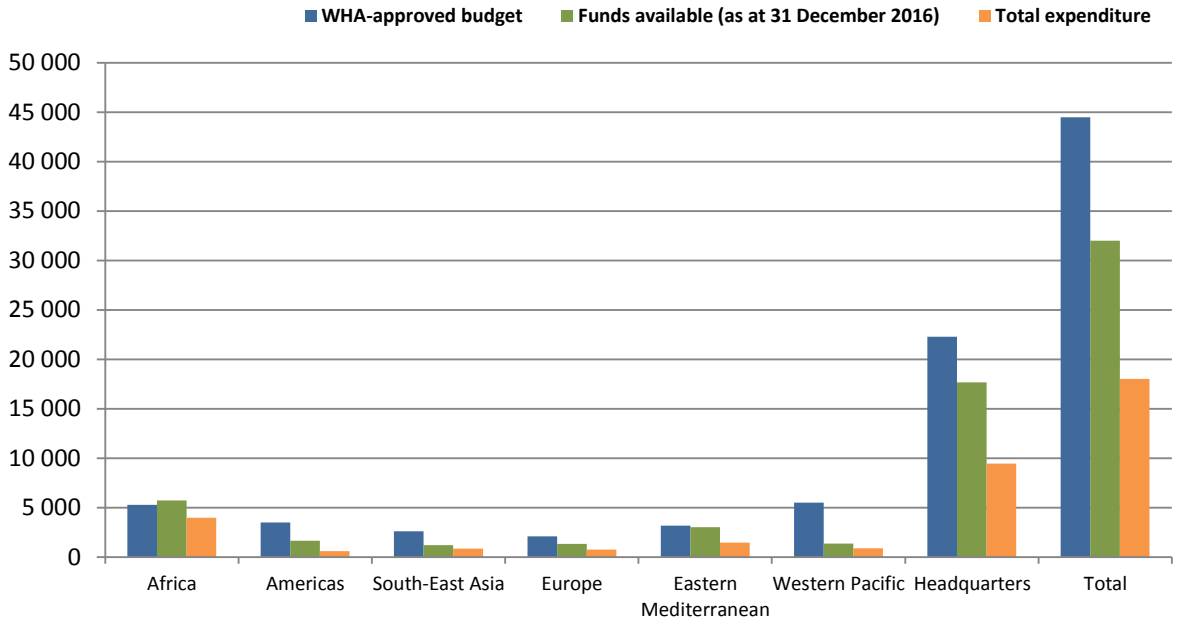


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	1 200	1 100	800	500	800	2 300	10 000	16 700
Funds available (as at 31 Dec 2016)								
Flexible funds	41	416	413	44	464	423	1 401	3 202
Voluntary contributions – specified	829	63	42	682	69	1 388	4 423	7 496
Total	**870**	**479**	**455**	**726**	**533**	**1 811**	**5 824**	**10 698**
Funds available as a % of budget	73%	44%	57%	145%	67%	79%	58%	64%
Staff costs	199	189	21	150	120	276	2 155	3 110
Activity costs	185	136	230	201	130	499	616	1 997
Total expenditure	**384**	**325**	**251**	**351**	**250**	**775**	**2 771**	**5 107**
Expenditure as a % of approved budget	32%	30%	31%	70%	31%	34%	28%	31%
Expenditure as a % of funds available	44%	68%	55%	48%	47%	43%	48%	48%
Staff expenditure by major office	6%	6%	1%	5%	4%	9%	69%	100%

2.5 Nutrition

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
2.5.1. Countries enabled to develop, implement and monitor action plans based on the maternal, infant and young child nutrition comprehensive implementation plan, which takes into consideration the double burden of malnutrition	✓	✓	✓	✓	✓	✓	✓
2.5.2. Norms and standards and policy options for promoting population dietary goals and cost-effective interventions to address the double burden of malnutrition, and their adoption by countries in developing national guidelines and legislation supporting effective nutrition actions	✓	✓	✓	✓	✓	!	✓

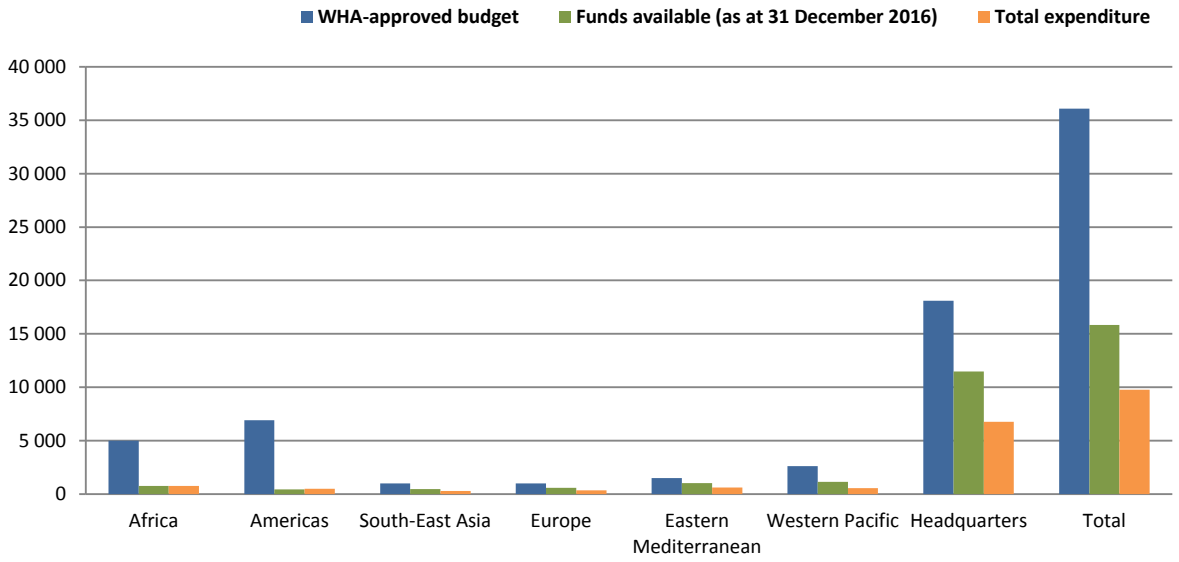


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	5 300	3 500	2 600	2 100	3 200	5 500	22 300	44 500
Funds available (as at 31 Dec 2016)								
Flexible funds	1 238	1 334	1 216	705	787	607	4 849	10 736
Voluntary contributions – specified	4 500	315	8	623	2 237	778	12 820	21 281
Total	**5 738**	**1 649**	**1 224**	**1 328**	**3 024**	**1 385**	**17 669**	**32 017**
Funds available as a % of budget	108%	47%	47%	63%	95%	25%	79%	72%
Staff costs	1 315	201	413	387	567	294	6 216	9 393
Activity costs	2 672	390	460	375	890	599	3 259	8 645
Total expenditure	**3 987**	**591**	**873**	**762**	**1 457**	**893**	**9 475**	**18 038**
Expenditure as a % of approved budget	75%	17%	34%	36%	46%	16%	42%	41%
Expenditure as a % of funds available	69%	36%	71%	57%	48%	64%	54%	56%
Staff expenditure by major office	14%	2%	4%	4%	6%	3%	66%	100%

2.6 Food safety

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
2.6.1. Technical assistance to enable Member States to control risk and reduce the burden of foodborne diseases	X	✓	✓	✓	✓	✓	✓
2.6.2. International standards and scientific advice, as well as a global information exchange platform, for effectively managing foodborne risks, in addition to the coordination needed to harness multisectoral collaboration	X	✓	✓	✓	✓	✓	✓

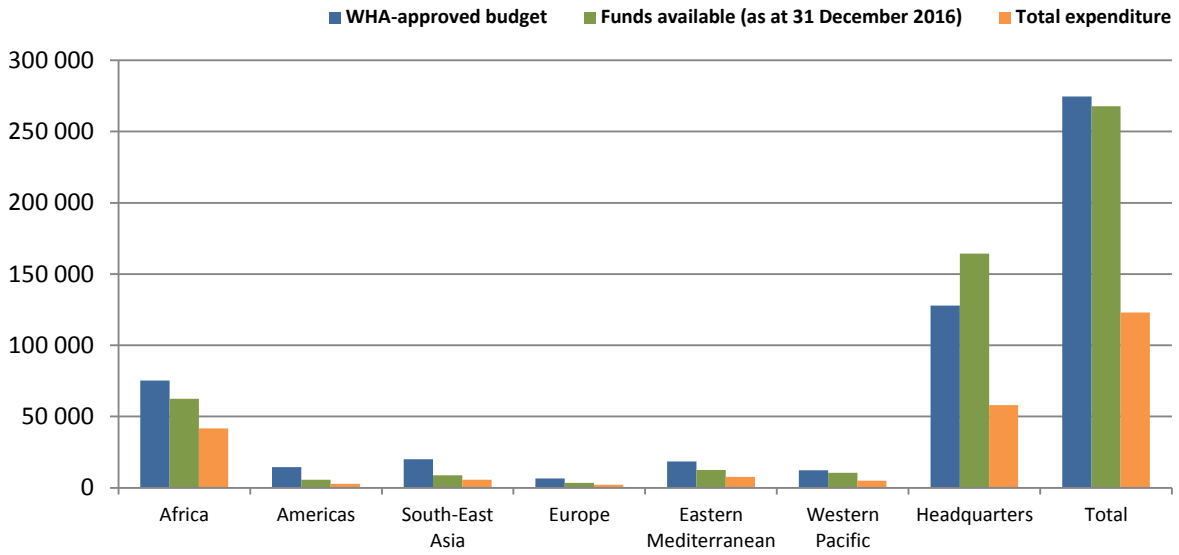


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	5 000	6 900	1 000	1 000	1 500	2 600	18 100	36 100
Funds available (as at 31 Dec 2016)								
Flexible funds	535	363	434	466	1 025	576	3 769	7 168
Voluntary contributions – specified	219	52	28	107	0	553	7 694	8 653
Total	**754**	**415**	**462**	**573**	**1 025**	**1 129**	**11 463**	**15 821**
Funds available as a % of budget	15%	6%	46%	57%	68%	43%	63%	44%
Staff costs	389	28	0	210	512	303	4 642	6 084
Activity costs	373	449	280	132	79	253	2 112	3 678
Total expenditure	**762**	**477**	**280**	**342**	**591**	**556**	**6 754**	**9 762**
Expenditure as a % of approved budget	15%	7%	28%	34%	39%	21%	37%	27%
Expenditure as a % of funds available	101%	115%	61%	60%	58%	49%	59%	62%
Staff expenditure by major office	6%	0%	0%	3%	8%	5%	76%	100%

3.1 Reproductive, maternal, newborn, child and adolescent health

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
3.1.1. Countries enabled to further expand access to, and improve quality of, effective interventions for ending preventable maternal, perinatal and newborn deaths, from pre-pregnancy to postpartum, focusing on the 24-hour period around childbirth	✓	✓	✓	✓	✓	✓	✓
3.1.2. Countries enabled to implement and monitor integrated strategic plans for newborn and child health, with a focus on expanding access to high-quality interventions to improve early childhood development and end preventable newborn and child deaths from pneumonia, diarrhoea and other conditions	✓	✓	✓	!	✓	✓	✓
3.1.3. Countries enabled to implement and monitor effective interventions to cover unmet needs in sexual and reproductive health	✓	✓	✓	✓	✓	✓	✓
3.1.4. Research undertaken and evidence generated and synthesized for designing key interventions in maternal, newborn, child and adolescent health, and other conditions and issues linked to it	!	✓	✓	✓	✓	✓	✓
3.1.5. Countries enabled to implement and monitor integrated policies and strategies for promoting adolescent health and development and reducing adolescent risk behaviours	✓	✓	✓	!	✓	✓	✓
3.1.6. Research undertaken and research capacity strengthened for sexual and reproductive health, including in family planning, maternal and perinatal health, adolescent sexual and reproductive health, sexually transmitted infections, preventing unsafe abortion, infertility, sexual health, female genital mutilation, violence against women, and sexual and reproductive health in humanitarian settings	✓	✓	✓	✓	✓	✓	✓

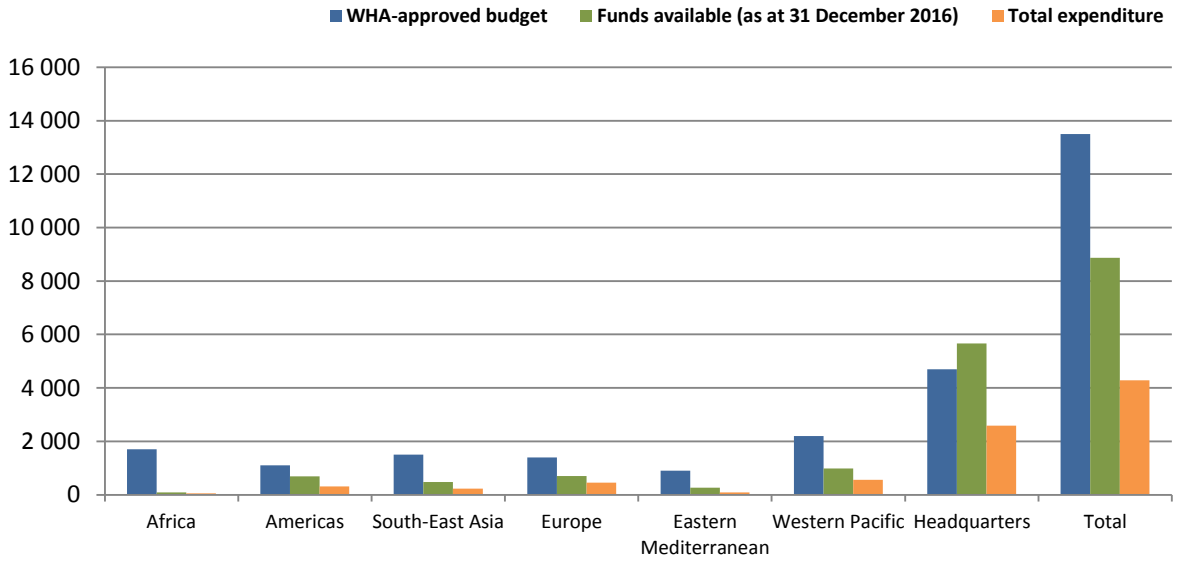


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	75 200	14 400	20 100	6 500	18 400	12 200	127 900	274 700
Funds available (as at 31 Dec 2016)								
Flexible funds	11 503	5 372	5 885	2 475	6 637	2 780	14 465	49 117
Voluntary contributions – specified	51 046	226	2 937	1 036	5 760	7 755	149 892	218 652
Total	**62 549**	**5 598**	**8 822**	**3 511**	**12 397**	**10 535**	**164 357**	**267 769**
Funds available as a % of budget	83%	39%	44%	54%	67%	86%	129%	97%
Staff costs	11 581	1 456	1 985	1 308	3 141	2 079	25 137	46 687
Activity costs	30 127	1 332	3 651	884	4 497	2 805	32 991	76 287
Total expenditure	**41 708**	**2 788**	**5 636**	**2 192**	**7 638**	**4 884**	**58 128**	**122 974**
Expenditure as a % of approved budget	55%	19%	28%	34%	42%	40%	45%	45%
Expenditure as a % of funds available	67%	50%	64%	62%	62%	46%	35%	46%
Staff expenditure by major office	25%	3%	4%	3%	7%	4%	54%	100%

3.2 Ageing and health

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
3.2.1. Countries supported in developing policies and strategies that foster healthy and active ageing	!	✓	✓	✓	✓	✓	✓
3.2.2. Countries enabled to deliver integrated person-centred services that respond to the needs of older women and men in low-, middle- and high-income settings	✓	✓	✓	✓	!	✓	✓
3.2.3. Evidence base strengthened, and monitoring and evaluation mechanisms established to address key issues relevant to the health of older people	✓	✓	✓	✓	!	✓	✓

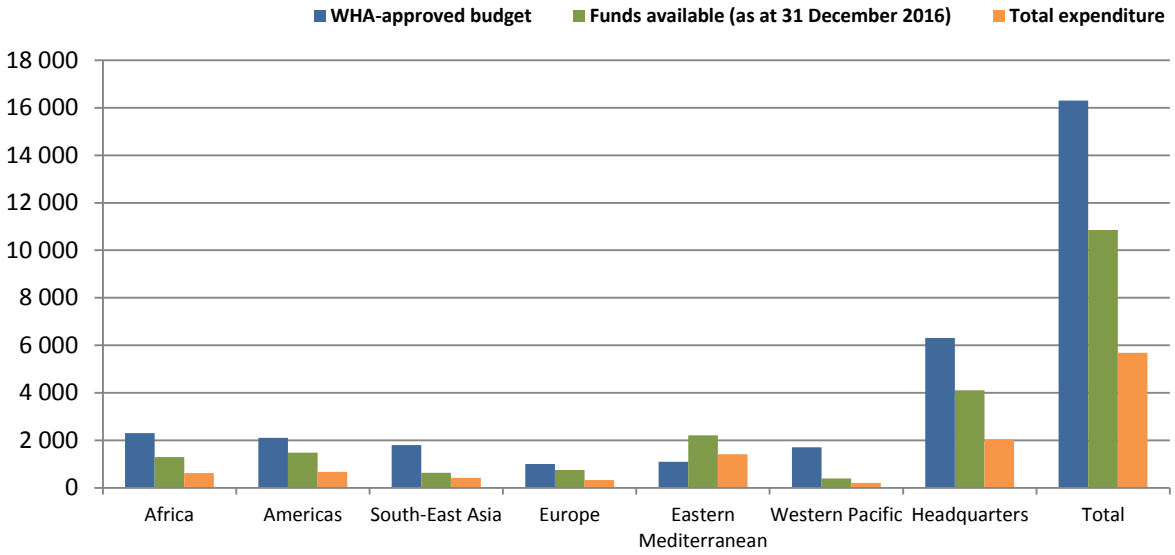


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	1 700	1 100	1 500	1 400	900	2 200	4 700	13 500
Funds available (as at 31 Dec 2016)								
Flexible funds	86	685	450	543	268	765	3 482	6 279
Voluntary contributions – specified	0	0	30	159	0	221	2 186	2 596
Total	86	685	480	702	268	986	5 668	8 875
Funds available as a % of budget	5%	62%	32%	50%	30%	45%	121%	66%
Staff costs	0	197	59	310	51	330	2 077	3 024
Activity costs	59	118	168	142	34	231	506	1 258
Total expenditure	59	315	227	452	85	561	2 583	4 282
Expenditure as a % of approved budget	3%	29%	15%	32%	9%	26%	55%	32%
Expenditure as a % of funds available	69%	46%	47%	64%	32%	57%	46%	48%
Staff expenditure by major office	0%	7%	2%	10%	2%	11%	69%	100%

3.3 Gender, equity and human rights mainstreaming

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
3.3.1. Gender, equity and human rights integrated in WHO's institutional mechanisms and programme deliverables	!	✓	✓	✓	✓	!	✓
3.3.2. Countries enabled to integrate and monitor gender, equity and human rights in national health policies and programmes	!	✓	✓	✓	✓	✓	✓

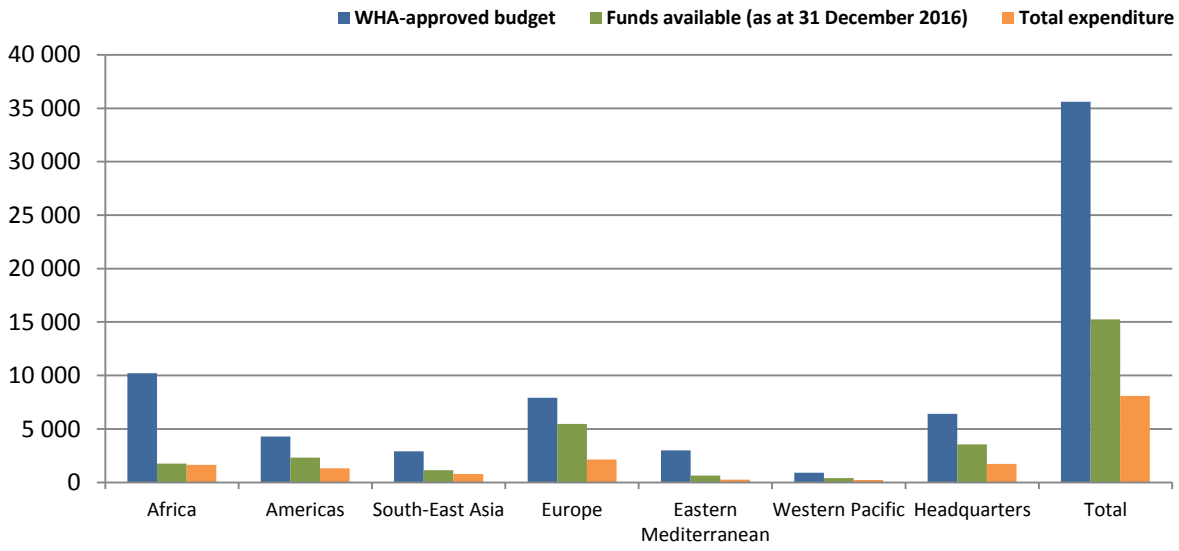


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	2 300	2 100	1 800	1 000	1 100	1 700	6 300	16 300
Funds available (as at 31 Dec 2016)								
Flexible funds	859	1 482	604	733	219	183	3 184	7 264
Voluntary contributions – specified	431	2	33	20	1 983	204	921	3 594
Total	**1 290**	**1 484**	**637**	**753**	**2 202**	**387**	**4 105**	**10 858**
Funds available as a % of budget	56%	71%	35%	75%	200%	23%	65%	67%
Staff costs	169	255	151	250	131	1	1 565	2 522
Activity costs	445	416	264	71	1 283	207	477	3 163
Total expenditure	**614**	**671**	**415**	**321**	**1 414**	**208**	**2 042**	**5 685**
Expenditure as a % of approved budget	27%	32%	23%	32%	129%	12%	32%	35%
Expenditure as a % of funds available	48%	45%	65%	43%	64%	54%	50%	52%
Staff expenditure by major office	7%	10%	6%	10%	5%	0%	62%	100%

3.4 Social determinants of health

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
3.4.1. Improved country policies, capacities and intersectoral actions for addressing the social determinants of health and reducing health inequities through "health-in-all-policies", governance and universal health coverage approaches in the Sustainable Development Goals	✓	✓	✓	✓	!	✓	✓
3.4.2. A social determinants of health approach to improving health and reducing health inequities integrated in national, regional and global health programmes and strategies, as well as in WHO	✓	✓	✓	✓	!	✓	✓
3.4.3. Trends in, and progress on, action on social determinants of health and health equity monitored, including under the universal health coverage framework and the Sustainable Development Goals	✓	✓	✓	✓	!	✓	✓

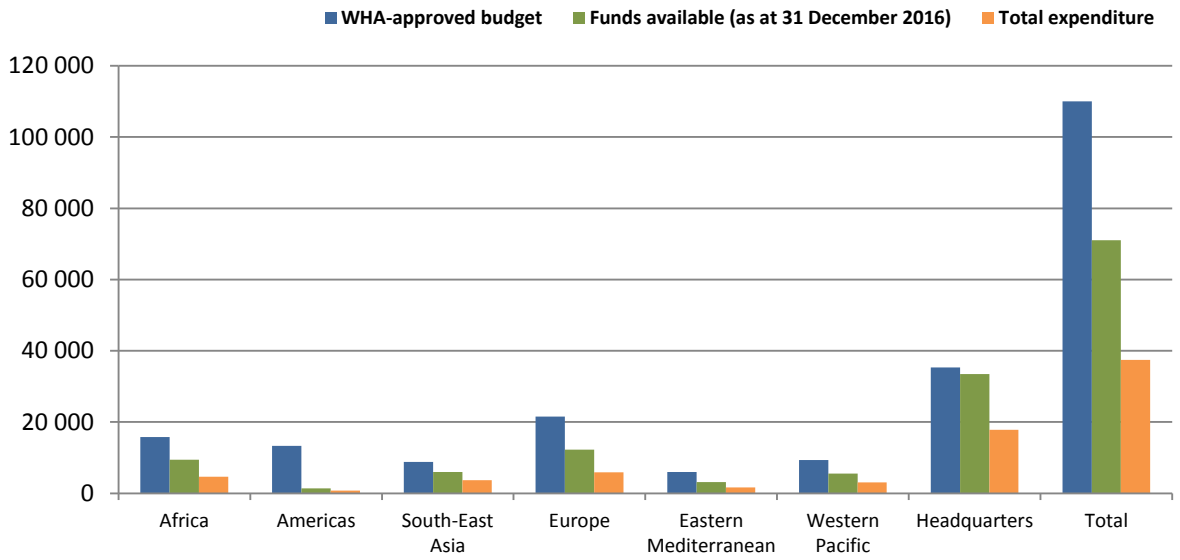


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	10 200	4 300	2 900	7 900	3 000	900	6 400	35 600
Funds available (as at 31 Dec 2016)								
Flexible funds	1 410	2 324	1 134	1 409	489	276	3 198	10 240
Voluntary contributions – specified	348	0	0	4 047	145	117	365	5 022
Total	**1 758**	**2 324**	**1 134**	**5 456**	**634**	**393**	**3 563**	**15 262**
Funds available as a % of budget	17%	54%	39%	69%	21%	44%	56%	43%
Staff costs	1 186	895	435	1 481	99	149	1 425	5 670
Activity costs	461	425	334	658	158	66	308	2 410
Total expenditure	**1 647**	**1 320**	**769**	**2 139**	**257**	**215**	**1 733**	**8 080**
Expenditure as a % of approved budget	16%	31%	27%	27%	9%	24%	27%	23%
Expenditure as a % of funds available	94%	57%	68%	39%	41%	55%	49%	53%
Staff expenditure by major office	21%	16%	8%	26%	2%	3%	25%	100%

3.5 Health and the environment

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
3.5.1. Countries enabled to assess health risks and develop and implement policies, strategies or regulations for the prevention, mitigation and management of the health impacts of environmental and occupational risks	✓	✓	✓	✓	✓	✓	✓
3.5.2. Norms and standards established and guidelines developed for environmental and occupational health risks and benefits associated with, for example, air and noise pollution, chemicals, waste, water and sanitation, radiation, nanotechnologies and climate change	✓	!	✓	✓	✓	✓	✓
3.5.3. Public health objectives addressed in implementation of multilateral agreements and conventions on the environment and in relation to the Sustainable Development Goals and the 2030 Agenda for Sustainable Development	✓	✓	✓	✓	✓	✓	✓

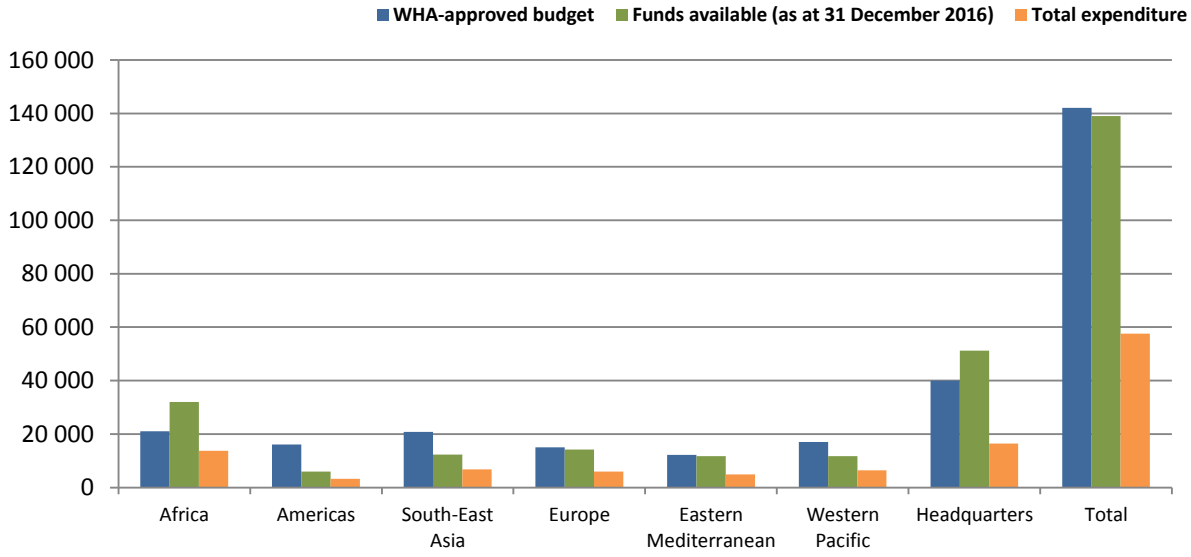


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	15 800	13 300	8 800	21 500	6 000	9 300	35 300	110 000
Funds available (as at 31 Dec 2016)								
Flexible funds	2 447	977	2 498	1 214	2 760	1 885	8 440	20 221
Voluntary contributions – specified	6 965	373	3 449	11 014	346	3 618	25 059	50 824
Total	**9 412**	**1 350**	**5 947**	**12 228**	**3 106**	**5 503**	**33 499**	**71 045**
Funds available as a % of budget	60%	10%	68%	57%	52%	59%	95%	65%
Staff costs	1 524	362	1 193	4 064	1 195	1 566	10 926	20 830
Activity costs	3 102	435	2 497	1 810	409	1 479	6 911	16 643
Total expenditure	**4 626**	**797**	**3 690**	**5 874**	**1 604**	**3 045**	**17 837**	**37 473**
Expenditure as a % of approved budget	29%	6%	42%	27%	27%	33%	51%	34%
Expenditure as a % of funds available	49%	59%	62%	48%	52%	55%	53%	53%
Staff expenditure by major office	7%	2%	6%	20%	6%	8%	52%	100%

4.1 National health policies, strategies and plans

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
4.1.1. Improved country governance capacity to formulate, implement and review comprehensive national health policies, strategies and plans (including multisectoral action, and "health in all policies" and equity policies)	✓	✓	✓	✓	✓	✓	✓
4.1.2. Improved national health financing strategies aimed at moving towards universal health coverage	✓	✓	✓	✓	✓	✓	✓

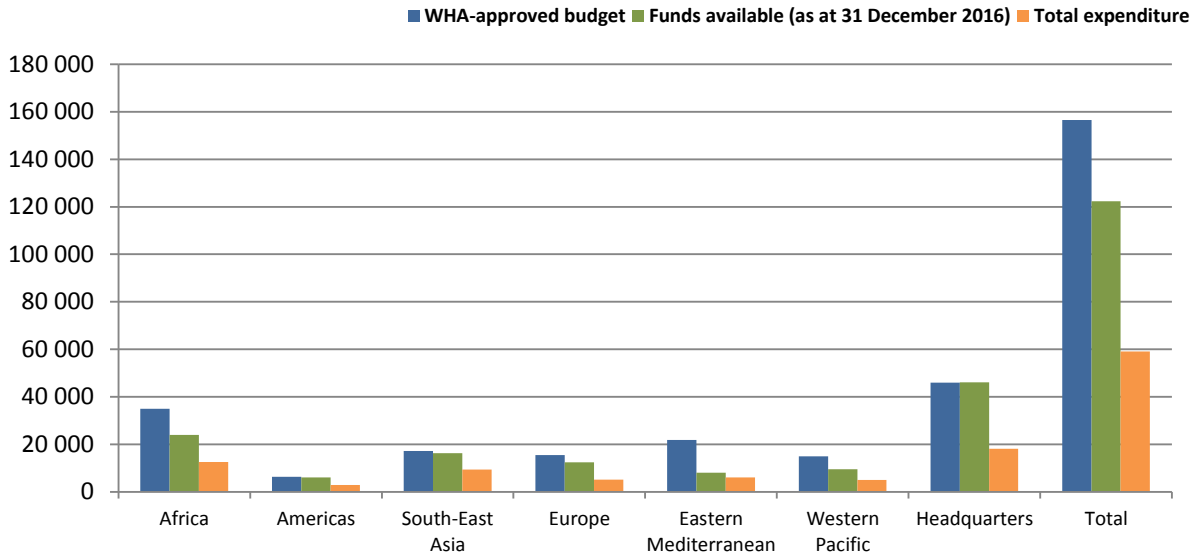


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	21 000	16 100	20 800	15 000	12 200	17 000	40 000	142 100
Funds available (as at 31 Dec 2016)								
Flexible funds	6 698	4 871	9 709	4 680	4 971	6 579	9 782	47 290
Voluntary contributions – specified	25 317	1 062	2 616	9 546	6 708	5 121	41 398	91 768
Total	**32 015**	**5 933**	**12 325**	**14 226**	**11 679**	**11 700**	**51 180**	**139 058**
Funds available as a % of budget	152%	37%	59%	95%	96%	69%	128%	98%
Staff costs	6 674	1 845	4 124	3 336	2 204	3 575	10 854	32 612
Activity costs	7 071	1 447	2 605	2 646	2 681	2 870	5 639	24 959
Total expenditure	**13 745**	**3 292**	**6 729**	**5 982**	**4 885**	**6 445**	**16 493**	**57 571**
Expenditure as a % of approved budget	65%	20%	32%	40%	40%	38%	41%	41%
Expenditure as a % of funds available	43%	55%	55%	42%	42%	55%	32%	41%
Staff expenditure by major office	20%	6%	13%	10%	7%	11%	33%	100%

4.2 Integrated people-centred health services

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
4.2.1. Equitable integrated, people-centred service delivery systems in place in countries and public health approaches strengthened	✓	✓	✓	✓	✓	!	✓
4.2.2. Health workforce strategies oriented towards universal health coverage implemented in countries	✓	✓	✓	✓	✓	✓	✓
4.2.3. Countries enabled to improve patient safety and quality of services, and patient empowerment within the context of universal health coverage	!	✓	✓	✓	✓	!	✓

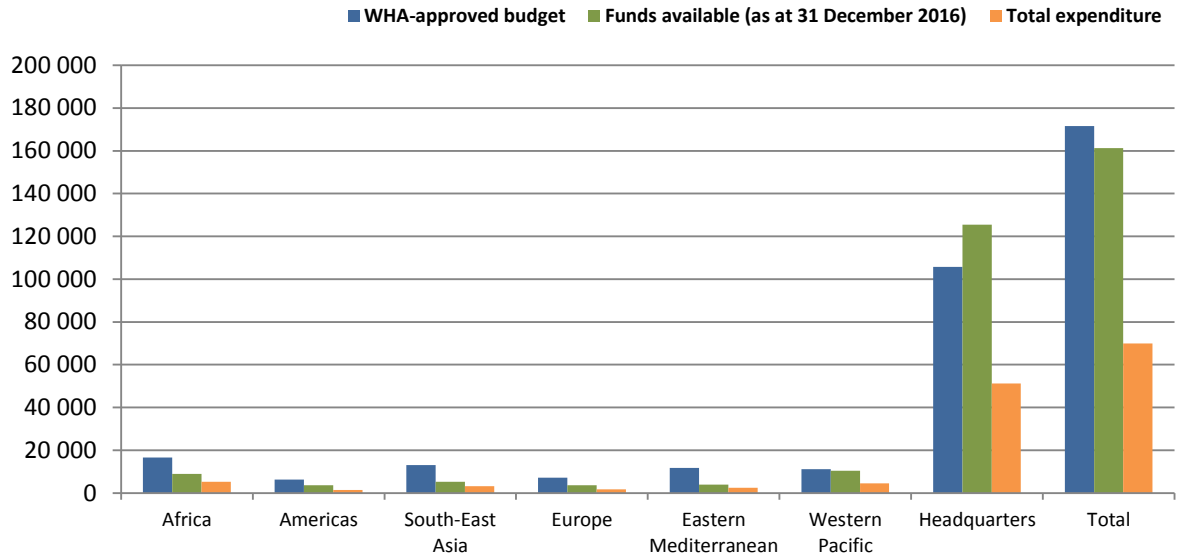


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	35 000	6 300	17 200	15 400	21 800	14 900	45 900	156 500
Funds available (as at 31 Dec 2016)								
Flexible funds	6 681	6 052	7 849	4 084	6 146	5 607	12 858	49 277
Voluntary contributions – specified	17 325	15	8 437	8 361	1 880	3 848	33 168	73 034
Total	**24 006**	**6 067**	**16 286**	**12 445**	**8 026**	**9 455**	**46 026**	**122 311**
Funds available as a % of budget	69%	96%	95%	81%	37%	63%	100%	78%
Staff costs	6 928	1 930	2 162	2 774	2 489	2 162	12 573	31 018
Activity costs	5 600	992	7 172	2 380	3 500	2 841	5 558	28 043
Total expenditure	**12 528**	**2 922**	**9 334**	**5 154**	**5 989**	**5 003**	**18 131**	**59 061**
Expenditure as a % of approved budget	36%	46%	54%	33%	27%	34%	40%	38%
Expenditure as a % of funds available	52%	48%	57%	41%	75%	53%	39%	48%
Staff expenditure by major office	22%	6%	7%	9%	8%	7%	41%	100%

4.3 Access to medicines and other health technologies and strengthening regulatory capacity

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
4.3.1. Countries enabled to develop or update, implement, monitor and evaluate national policies on better access to medicines and other health technologies; and to strengthen their evidence-based selection and rational use	✓	✓	✓	✓	✓	✓	✓
4.3.2. Implementation of the global strategy and plan of action on public health, innovation and intellectual property	!	✓	✓	✓	!	✓	✓
4.3.3. Improved quality and safety of medicines and other health technologies through norms, standards and guidelines, strengthening of regulatory systems, and prequalification	✓	✓	✓	✓	✓	✓	✓

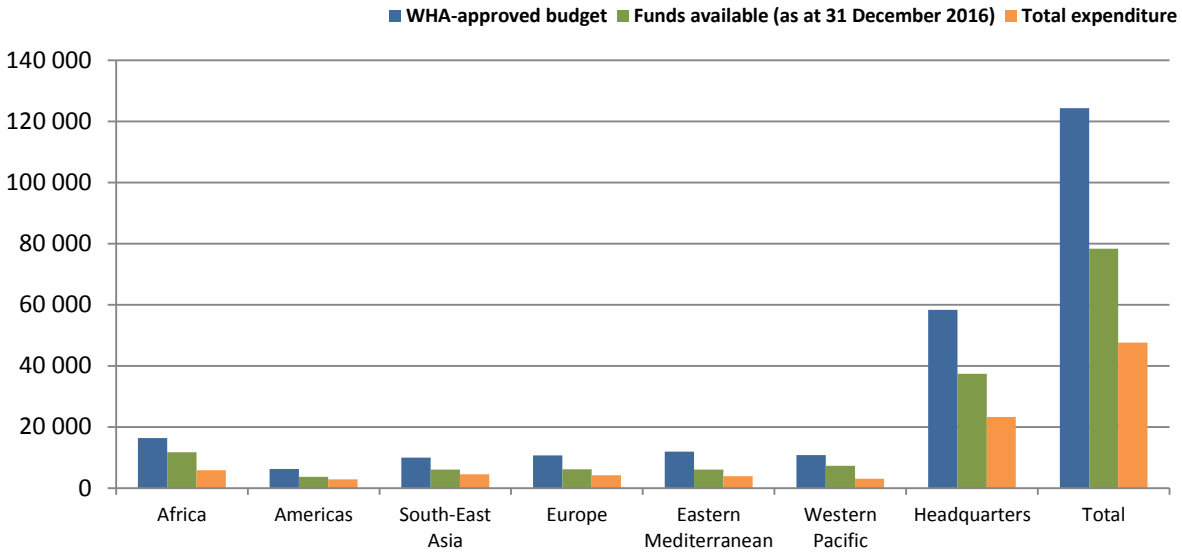


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	16 600	6 200	13 100	7 100	11 700	11 200	105 700	171 600
Funds available (as at 31 Dec 2016)								
Flexible funds	3 037	3 655	4 379	1 553	2 738	3 042	19 577	37 981
Voluntary contributions – specified	5 885	34	893	2 057	1 127	7 313	105 933	123 242
Total	**8 922**	**3 689**	**5 272**	**3 610**	**3 865**	**10 355**	**125 510**	**161 223**
Funds available as a % of budget	54%	60%	40%	51%	33%	92%	119%	94%
Staff costs	2 769	929	1 494	909	1 148	1 565	34 775	43 589
Activity costs	2 537	531	1 741	788	1 248	2 941	16 490	26 276
Total expenditure	**5 306**	**1 460**	**3 235**	**1 697**	**2 396**	**4 506**	**51 265**	**69 865**
Expenditure as a % of approved budget	32%	24%	25%	24%	20%	40%	49%	41%
Expenditure as a % of funds available	59%	40%	61%	47%	62%	44%	41%	43%
Staff expenditure by major office	6%	2%	3%	2%	3%	4%	80%	100%

4.4 Health systems, information and evidence

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
4.4.1. Comprehensive monitoring of the global, regional and country health situation, trends, inequalities and determinants, using global standards, including data collection and analysis to address data gaps and system performance assessment	✓	✓	✓	✓	✓	✓	!
4.4.2. Countries enabled to plan, develop and implement an eHealth strategy	✓	✓	✓	✓	!	✓	X
4.4.3. Knowledge management policies, tools, networks and resources developed and used by WHO and countries to strengthen their capacity to generate, share and apply knowledge	✓	✓	✓	✓	✓	✓	!
4.4.4. Policy options, tools and technical support provided to promote research for health and address ethical issues in public health and research	✓	✓	✓	✓	✓	✓	✓

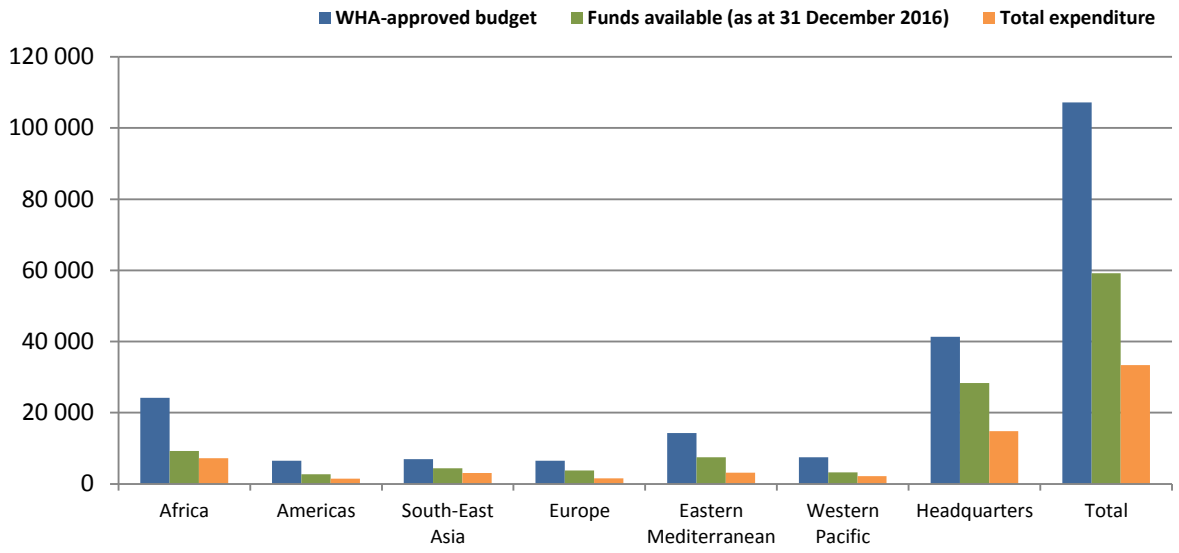


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	16 400	6 200	10 000	10 700	11 900	10 800	58 300	124 300
Funds available (as at 31 Dec 2016)								
Flexible funds	2 992	3 156	4 685	5 708	5 506	2 934	22 983	47 964
Voluntary contributions – specified	8 741	526	1 352	409	574	4 290	14 445	30 337
Total	**11 733**	**3 682**	**6 037**	**6 117**	**6 080**	**7 224**	**37 428**	**78 301**
Funds available as a % of budget	72%	59%	60%	57%	51%	67%	64%	63%
Staff costs	3 211	1 298	2 139	2 579	2 280	1 347	19 896	32 750
Activity costs	2 645	1 587	2 369	1 592	1 571	1 726	3 363	14 853
Total expenditure	**5 856**	**2 885**	**4 508**	**4 171**	**3 851**	**3 073**	**23 259**	**47 603**
Expenditure as a % of approved budget	36%	47%	45%	39%	32%	28%	40%	38%
Expenditure as a % of funds available	50%	78%	75%	68%	63%	43%	62%	61%
Staff expenditure by major office	10%	4%	7%	8%	7%	4%	61%	100%

E.1 Infectious hazard management

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
E.1.1 Control strategies, plans and capacities developed for diseases such as cholera, viral haemorrhagic fever, meningitis and influenza and those due to vector-borne, emerging and re-emerging pathogens	✓	✓	✓	✓	✓	✓	✓
E.1.2 Global expert networks and innovative mechanisms developed to manage new and evolving high-threat infectious hazards (such as for clinical management, laboratories, social science, and data modelling)	✓	✓	✓	✓	X	✓	✓

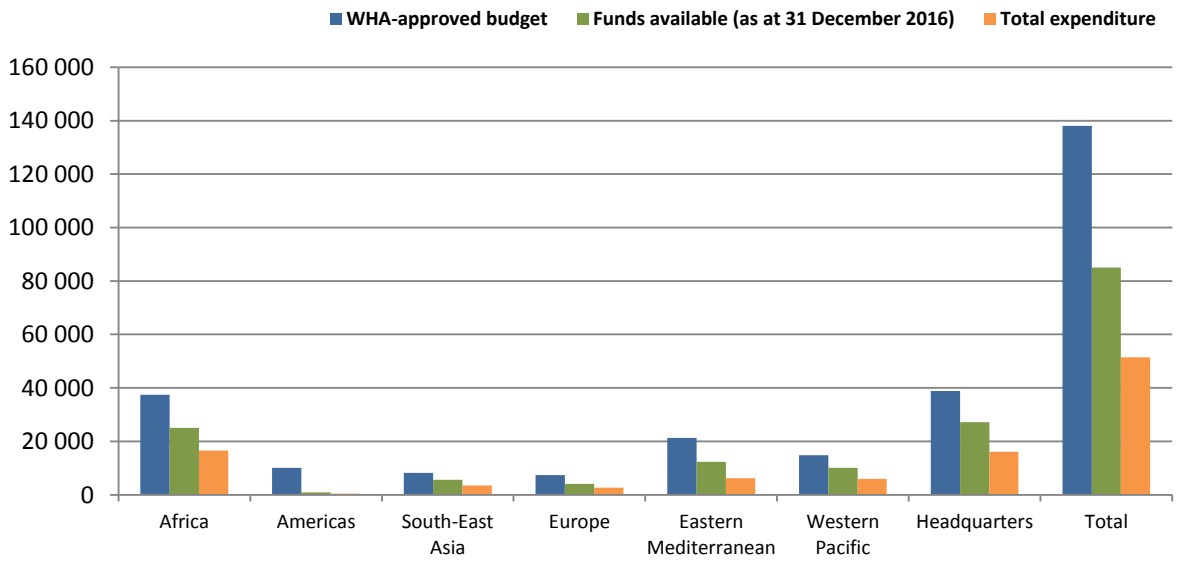


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	24 200	6 500	6 900	6 500	14 300	7 500	41 300	107 200
Funds available (as at 31 Dec 2016)								
Flexible funds	1 918	2 211	1 286	1 182	1 784	854	4 442	13 677
Voluntary contributions – specified	7 333	506	3 096	2 606	5 729	2 358	23 923	45 551
Total	9 251	2 717	4 382	3 788	7 513	3 212	28 365	59 228
Funds available as a % of budget	38%	42%	64%	58%	53%	43%	69%	55%
Staff costs	1 578	557	821	850	978	1 285	10 490	16 559
Activity costs	5 600	945	2 215	676	2 162	912	4 303	16 813
Total expenditure	7 178	1 502	3 036	1 526	3 140	2 197	14 793	33 372
Expenditure as a % of approved budget	30%	23%	44%	23%	22%	29%	36%	31%
Expenditure as a % of funds available	78%	55%	69%	40%	42%	68%	52%	56%
Staff expenditure by major office	10%	3%	5%	5%	6%	8%	63%	100%

E.2 Country health emergency preparedness and the International Health Regulations (2005)

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
E.2.1 Country core capacities for health emergency preparedness and the International Health Regulations (2005) independently assessed and national action plans developed	✓	✓	✓	✓	✓	✓	✓
E.2.2 Critical core capacities for health emergency preparedness and the International Health Regulations (2005) strengthened in all countries	✓	✓	✓	✓	✓	✓	✓
E.2.3 Operational readiness plans (WHO and partners) implemented and tested for specific threats in highly vulnerable countries	✓	✓	✓	✓	✓	✓	✓
E.2.4 Secretariat support provided for implementation of the International Health Regulations (2005)	✓	✓	✓	✓	✓	✓	✓

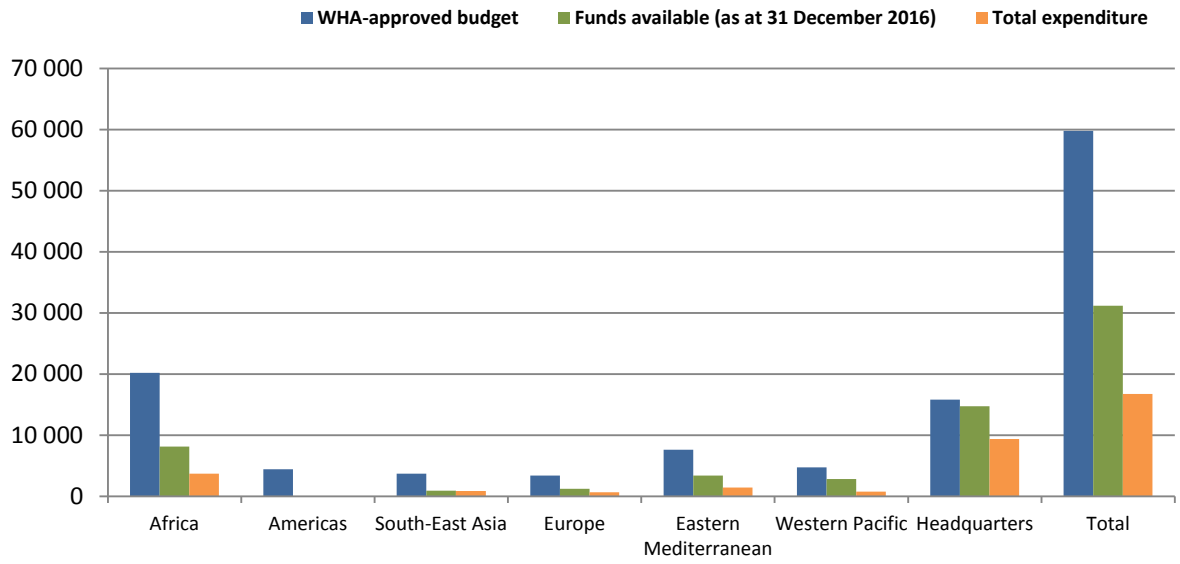


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	37 400	10 100	8 200	7 400	21 300	14 800	38 900	138 100
Funds available (as at 31 Dec 2016)								
Flexible funds	4 329	856	4 009	1 590	3 991	2 273	6 455	23 503
Voluntary contributions – specified	20 712	67	1 583	2 451	8 314	7 775	20 676	61 578
Total	25 041	923	5 592	4 041	12 305	10 048	27 131	85 081
Funds available as a % of budget	67%	9%	68%	55%	58%	68%	70%	62%
Staff costs	7 635	178	1 709	1 408	3 051	3 099	9 683	26 763
Activity costs	8 974	287	1 791	1 243	3 158	2 838	6 364	24 655
Total expenditure	16 609	465	3 500	2 651	6 209	5 937	16 047	51 418
Expenditure as a % of approved budget	44%	5%	43%	36%	29%	40%	41%	37%
Expenditure as a % of funds available	66%	50%	63%	66%	50%	59%	59%	60%
Staff expenditure by major office	29%	1%	6%	5%	11%	12%	36%	100%

E.3 Health emergency information and risk assessment

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
E.3.1 New events detected and public health risks assessed	✓	✓	✓	✓	✓	✓	✓
E.3.2 Reliable and up-to-date information available to inform public health interventions and monitor response operations	✓	✓	✓	✓	✓	!	✓
E.3.3 Accurate information about emergency events reported in a timely manner	✓	✓	✓	✓	✓	!	✓

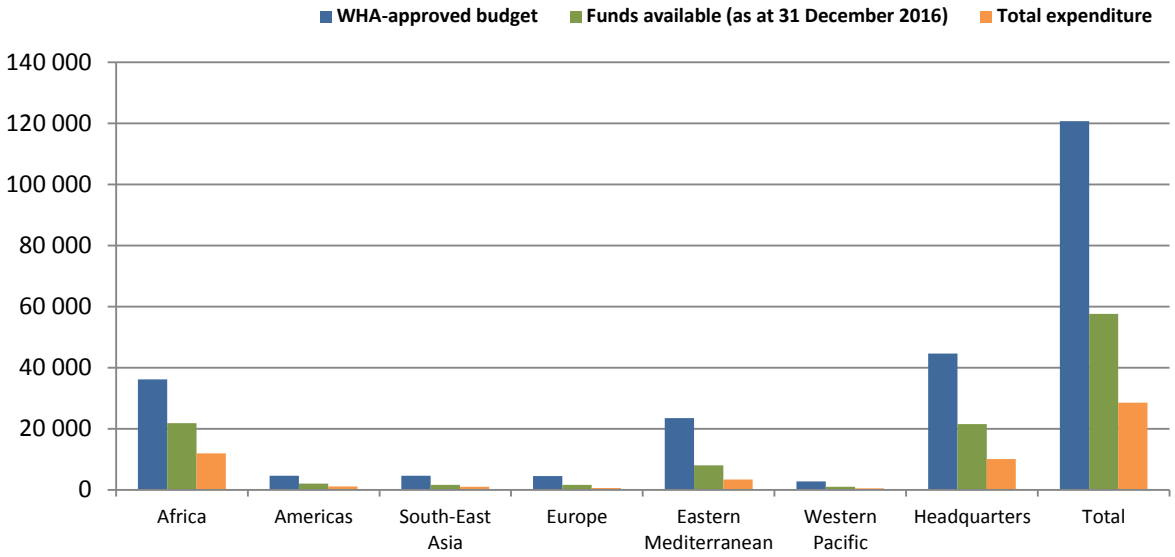


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	20 200	4 400	3 700	3 400	7 600	4 700	15 800	59 800
Funds available (as at 31 Dec 2016)								
Flexible funds	1 036	0	811	779	1 156	320	6 004	10 106
Voluntary contributions – specified	7 100	0	96	451	2 207	2 494	8 737	21 085
Total	**8 136**	**0**	**907**	**1 230**	**3 363**	**2 814**	**14 741**	**31 191**
Funds available as a % of budget	40%	0%	25%	36%	44%	60%	93%	52%
Staff costs	935	0	429	611	540	416	9 081	12 012
Activity costs	2 779	0	404	25	890	338	292	4 728
Total expenditure	**3 714**	**0**	**833**	**636**	**1 430**	**754**	**9 373**	**16 740**
Expenditure as a % of approved budget	18%	0%	23%	19%	19%	16%	59%	28%
Expenditure as a % of funds available	46%	0%	92%	52%	43%	27%	64%	54%
Staff expenditure by major office	8%	0%	4%	5%	4%	3%	76%	100%

E.4 Emergency operations

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
E.4.1 Health operations effectively managed in support of national and local response	✓	✓	✓	✓	✓	✓	✓
E.4.2 Collective response by operational partners effectively coordinated	✓	✓	✓	✓	✓	✓	✓
E.4.3 Effective logistics and operational support rapidly established and maintained	✓	✓	✓	✓	✓	✓	!
E.4.4 Priority gaps in humanitarian policy and guidance addressed, with specific emphasis on health	N/A	N/A	N/A	N/A	N/A	N/A	✓

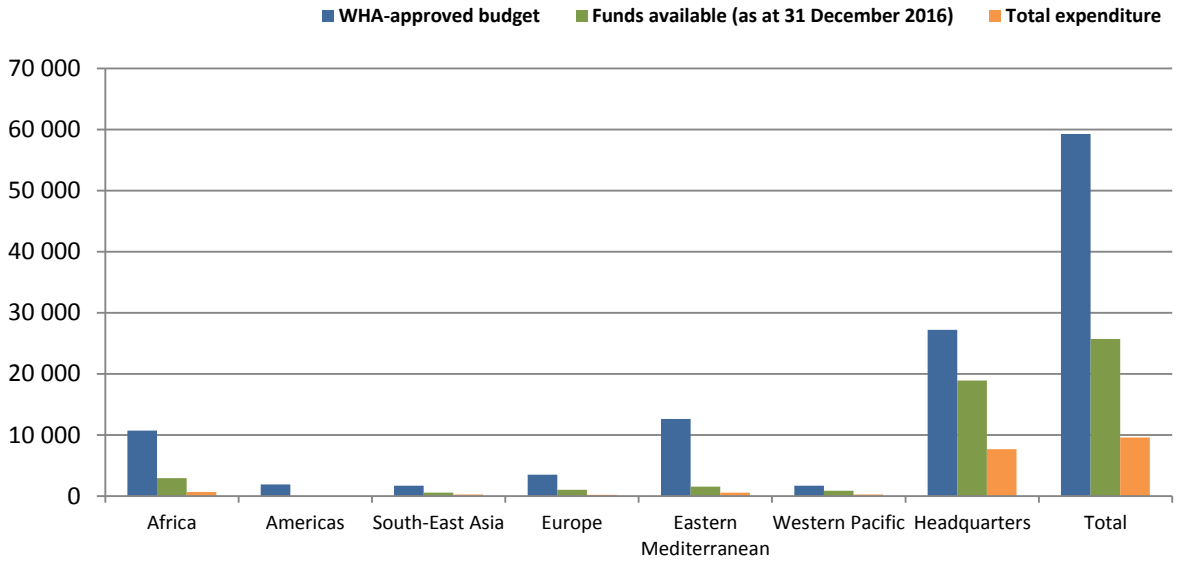


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	36 200	4 600	4 600	4 500	23 500	2 700	44 600	120 700
Funds available (as at 31 Dec 2016)								
Flexible funds	5 688	1 485	688	1 005	4 278	494	7 249	20 887
Voluntary contributions – specified	16 163	579	947	575	3 717	472	14 221	36 674
Total	**21 851**	**2 064**	**1 635**	**1 580**	**7 995**	**966**	**21 470**	**57 561**
Funds available as a % of budget	60%	45%	36%	35%	34%	36%	48%	48%
Staff costs	3 166	429	394	265	1 031	309	7 512	13 106
Activity costs	8 759	696	595	258	2 358	192	2 554	15 412
Total expenditure	**11 925**	**1 125**	**989**	**523**	**3 389**	**501**	**10 066**	**28 518**
Expenditure as a % of approved budget	33%	24%	22%	12%	14%	19%	23%	24%
Expenditure as a % of funds available	55%	55%	60%	33%	42%	52%	47%	50%
Staff expenditure by major office	24%	3%	3%	2%	8%	2%	57%	100%

E.5 Emergency core services

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
E.5.1 WHO Health Emergencies Programme effectively managed and sustainably staffed and financed	✓	✓	✓	✓	✓	✓	✓
E.5.2 Effective communication and resource mobilization	✓	✓	✓	✓	!	✓	!
E.5.3 Effective leadership, planning and performance management	✓	✓	✓	✓	✓	✓	✓

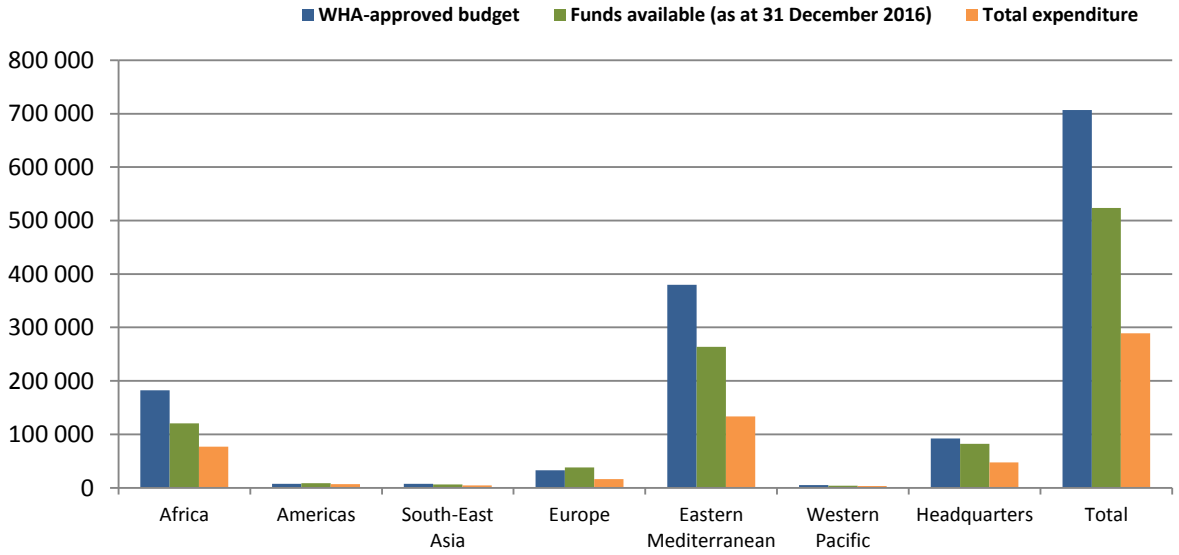


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	10 700	1 900	1 700	3 500	12 600	1 700	27 200	59 300
Funds available (as at 31 Dec 2016)								
Flexible funds	2 520	0	499	833	948	528	8 455	13 783
Voluntary contributions – specified	404	0	37	149	583	316	10 426	11 915
Total	**2 924**	**0**	**536**	**982**	**1 531**	**844**	**18 881**	**25 698**
Funds available as a % of budget	27%	0%	32%	28%	12%	50%	69%	43%
Staff costs	639	0	255	199	547	246	7 503	9 389
Activity costs	1	0	0	0	0	3	156	160
Total expenditure	**640**	**0**	**255**	**199**	**547**	**249**	**7 659**	**9 549**
Expenditure as a % of approved budget	6%	0%	15%	6%	4%	15%	28%	16%
Expenditure as a % of funds available	22%	0%	48%	20%	36%	30%	41%	37%
Staff expenditure by major office	7%	0%	3%	2%	6%	3%	80%	100%

E.6 Outbreak and crisis response

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
E.6.1 In acute/unforeseen emergencies and disasters with public health consequences, Emergency Response Framework implemented	✓	✓	✓	✓	✓	✓	✓
E.6.2 In protracted emergencies, gap-filling, life-saving activities as "provider of last resort" implemented and included in the health sector response plans and appeals	✓	✓	✓	✓	✓	✓	✓
E.6.3 In countries recovering from major emergencies and disasters, early recovery health activities implemented as defined in the health sector recovery plans and in appeals	✓	✓	✓	✓	✓	✓	✓

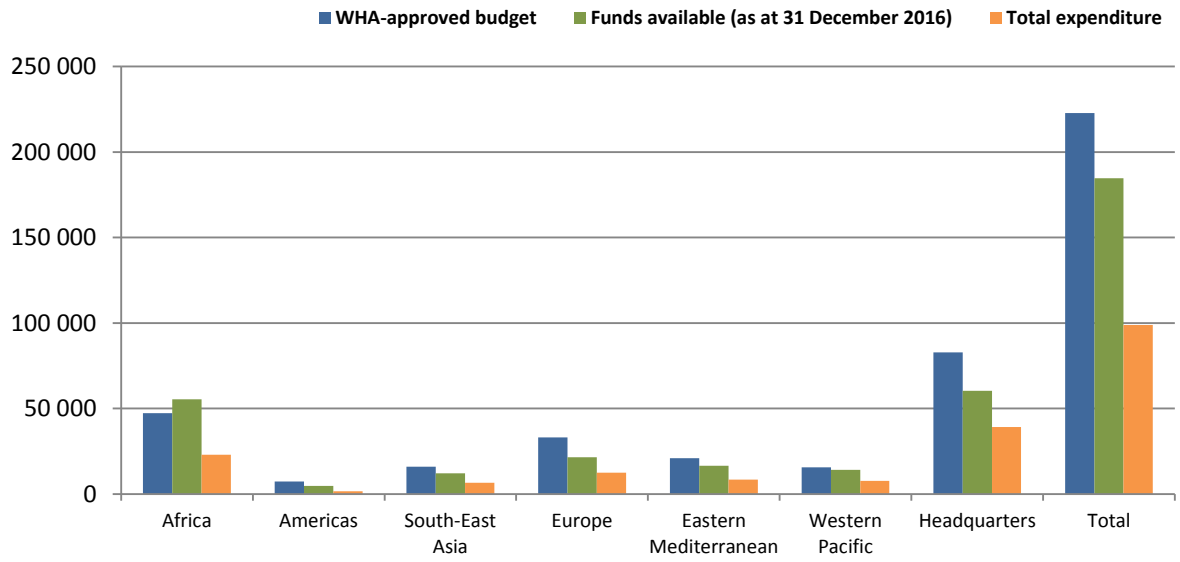


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	182 300	7 600	7 381	32 733	380 000	4 900	92 170	707 084
Funds available (as at 31 Dec 2016)								
Flexible funds	907	0	625	240	2 500	0	10 950	15 222
Voluntary contributions – specified	119 481	8 629	5 838	37 995	261 360	3 756	71 216	508 275
Total	**120 388**	**8 629**	**6 463**	**38 235**	**263 860**	**3 756**	**82 166**	**523 497**
Funds available as a % of budget	66%	114%	88%	117%	69%	77%	89%	74%
Staff costs	10 228	178	124	3 640	15 119	49	13 884	43 222
Activity costs	66 808	6 736	4 597	12 640	118 531	3 122	33 600	246 034
Total expenditure	**77 036**	**6 914**	**4 721**	**16 280**	**133 650**	**3 171**	**47 484**	**289 256**
Expenditure as a % of approved budget	42%	91%	64%	50%	35%	65%	52%	41%
Expenditure as a % of funds available	64%	80%	73%	43%	51%	84%	58%	55%
Staff expenditure by major office	38%	1%	0%	14%	56%	0%	52%	161%

6.1 Leadership and governance

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
6.1.1. Effective WHO leadership and management in accordance with leadership priorities	✓	✓	✓	✓	✓	✓	✓
6.1.2. Effective engagement with other United Nations agencies and non-State actors in building a common health agenda that responds to Member States' priorities	✓	✓	✓	✓	✓	✓	✓
6.1.3. WHO governance strengthened with effective oversight of governing body sessions and efficient, aligned agendas	✓	✓	✓	✓	✓	✓	✓
6.1.4. Integration of WHO reform in the work of the Organization	✓	✓	✓	✓	✓	✓	✓

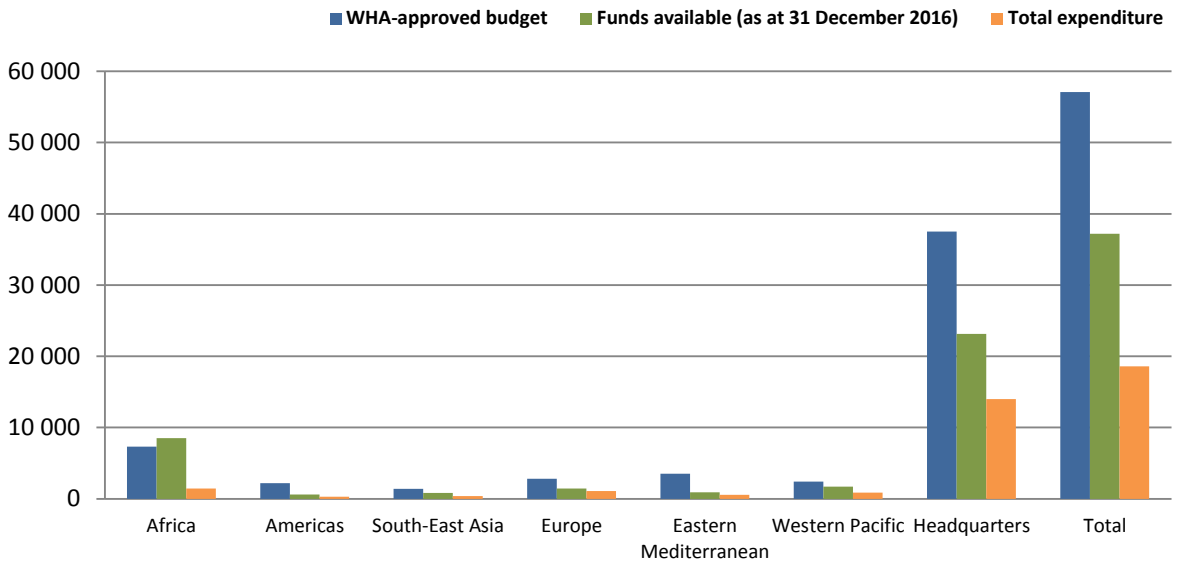


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	47 200	7 300	16 000	33 100	20 900	15 500	82 700	222 700
Funds available (as at 31 Dec 2016)								
Flexible funds	53 257	4 764	11 989	21 317	14 473	12 422	54 500	172 722
Voluntary contributions – specified	2 078	0	104	113	2 076	1 673	163	6 207
Post Occupancy Charge	0	0	0	0	0	0	5 700	5 700
Total	**55 335**	**4 764**	**12 093**	**21 430**	**16 549**	**14 095**	**60 363**	**184 629**
Funds available as a % of budget	117%	65%	76%	65%	79%	91%	73%	83%
Staff costs	19 116	900	5 257	10 908	7 475	6 376	31 442	81 474
Activity costs	3 910	693	1 289	1 551	928	1 291	7 751	17 413
Total expenditure	**23 026**	**1 593**	**6 546**	**12 459**	**8 403**	**7 667**	**39 193**	**98 887**
Expenditure as a % of approved budget	49%	22%	41%	38%	40%	49%	47%	44%
Expenditure as a % of funds available	42%	33%	54%	58%	51%	54%	65%	54%
Staff expenditure by major office	23%	1%	6%	13%	9%	8%	39%	100%

6.2 Transparency, accountability and risk management

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
6.2.1. Accountability ensured and corporate risk management strengthened at all levels of the Organization	✓	✓	✓	✓	✓	✓	✓
6.2.2. Organizational learning through implementation of evaluation policy and plans	✓	✓	✓	✓	!	✓	✓
6.2.3. Ethical behaviour, decent conduct and fairness promoted across the Organization	✓	✓	✓	✓	✓	✓	✓

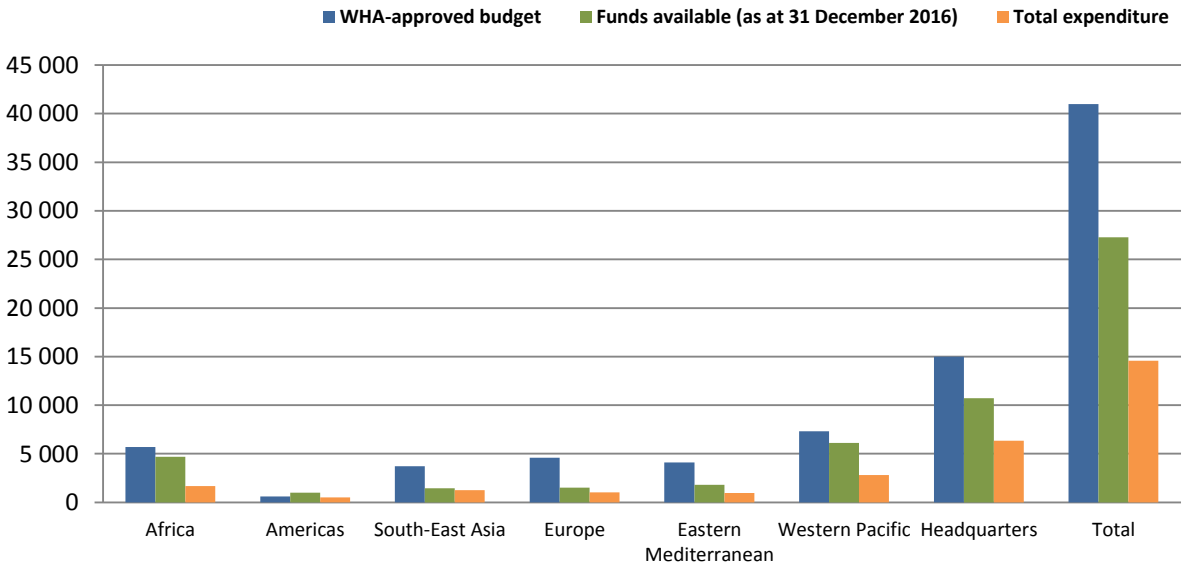


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	7 300	2 200	1 400	2 800	3 500	2 400	37 500	57 100
Funds available (as at 31 Dec 2016)								
Flexible funds	8 422	616	811	1 407	924	1 663	20 350	34 193
Voluntary contributions – specified	110	0	0	50	0	35	495	690
Post Occupancy Charge	0	0	0	0	0	0	2 300	2 300
Total	**8 532**	**616**	**811**	**1 457**	**924**	**1 698**	**23 145**	**37 183**
Funds available as a % of budget	117%	28%	58%	52%	26%	71%	62%	65%
Staff costs	840	260	334	1 044	528	844	11 812	15 662
Activity costs	619	10	62	30	33	0	2 185	2 939
Total expenditure	**1 459**	**270**	**396**	**1 074**	**561**	**844**	**13 997**	**18 601**
Expenditure as a % of approved budget	20%	12%	28%	38%	16%	35%	37%	33%
Expenditure as a % of funds available	17%	44%	49%	74%	61%	50%	60%	50%
Staff expenditure by major office	5%	2%	2%	7%	3%	5%	75%	100%

6.3 Strategic planning, resource coordination and reporting

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
6.3.1. Needs-driven priority-setting in place and resource allocation aligned to delivery of results	✓	✓	✓	✓	!	✓	✓
6.3.2. Predictable, adequate and aligned financing in place that allows for full implementation of WHO's programme budget across all programme areas and major offices	✓	!	✓	✓	!	!	✓

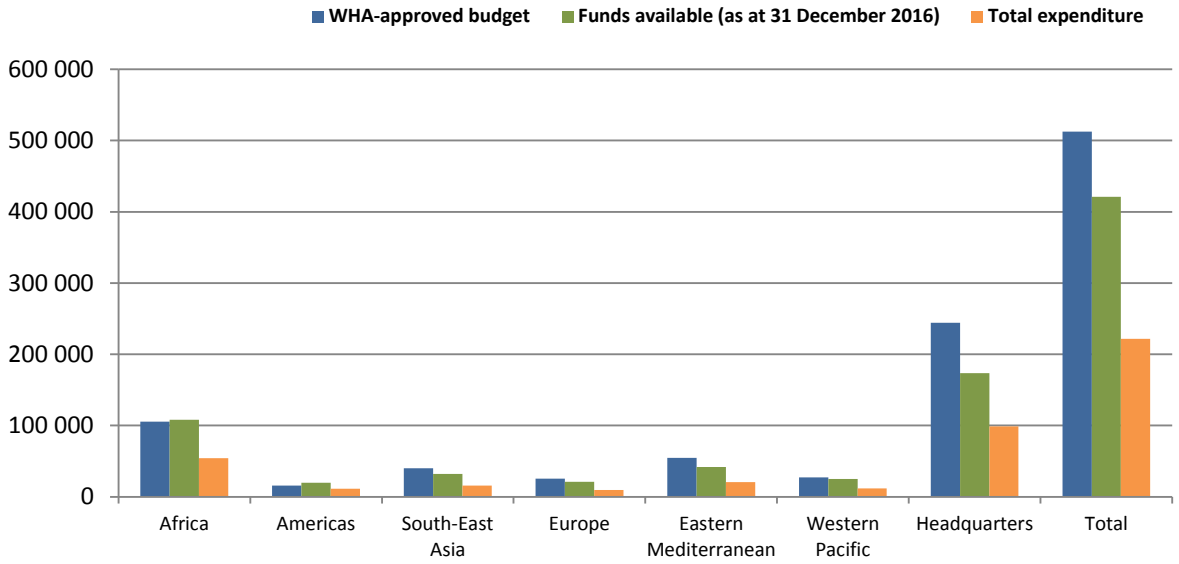


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	5 700	600	3 700	4 600	4 100	7 300	15 000	41 000
Funds available (as at 31 Dec 2016)								
Flexible funds	4 672	980	1 453	1 527	1 788	5 826	10 350	26 596
Voluntary contributions – specified	15	0	0	0	0	302	380	697
Post Occupancy Charge								0
Total	**4 687**	**980**	**1 453**	**1 527**	**1 788**	**6 128**	**10 730**	**27 293**
Funds available as a % of budget	82%	163%	39%	33%	44%	84%	72%	67%
Staff costs	1 362	340	1 056	994	942	2 446	5 483	12 623
Activity costs	323	158	183	44	26	364	863	1 961
Total expenditure	**1 685**	**498**	**1 239**	**1 038**	**968**	**2 810**	**6 346**	**14 584**
Expenditure as a % of approved budget	30%	83%	33%	23%	24%	38%	42%	36%
Expenditure as a % of funds available	36%	51%	85%	68%	54%	46%	59%	53%
Staff expenditure by major office	11%	3%	8%	8%	7%	19%	43%	100%

6.4 Management and administration

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
6.4.1. Sound financial practices managed through an adequate control framework	✓	✓	✓	✓	✓	✓	✓
6.4.2. Effective and efficient human resources management and coordination in place	✓	✓	✓	✓	✓	✓	✓
6.4.3. Efficient and effective computing infrastructure, corporate and health-related systems and applications	✓	✓	✓	✓	✓	✓	✓
6.4.4. Provision of operational and logistics support, procurement, infrastructure maintenance and asset management, and of a secure environment for WHO staff and property	✓	✓	✓	✓	✓	✓	✓

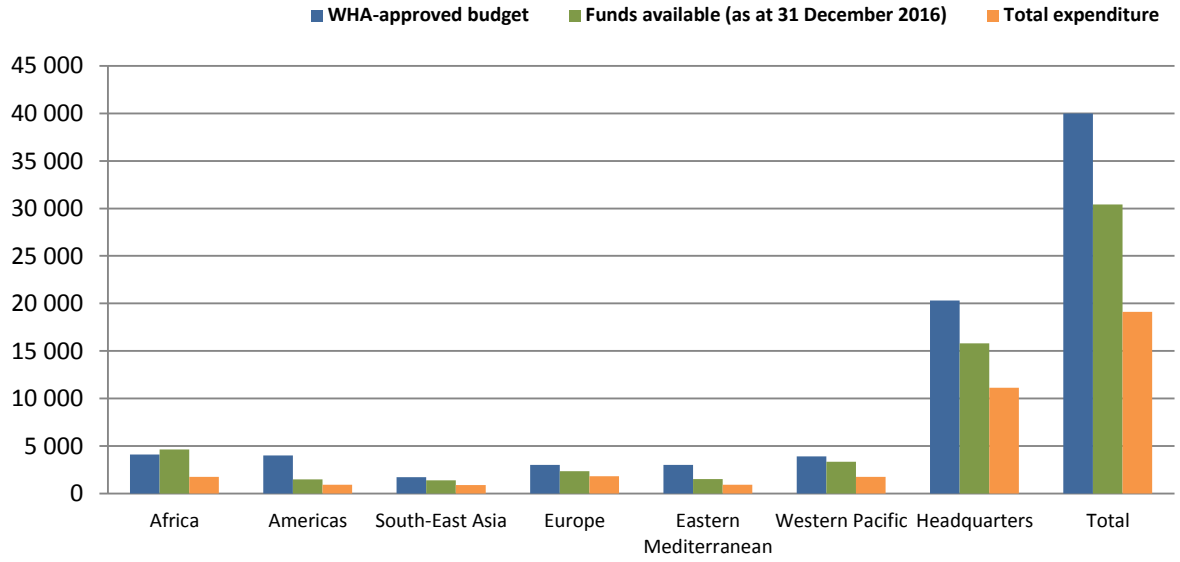


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	105 600	15 600	39 800	25 500	54 700	27 100	244 400	512 700
Funds available (as at 31 Dec 2016)								
Flexible funds	79 543	19 852	25 615	12 071	33 921	18 574	103 050	292 626
Voluntary contributions – specified	7 332	0	531	382	64	0	1 437	9 746
Post Occupancy Charge	21 300	0	5 700	8 682	7 800	6 400	68 818	118 700
Total	**108 175**	**19 852**	**31 846**	**21 135**	**41 785**	**24 974**	**173 305**	**421 072**
Funds available as a % of budget	102%	127%	80%	83%	76%	92%	71%	82%
Staff costs	34 749	7 915	8 864	6 172	13 588	6 244	63 311	140 843
Activity costs	19 464	3 321	6 787	3 412	6 937	5 335	35 696	80 952
Total expenditure	**54 213**	**11 236**	**15 651**	**9 584**	**20 525**	**11 579**	**99 007**	**221 795**
Expenditure as a % of approved budget	51%	72%	39%	38%	38%	43%	41%	43%
Expenditure as a % of funds available	50%	57%	49%	45%	49%	46%	57%	53%
Staff expenditure by major office	25%	6%	6%	4%	10%	4%	45%	100%

6.5 Strategic communications

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
6.5.1. Accurate and timely health information accessible through a platform for effective communication and related practices	✓	✓	✓	✓	✓	✓	✓
6.5.2. Organizational capacity enhanced for timely and accurate provision of internal and external communications in accordance with WHO's programmatic priorities, including during disease outbreaks, public health emergencies and humanitarian crises	✓	✓	✓	✓	✓	✓	✓

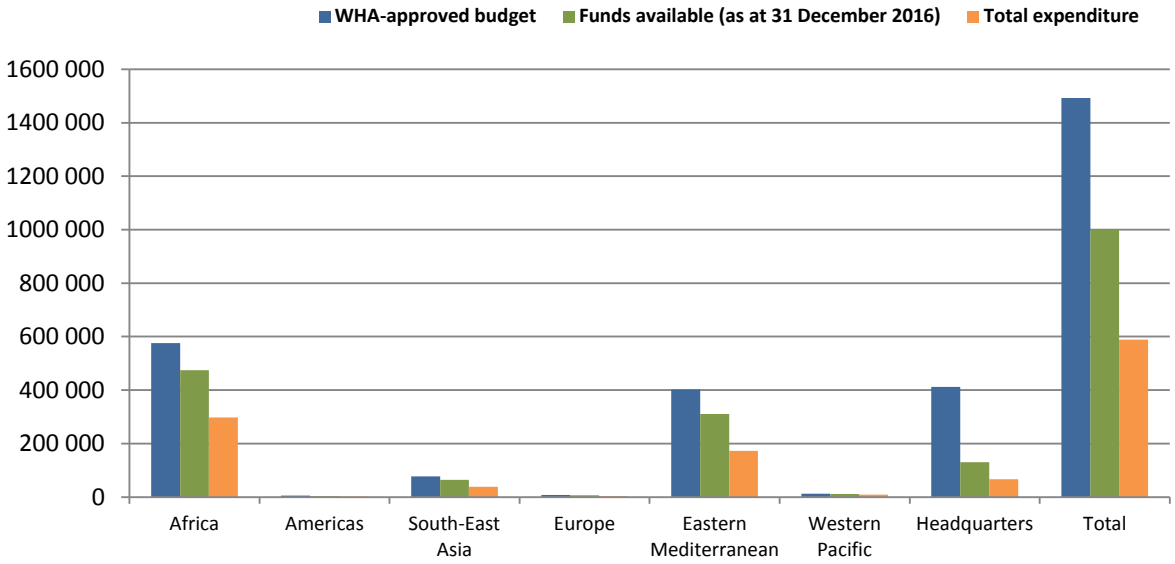


2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	4 100	4 000	1 700	3 000	3 000	3 900	20 300	40 000
Funds available (as at 31 Dec 2016)								
Flexible funds	4 060	1 490	1 363	2 325	1 495	3 156	15 800	29 689
Voluntary contributions – specified	561	0	0	0	0	177	0	738
Post Occupancy Charge								0
Total	4 621	1 490	1 363	2 325	1 495	3 333	15 800	30 427
Funds available as a % of budget	113%	37%	80%	78%	50%	85%	78%	76%
Staff costs	1 212	799	743	1 689	865	1 276	9 955	16 539
Activity costs	519	122	135	135	49	455	1 161	2 576
Total expenditure	1 731	921	878	1 824	914	1 731	11 116	19 115
Expenditure as a % of approved budget	42%	23%	52%	61%	30%	44%	55%	48%
Expenditure as a % of funds available	37%	62%	64%	78%	61%	52%	70%	63%
Staff expenditure by major office	7%	5%	4%	10%	5%	8%	60%	100%

Polio eradication

(✓) On track (!) At Risk (X) In trouble (N/A) Not applicable

Output	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
5.5.1. Technical assistance to enhance surveillance and raise population immunity to the threshold needed to stop polio transmission in affected and at-risk areas	✓	✓	✓	✓	✓	✓	✓
5.5.2. Use of oral poliovirus vaccine type 2 stopped in all routine immunization programmes globally	✓	✓	✓	✓	✓	✓	✓
5.5.3. Processes established for long-term poliovirus risk management, including containment of all residual polioviruses, and the certification of polio eradication globally	✓	✓	✓	✓	✓	✓	✓
5.5.4. Polio legacy workplan finalized and under implementation globally	✓	✓	✓	✓	✓	✓	!



2016–2017 (US$ 000)	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
WHA approved budget	575 658	5 000	77 000	7 400	402 507	12 753	412 134	1 492 452
Funds available (as at 31 Dec 2016)								
Flexible funds	424	0	65	48	0	0	0	537
Voluntary contributions – specified	473 646	2 493	63 900	6 126	310 922	11 347	129 703	998 137
Total	474 070	2 493	63 965	6 174	310 922	11 347	129 703	998 674
Funds available as a % of budget	82%	50%	83%	83%	77%	89%	31%	67%
Staff costs	60 881	82	2 583	727	16 849	857	17 449	99 428
Activity costs	236 637	1 792	35 276	2 316	156 384	8 051	48 839	489 295
Total expenditure	297 518	1 874	37 859	3 043	173 233	8 908	66 288	588 723
Expenditure as a % of approved budget	52%	37%	49%	41%	43%	70%	16%	39%
Expenditure as a % of funds available	63%	75%	59%	49%	56%	79%	51%	59%
Staff expenditure by major office	61%	0%	3%	1%	17%	1%	18%	100%

ANNEX 3

GLOSSARY OF TERMS

Accrual basis is the accounting basis under which transactions and other events are recognized when they occur (and not only when cash or its equivalent is received or paid). Therefore, transactions and events are recorded in the accounting records and recognized in the financial statements of the periods to which they relate. The elements recognized under accrual accounting are assets, liabilities, net assets/equity, revenue and expenses.

Achievement is: (a) the actual change that results from delivering a programme or implementing an intervention; and (b) the actual value of a performance indicator measured at any point of time.

Assets are resources controlled by an entity as a result of past events and from which future economic benefits or service potential are expected to flow to the entity. Assets used to deliver goods and services in accordance with an entity's objectives, but which do not directly generate net cash inflows, are often described as having a service potential.

Accounting policies are the specific principles, bases, conventions, rules and practices applied by an entity in preparing and presenting financial statements.

Actuarial gains and losses comprise: (a) experience adjustments (the effects of differences between the previous actuarial assumptions and what has actually occurred); and (b) the effects of changes in actuarial assumptions.

Amortization is the systematic allocation of the amortizable amount of an intangible asset over its estimated useful life.

Appropriation is an authorization granted by a legislative body to allocate funds for purposes specified by the legislature or similar authority. For WHO, appropriations are voted by the World Health Assembly.

Cash equivalents are short-term, highly-liquid investments that are readily convertible to known amounts of cash and that are subject to an insignificant risk of changes in value.

Class of property, plant and equipment is a grouping of assets of a similar nature or function in an entity's operations that is shown as a single item for the purpose of disclosure in the financial statements.

Contingent asset is a possible asset that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the entity.

Contingent liability is: (a) a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the entity; or (b) a present obligation that arises from past events but which is not recognized because it is not probable that an outflow of resources embodying economic benefits or service potential will be required to settle the obligation or because the amount of the obligation cannot be measured with sufficient reliability.

Depreciation is the systematic allocation of the depreciable amount of a tangible asset over its estimated useful life.

Employee benefits are all forms of consideration given by an entity in exchange for service rendered by employees. Employee benefits mean all entitlements, salaries, allowances, benefits and incentives.

Exchange transactions are transactions in which one entity receives assets or services, or has liabilities extinguished, and directly gives approximately equal value (primarily in the form of cash, goods, services, or use of assets) to another entity in exchange.

Fair value is the amount for which an asset could be exchanged, or a liability settled, between knowledgeable, willing parties in an arm's length transaction.

Functional currency is the currency of the primary economic environment in which the entity operates. For WHO this is considered to be the United States dollar.

Funds available comprise the amount carried over from the prior biennium and the revenue received within the current biennium.

Impact is a sustainable change in the health of populations to which the Secretariat and Member States contribute.

Impairment is a loss in the future economic benefits or service potential of an asset, over and above the systematic recognition of the loss of the asset's future economic benefits or service potential through depreciation.

Intangible assets are identifiable non-monetary assets without physical substance.

Interest cost is the increase during a financial period in the present value of a defined benefit obligation which arises because the benefits are one period closer to settlement.

Inventories are assets: (a) in the form of materials or supplies to be consumed in the production process; (b) in the form of materials or supplies to be consumed or distributed in the rendering of services; (c) held for sale or distribution in the ordinary course of operations; or (d) in the process of production for sale or distribution. Care should be taken to avoid confusion when using the word "inventory". Property, plant and equipment are not inventory as defined above, although they may be inventoried by being counted and physically verified.

Key management personnel are defined under International Public Sector Accounting Standards as those officials who are responsible for the planning, directing and controlling activities of the reporting entity.

Lease is an agreement whereby the lessor conveys to the lessee in return for a payment or series of payments the right to use an asset for an agreed period of time.

Liabilities are present obligations of an entity arising from past events, the settlement of which is expected to result in an outflow from the entity of resources embodying economic benefits or service potential.

Net assets/equity is the residual interest in the assets of an entity after deduction of all its liabilities. This is the residual measure in the statement of financial position.

Net realizable value is the estimated selling price in the ordinary course of operations less the estimated costs of completion and the estimated costs necessary to make the sale, exchange or distribution.

Non-exchange transactions are transactions that are not exchange transactions. In a non-exchange transaction, an entity either receives value from another entity without directly giving approximately equal value in exchange, or gives value to another entity without directly receiving approximately equal value in exchange.

Operating lease is a lease other than a finance lease.

Outcomes represent changes in the institutional and behavioural capacities for development conditions that occur between the completion of outputs and the achievement of impacts.

Outputs are changes in skills or abilities and capacities of individuals or institutions, or the availability of new products and services, that result from the completion of activities within the control of the Secretariat. They are achieved with the resources provided and within the time period specified.

Performance indicator: a unit of measurement that specifies what is to be measured along a scale or dimension. Performance indicators are a qualitative or quantitative means of measuring an output or outcome, with the intention of gauging the performance of a programme or investment.

Property, plant and equipment are tangible items that are: (a) held for use in the production or supply of goods or services, for rental to others or for administrative purposes; and (b) expected to be used during more

than one reporting period. Property, plant and equipment should not be confused with inventories as defined above, although they may be counted and physically verified.

Provision is a liability of uncertain timing or amount.

Related parties are parties considered to be related if one party has the ability to control, or exercise significant influence over, the other party in making financial and operating decisions, or if the related party entity and another entity are subject to common control.

Revenue is the gross inflow of economic benefits or service potential during the reporting period when those inflows result in an increase in net assets/equity other than increases relating to contributions from owners.

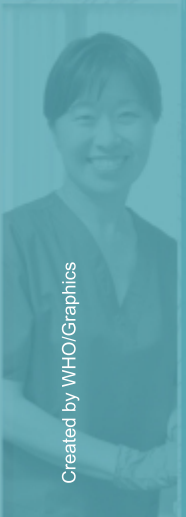
Risk corresponds to a potential future event, fully or partially beyond control, that may negatively affect the achievement of results.

Segment is a distinguishable activity or group of activities of an entity for which it is appropriate to separately report financial information for the purpose of evaluating the entity's past performance in achieving its objectives and for making decisions on the future allocation of resources.

= = =






Created by WHO/Graphics