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MEDIUM-TERM STRATEGIC PLAN 2008–2013

AMENDED (DRAFT)

This document represents the draft of an amended version of the Medium-term strategic plan 2008–2013 for discussion at regional committee meetings to be held during the period September–October 2008. It includes revisions of or additions to the explanatory text for several strategic objectives, as well as the refinement, replacement or deletion of indicators.

In the resources tables, "Budget 2008–2009" refers to the budget approved by the Health Assembly in resolution WHA60.12; "Proposed budget 2010–2011" refers to the Proposed programme budget 2010–2011; and "Estimates 2012–2013" refers to initial estimate presented to the Sixtieth World Health Assembly in the Draft Medium-term strategic plan 2008–2013.

Throughout the document, underlining indicates that the text has been changed.

Geneva, June 2008

MEDIUM-TERM STRATEGIC PLAN 2008–2013

AMENDED (DRAFT)

CONTENTS

INTRODUCTION

Challenges, gaps and future needs

1. The Eleventh General Programme of Work 2006–2015 analyses current health challenges. Health is increasingly seen as a key aspect of human security and occupies a prominent place in debates on priorities for development.

2. Over the past 20 years, there have been major gains in life expectancy overall, but there are widening gaps in health status; some countries have witnessed reversals of earlier gains, because of such factors as infectious diseases, in particular HIV/AIDS, collapsing health services, and deteriorating social and economic conditions. Prospects for achieving the health-related Millennium Development Goals are not encouraging.

3. The analysis in the General Programme of Work reveals several areas of unrealized potential for improving health, particularly the health of the poor. The missing elements can be summarized as:

- **gaps in social justice**: efforts have been insufficient to ensure equity, health-related human rights and gender equality in health policy and action

- **gaps in responsibility**: the increasing number of sectors, actors and partners involved in health work has led to gaps in accountability and lack of synergy in the coordination of actions to improve health

- **gaps in implementation**: many populations still do not have adequate access to essential public-health interventions; international assistance is often insufficiently aligned to national priorities and systems or harmonized across organizations

- **gaps in knowledge**: knowledge of ways to tackle some of the major health challenges is still weak; research is not always focused on areas of greatest need, and health policy is not always based on best available evidence.

4. Future progress requires strong political will, integrated policies and broad participation. Any significant progress towards achieving the health-related Millennium Development Goals will require action in many sectors and at all levels – individual, community, national, regional and global. The past 10 years have seen a dramatic increase in the number of international partnerships in health. Global health partnerships offer the potential to combine the different strengths of public and private organizations, along with civil society, in tackling health problems. Demands on the United Nations system as a whole are increasing, as are demands for it to reform and show more clearly where it can add value. Academic, industrial, government and nongovernmental research continues to shape the generation of knowledge and its use.

5. In September 2000, the United Nations Millennium Declaration committed countries to a global partnership to reduce poverty and improve health and education, along with promoting peace, human rights, gender equality and environmental sustainability. The seven-point **global health agenda** contained in the Eleventh General Programme of Work reflects this and other agreements adopted by world leaders, and requires action from many different players across the international community, across society and across government, in the following areas: investing in health to reduce poverty; building individual and global health security; promoting universal coverage, gender equality and health-related human rights; tackling the determinants of health; strengthening health systems and equitable access; harnessing knowledge, science and technology; strengthening governance, leadership and accountability.

6. In effectively addressing these challenges and gaps and in meeting future needs, WHO will continue to build upon the insights and lessons learnt over previous bienniums. Drawing upon

information derived from the Organization's formal monitoring and evaluation mechanisms, and input received from the Governing bodies, individual Member States, and other partners, key lessons have been identified which have helped to shape the content of the Medium-term strategic plan.

Lessons learnt

7. WHO is in a unique position to shape the global public-health agenda through consensus building and binding agreements. Examples of the latter include WHO's Framework Convention on Tobacco Control and the International Health Regulations (2005). These experiences have enabled the Organization to identify which health issues require a formal negotiated agreement, and which are best approached through consensus building.

8. WHO participates in more than 80 global health partnerships and in numerous global, regional and national health networks. These partnerships and networks contribute to the achievement of WHO's objectives, and benefit from the Organization's convening power and technical expertise. WHO continues to learn optimal ways of participating in these partnerships, while maintaining its identity and mandate.

9. In response to increasing demands and current reform of the United Nations system, the Organization will strive to build more effective alliances within both the system and the broader development community. It will work to harmonize the health environment at country level and will engage in the reform process aimed at creating an effective country team under a common United Nations lead.

10. Over the past 60 years WHO has played a prominent role in launching, coordinating, and implementing public-health programmes and initiatives. Some examples are eradication of smallpox, the Expanded Programme on Immunization, the Action Programme on Essential Drugs, the Stop TB Partnership, and efforts to eradicate poliomyelitis, to eliminate leprosy, and to control SARS and avian influenza. WHO has been able to adapt or transform itself in order to meet the needs of specific public-health programmes. For Member States, however, these and other challenges are placing increasing demands on health systems in critical areas related to health workforce, financing, and information. In this regard, work in recent years has revealed the pressing need for greater international consensus about the way health systems should function and how their core functions can be strengthened.

11. Many important determinants of health fall outside of the direct sphere of influence of the health sector. Although WHO continues to draw from experience and develop capacity to work with sectors other than health in order to enhance their understanding of what can realistically be done to improve national health, it is evident that more needs to be done to monitor global trends that are of significance to health in such areas as trade and agriculture. WHO will work with ministries of health and other sectors to craft appropriate responses.

12. Experience over the last bienniums has shown that clarity and consistency is required on the concept of health equity, which needs to be built into all relevant aspects of WHO's work. WHO will lead by example, integrating gender in the mainstream of its activities, building it into its technical guidance and normative work, and using sex-disaggregated data in the planning and monitoring of its programmes.

13. WHO will need to be more systematic in its contacts with civil society and industry, including the international health-care and pharmaceutical industries. As scientific advances continue, WHO will be more proactive in leading a dialogue on setting priorities and ethical standards for research. The past years have seen many new initiatives in the area of management and administration. The challenge now lies in the need to consolidate and institutionalize changes already introduced, and to complete reforms without compromising operational capability or staff confidence.

14. Although WHO has been fairly successful in mobilizing resources, a key challenge has been to ensure alignment between the activities planned and the resources mobilized, as voluntary contributions are often earmarked for specific programmes and projects. Internal mechanisms, such as the advisory group on financial resources to channel resources to where they are most needed, require strengthening.

15. In an organization using nearly half its resources on personnel, efficient management of human resources is a key challenge. Personnel policy and practice in the past have not, for example, facilitated the mobility of staff to ensure that the right skills and competencies are always in the right place. The individual performance management system is not being used effectively and needs to be strengthened. The initial work around WHO's global leadership programme needs to be consolidated.

16. Recent bienniums have seen a shift in the pattern of expenditure across the three levels of the Organization, with more resources being put to work in countries and regions. This trend needs to be supported by increased managerial skills and capacities in countries and regions and by more robust accountability.

17. Experience with results-based management over the past 10 years has significantly influenced the Medium-term strategic plan, and some key lessons learnt are reflected in definition of its priorities, strategic objectives and expected results.

18. First, it has become clear that a two-year time frame is inadequate to reflect the work of the Organization in many aspects of health. Successful activities require a significantly longer period to achieve the results expected. A medium-term plan provides an opportunity to adopt a more strategic and realistic approach to planning and the achievement of health outcomes.

19. Second, the plan is structured so as to create synergies between the different programmes and levels of WHO. The former planning structure of areas of work reinforced the tendency to compartmentalization, as organizational structures reflected those areas. Although such a division of labour facilitated resource allocation, it limited opportunities for collaboration across the Secretariat. The move to a smaller number of strategic objectives will significantly facilitate such collaboration. The strategic objectives are not mutually exclusive; they encourage differing but complementary perspectives for tackling common priorities.

20. Third, achievement of desired health outcomes is rarely attributable to a single intervention, or work by any one organization; the plan highlights work conducted within many collaborative arrangements. WHO will need to provide forums for engaging in dialogue with the increasing number and type of entities involved in health and development, including systematic contact with civil society and industry, including the international health-care and pharmaceutical industries.

21. Lastly, new business processes are required to support new ways of working. Greater dependence on voluntary contributions, increased internal collaboration across organizational structures, decentralization of resources, larger role played in operational aspects of health emergencies and disease outbreaks, and the growth of health-related legal frameworks, all require modern and flexible management systems. Introduction of the Global Management System and related enterprise resource planning, along with the service delivery model will back up these innovations.

Strategic direction for 2008–2013

22. During the six years 2008–2013, WHO will continue to provide leadership in matters of public health, optimizing its impartiality and near universal membership. Guidance from governments through the Executive Board, the Health Assembly and the regional committees ensures legitimacy for the work of the Organization; in turn, the Secretariat's reporting to the governing bodies ensures its accountability for implementation. WHO's convening power enables diverse groups to stimulate collective action worldwide.

23. WHO's role in tackling diseases is unparalleled, whether it acts by marshalling the necessary scientific evidence, promoting global strategies for eradication, elimination or prevention, or by identifying and helping to control outbreaks.

24. WHO will promote evidence-based debate, analysis and framing of policy development for health through the work of the Secretariat, expert and advisory groups, collaborating centres, and the numerous formal and informal networks in which it participates.

25. The structure of WHO's Secretariat assures involvement with countries. Headquarters focuses on issues of global concern and technical backstopping for regions and countries. Regional offices focus on technical support and building of national capacities. WHO's presence in countries allows it to have a close relationship with ministries of health and with its partners inside and outside government. The Organization collaborates closely with bodies of the United Nations system and provides channels for emergency support.

26. Through its decentralized structure and close working relations with governments, the Secretariat is able to gather health information and monitor trends over time, across countries, regions, and worldwide.

27. WHO is operating in an increasingly complex and rapidly changing landscape. The boundaries of public health action have become less clear, extending into other sectors that influence health opportunities and outcomes. The importance of economic, social, and environmental determinants of health has grown. Demographic and epidemiological transitions now combine with nutritional and behavioural transitions, influenced by globalization and urbanization, to create unfavourable new trends.

A six-item agenda: health development and security, systems and evidence, partnerships and performance

28. In its role as the directing and coordinating authority on international health work, WHO is expected to address, directly or indirectly, the problems outlined above. The complex task of improving world health, for which the strategic objectives provide a structure, can be envisaged as a six-item agenda. Two items address fundamental needs: for health development and health security. Two items are strategic: strengthening health systems and gathering and analysing the evidence needed to set priorities and measure progress. Two items are operational: managing partnerships to achieve the best results in countries, and ensuring that WHO performs well.

29. The clear links between health and development have brought welcome attention, resources, and impetus to international health work. Nevertheless, the multiple activities under way are an added burden in a number of recipient countries. A central role of WHO is to align these activities in ways that avoid duplication, consistently adhere to best technical practices, and have a measurable impact on health outcomes. Such activities need to be firmly rooted in the capacities of recipient countries and driven by their priorities.

30. At the policy level, health development is directed by the ethical principle of equity: access to life-saving or health-promoting interventions should not be denied for unfair reasons, including those with an economic or social basis. Commitment to this principle ensures that WHO activities aimed at developing health give priority to health outcomes in poor, disadvantaged, or vulnerable groups. This guiding principle applies to, among others, two large populations: women and the African people. The health problems in both groups are multiple, and are addressed by many programmes and partnerships. Changes in the health status of these two groups are an important indicator of the overall performance of WHO. WHO will keep health improvements in these two populations at the forefront of international health policy.

31. The pressing need to address the global burden of communicable diseases is reflected in the formulation of several WHO strategies for expanding interventions to reduce the burden of HIV, tuberculosis, malaria and vaccine-preventable diseases, and to make rapid progress in eradicating, eliminating or controlling diseases such as poliomyelitis, leprosy, dracunculiasis, onchocerciasis, schistosomiasis, and lymphatic filariasis.

32. Several high-level strategies reviewed by Member States will guide the work of the Organization in improving sexual and reproductive health and child health, increasing immunization coverage, and tackling noncommunicable diseases, such as cancer and cardiovascular diseases. Interventions related to the health of mothers and children will be linked through a continuum of care throughout the life-cycle.

33. Population-based, environmental and behavioural approaches will be adopted to reduce such risks to health as obesity, high blood-pressure, harmful use of alcohol, and unsafe sex. Measures consistent with the Framework Convention on Tobacco Control will back up work to reduce tobacco consumption. WHO will also consolidate and expand its work on health promotion, nutrition, food safety, food security, and prevention of injury and violence.

34. Global health security is threatened by emerging and epidemic-prone diseases, which have become a greater menace under conditions prevailing in the current century. Vulnerability to these diseases and their consequences is universal. Application of the revised International Health Regulations (2005) implies a pre-emptive approach to outbreak alert and response, whereby action at the outbreak source can prevent a local event from becoming an international emergency. To ensure collective security under the Regulations, many countries will need support in strengthening core capacities for outbreak detection and response.

35. WHO has established infrastructures and mechanisms for disease-outbreak alert and response, and for addressing other public health emergencies when they arise. Clear responsibilities and time frames for action for WHO, both Member States and Secretariat, are set out in the Regulations. New in the Regulations are provisions for detecting and responding to threats from emerging diseases and the central importance given to surveillance. For example, once poliomyelitis is eradicated, the infrastructure established to ensure surveillance and programme delivery will adapt to the growing needs for outbreak alert and response, and disease surveillance.

36. Abrupt shocks to health can arise from conflicts and natural disasters, especially when routine services are disrupted or infrastructures are damaged. In such situations, WHO is increasingly called upon to ensure continuity of essential care and to prevent outbreaks of epidemic-prone diseases. To meet broader population needs, reforms within the United Nations system aimed at better coordination are continuing to improve the speed and efficiency of responses.

37. WHO has well-tested mechanisms for mitigating the health consequences of emergencies arising from conflicts and natural disasters. In this regard, as the lead agency for the United Nations health cluster, it will continue to work in the context of reform of humanitarian action in the United Nations system, and to strengthen its partnerships with other organizations of the system, national institutions, and nongovernmental organizations.

38. WHO has, for several years, underlined that the health risks posed by climate change are significant; that they are distributed across the globe and difficult to reverse; and that recent changes in the climate have had a significant and diverse impact on health. It is therefore essential to formulate clear responses that support the protection of human health and ensure that the risk to health is placed at the centre of the debate on climate change. WHO's response will focus on the following actions: assessing the implications of climate change for health and health systems; identifying appropriate and comprehensive strategies and measures for tackling these implications; providing support for appropriate health-sector capacity building; and fostering collaboration with government and nongovernmental partners in order to raise awareness of the health impacts of climate change.

39. Health systems are being required to perform better at a time when the demands on them are increasing. National systems in a number of countries face fundamental weaknesses. Shortcomings exist in infrastructure, financing, human resources, supplies of high-quality essential commodities, and equitable access to services. Numerous health initiatives are geared to delivering outcomes, often for a single disease; such delivery needs a functioning health system. WHO's work on strengthening health systems will be based on the principle of primary health care and will promote ways to integrate service delivery: better and more equitable health outcomes depend on better service delivery.

40. The primary health care approach provides a reliable and sustainable way to address the pressing health needs of impoverished, disadvantaged, and vulnerable groups. Maternal and child health services have long served as the backbone of primary health care and a platform for other health programmes. Primary health care services are also well placed to deliver sexual and reproductive health services, and address the need for adequate nutrition, especially for children and elderly people.

41. Universal coverage with effective public-health interventions depends on well-functioning health systems. *The world health report 2006*[1] highlights the crisis in the global health workforce and identifies steps that countries and partners need to take if health commitments and targets such as those in the Millennium Development Goals are to be met. WHO also will enhance its capacity to provide support to Member States for putting in place strategies to improve other key components of health systems related to financing, information, research and essential medicines and technologies. These strategies will be fully integrated and coordinated with health systems, and will build on opportunities and resources included in priority programmes such as HIV/AIDS and immunization, and maternal health.

42. Evidence underpins the setting of priorities and the measurement of results, and is thus essential for formulating health strategies at both national and global levels. Populations need access to reliable information on health risks and how to avoid them. Evidence also contributes to the protection of public health on a daily basis, and WHO has well-established mechanisms for determining international norms and standards based on the best science. Building on this work WHO will aim to close the gap between knowing what to do and doing it.

43. The management of partnerships has become a high priority for WHO. Although WHO cannot be the principal implementing agency within countries, it is expected to set the global health agenda and to establish best technical practices. Delivery of packages of services in an integrated way contributes to amplifying the health impact of partnerships.

44. The complexity of the public-health landscape requires WHO to operate flexibly, to optimize its capacity for direct contact with ministries of health, and to adapt to changing needs and priorities. The health agenda is set at global level, with headquarters providing best technical practices as guidance for health ministries and international partners. Regional offices focus on specific needs for technical support at regional level, and on the building of national capacities. WHO country offices coordinate work with health ministries and with implementing agencies working at country level.

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[1] *The world health report 2006. Working together for health.* Geneva, World Health Organization, 2006.

45. The number of stakeholders working in health at both national and international levels has increased. WHO has responded flexibly and rapidly to this evolution. It has helped to ensure that national policy-makers are fully involved in international forums that discuss health-related issues, and that the numerous actors in public health outside government and intergovernmental bodies have forums enabling them to contribute to global and national debates on health-related policy. WHO will continue to use its convening power to stimulate action across different sectors, while building the capacity of governments to play this role nationally. It will take the lead in promoting effective partnerships for health, shaping the global health environment, and operationalizing reform of the United Nations system at global, regional and country levels.

46. To meet the challenges it faces, WHO will continue to evolve as a learning organization and to strengthen its managerial capacity. More integrated, strategic and equitable approaches to financing the programme budget and managing financial resources throughout the Organization will be instituted. More cost-effective ways to provide administrative, information and managerial systems and services will continuously be sought, optimizing the locations from which such services are delivered. The Organization will assure strong accountability mechanisms while supporting collaboration and coordination across its different levels.

47. The **core functions** of WHO will guide the work of the Secretariat, influence approaches for achieving the strategic objectives, and provide a framework for assuring consistency and output at global, regional and country levels. The core functions are:

- providing **leadership** on matters critical to health and engaging in partnerships where joint action is needed
- shaping the **research** agenda, and stimulating the generation, dissemination and application of valuable knowledge
- setting **norms and standards**, and promoting and monitoring their implementation
- articulating ethical and evidence-based **policy options**
- providing **technical support**, catalysing change and building sustainable institutional capacity
- **monitoring** the health situation and assessing health trends.

48. Expected achievements over the period of the Medium-term strategic plan reflecting the Director-General’s agenda for action, notably health development and security, systems and evidence, partnerships and performance, are described in **13 strategic objectives** set out below. They provide clear, measurable and budgeted expected results for the Organization. They also promote collaboration across disease-specific programmes by capturing the multiple links among the determinants of health and health outcomes, policies, systems and technologies.

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

2. To combat HIV/AIDS, tuberculosis and malaria

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

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

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

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

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

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

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

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

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

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

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

49. The individual strategic objectives should not be viewed in isolation from one another as they reflect WHO's different but interdependent actions for realizing the "agenda for action". For example, those that relate to the specific disease interventions are supported by work undertaken to provide evidence and information and to strengthen the capacity of the health system for effective programme delivery. By tackling the social and economic determinants, the underlying conditions and behaviour that impact on health conditions are addressed.

50. The Medium-term strategic plan – an integral element in WHO's framework for results-based management – translates the Eleventh General Programme of Work's long-term vision for health into strategic objectives, reflects country priorities (particularly those expressed in country cooperation strategies) and provides the basis for the Organization's detailed operational planning.

WHO's framework for results-based management

51. The Eleventh General Programme of Work provides a long-term perspective on the determinants of health and the measures required for improving health while setting forth a global health agenda.[1]

52. The Medium-term strategic plan 2008–2013 stems from the General Programme of Work. It provides the strategic direction for the Organization for the six-year period, advancing the global health agenda through a multi-biennial framework. It guides preparation of three biennial programme budgets and operational plans through each biennium.

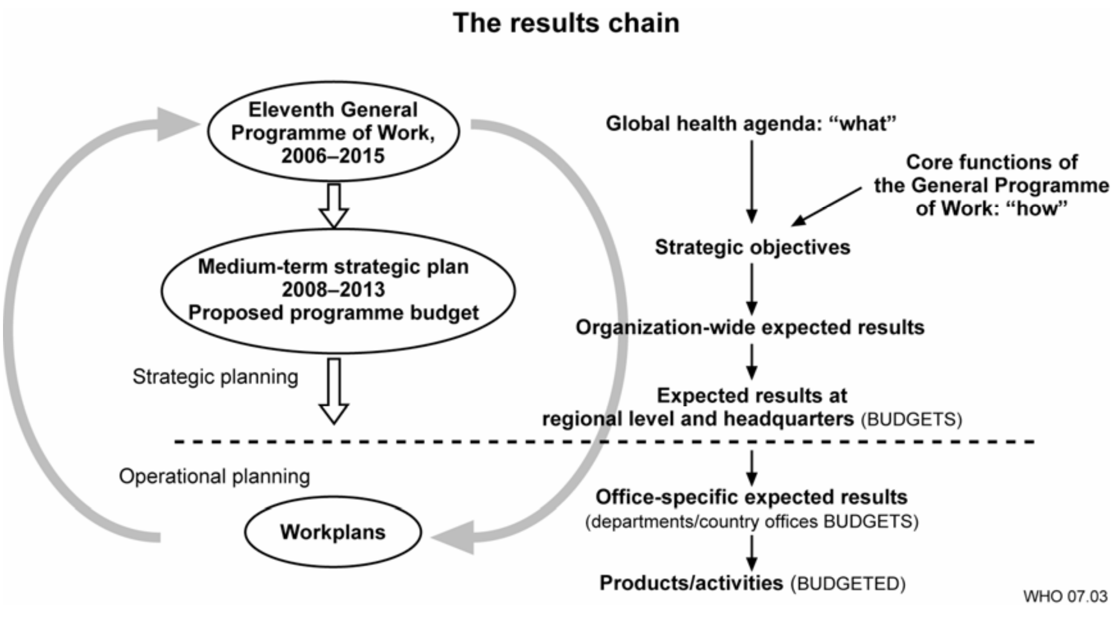
[1] Document A59/25.

53. The 13 strategic objectives set out above take into account the complementarities between strategic objectives. For example, they recognize that for health interventions effectively to achieve better health outcomes and reduce the burden of disease, it is as essential to strengthen health systems as it is to develop norms and standards for specific diseases and work with other sectors in tackling determinants of health.

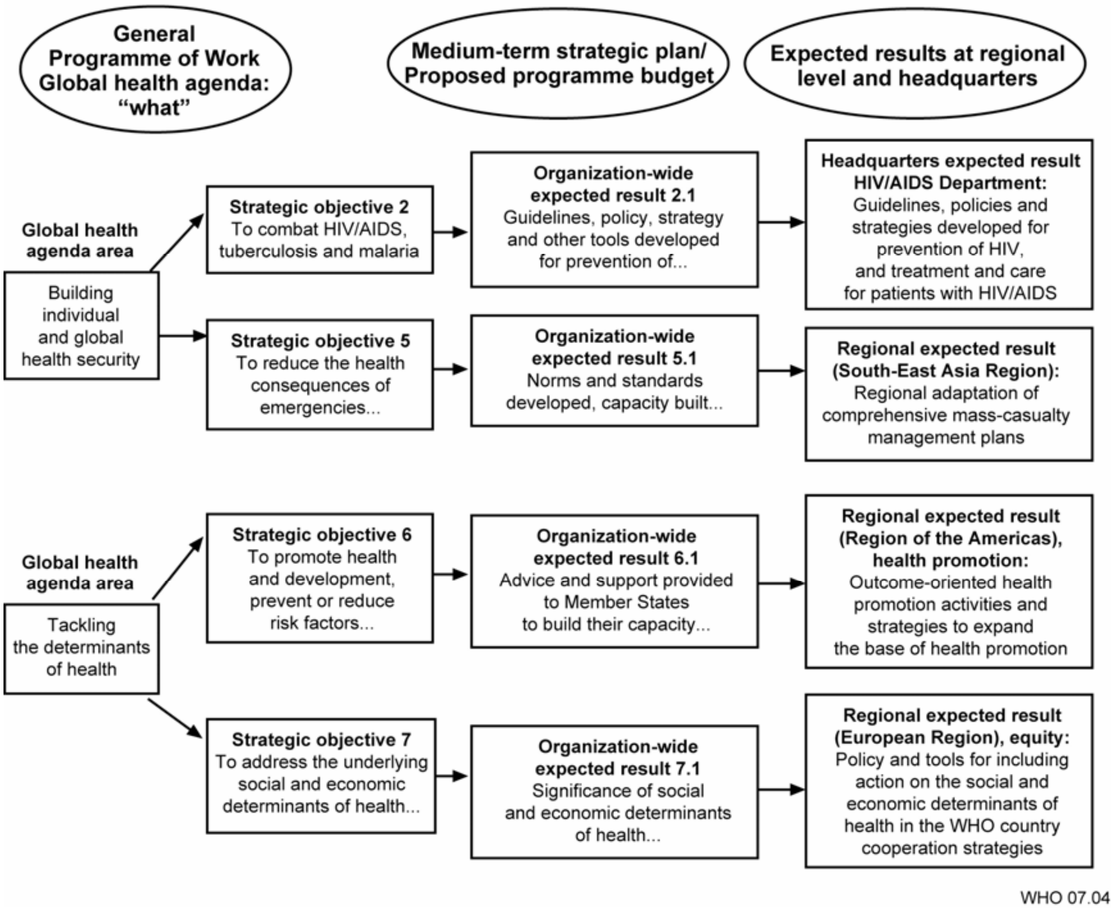
54. As confirmed by the analysis of 132 country cooperation strategies, these broad strategic objectives and related expected results provide a flexible programme structure that better reflects the needs of countries and regions. Collaboration throughout the Organization is facilitated by means of Organization-wide teams built around strategic objectives.

55. On the basis of an analysis of the issues and challenges, taking into account the lessons learnt over the past bienniums, examining risks and considering various options, the plan identifies for each strategic objective a series of Organization-wide expected results for which the Secretariat will be accountable over the three bienniums. It provides indicators, targets and resources required for their achievement. Recognizing that flexibility and responsiveness are essential in order to respond effectively to the rapid changes foreseen in health needs and opportunities, WHO will continue to monitor trends and to modify expected results accordingly.

Figure 1. WHO's framework for results-based management



The results chain: example



56. The Medium-term strategic plan requires technically sound approaches and an enabling environment to support efficient and effective implementation. The enabling environment includes responsive, flexible and efficient internal management of the Organization, and the ability to work strategically with a wide range of partners. Robust accountability mechanisms ensure integrity of the assessment of the Organization's performance and management of its resources.

57. The programme budgets make the Medium-term strategic plan operational, identifying the scope of activities and specifying achievements expected. For each Organization-wide expected result, they set the targets for individual bienniums, and indicate the resources required for their achievement.

58. The programme budgets are the basis for operational planning. During the operational planning phase, country and regional offices and headquarters identify their contribution towards achieving the Organization-wide expected results. These operational plans, also referred to as workplans, establish the specific products and services that the Secretariat will provide in order to meet its commitments set out in the strategic plan and biennial budgets. In these workplans, time frames and responsibility and accountability for delivering products and services are identified for each organizational entity and level, thus linking strategic objectives and Organization-wide expected results with the organizational structure.

59. Comprehensive reform is under way to improve management of the Organization, the main thrust of which is set out in strategic objective 13. It is captured also in an Organization-wide guide, which is continuously under review to ensure that it effectively addresses the changing needs of the Organization. Managerial reform also is a standing item on the agenda of the Programme, Budget and Administration Committee of the Executive Board. The scope of these reforms spans the results-based management framework, management of financial resources, provision of effective operational support, and assurance of robust accountability.

60. With the aim of measuring organizational effectiveness, a set of key operational performance indicators are currently under development. These indicators will be used across the Organization to analyse progress in areas such as programme performance, human resource management, financial management, and the promotion of multilingualism. The status of indicators will be regularly reviewed at a high level. Their development and utilization for decision-making and managerial reform are expected to progress steadily over the period of the Medium-term strategic plan.

61. The Organization faces the challenge of working efficiently across different, but related, programme areas, and across its three levels. Organizational processes such as joint planning and peer reviews can facilitate this work, together with collaborative methods that promote interdependence, such as greater staff mobility and rotation across the Organization.

62. As a decentralized organization, efficient and effective programme management requires balancing the need to assure an Organization-wide approach and responsibility, and to recognize regional specificities. Transparent governance mechanisms and common systems and approaches across the Organization will be increasingly adopted, linked to further devolution of decision-making and greater accountability. This trend will be facilitated by moving from managing through tight bureaucratic controls to greater reliance on performance monitoring.

63. Managers will play a crucial role, as they drive change within the Organization. Managers must foster integration and team work, ensure the effective use of resources, build and promote partnerships across the Organization, and provide a model of ethical behaviour. They also manage performance of both programmes and individual staff. WHO's Global Leadership Programme aims to provide support for these aspects of their work.

64. Accountability is a critical element supporting the results-based management approach. WHO has adopted an accountability framework that brings together aspects of responsibility, accountability and authority, based on overarching principles that ensure good governance. These include having well-understood organizational values, behaviours and aims, managing risk competently, and reporting transparently to all stakeholders.

65. Mechanisms to ensure accountability and integrity in the work of the Organization include programme monitoring and assessment; programme-related evaluations; internal audits; an independent external auditor who reports directly to the Health Assembly; staff and financial regulations and rules; ombudsman functions; mechanisms to ensure internal justice, annual reporting on financial and human resources to governing bodies; and a performance evaluation system for staff. Increased attention is being paid to these important functions, both internally and by key stakeholders.

Effective financing of the Medium-term strategic plan

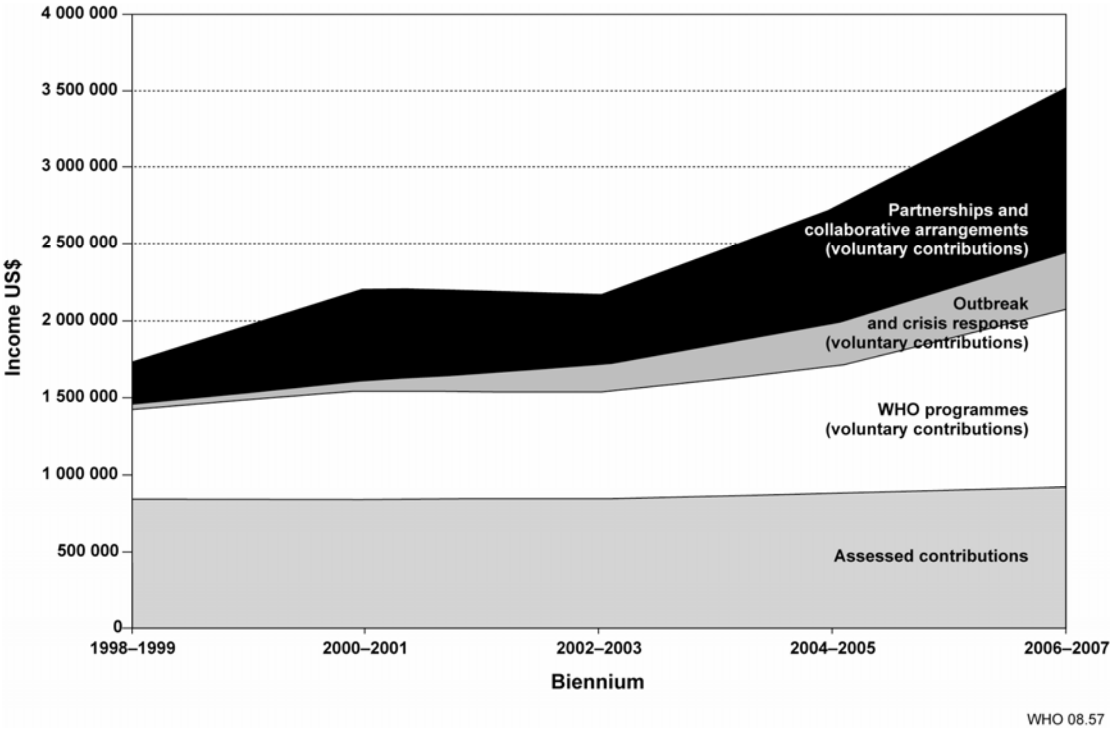
66. WHO has adopted a results-based management approach to determining resource requirements, with an integrated budget comprising all sources of funding. The costs of achieving the results concerned in a given time frame are therefore financed with funds from different sources.

67. WHO receives its funding principally through assessed contributions from Member States and voluntary contributions. Assessed contributions are gradually becoming a smaller proportion of the total resources received, and there is an increasing reliance upon voluntary contributions provided by a limited number of partners and donors, both large and small.

68. Voluntary contributions to the Organization have risen significantly and now constitute the major source of funding for WHO. This increase is accounted for by a greater awareness, especially within the donor community, of the relationship between development and public health. Further, increasingly frequent "public health crises" attract considerable partner and donor funding. Such crises include outbreaks of communicable diseases (e.g. severe acute respiratory syndrome and avian influenza) together with natural or man-made disasters (e.g. earthquakes, hurricanes, tsunamis and

wars). Just as the size and characteristics of the demand for international public health assistance have evolved, so has the composition of the donor community financing international public health. Now, in addition to Member States, national overseas development assistance programmes are playing a more important role, and contributions from other multilateral organizations, development banks, and private foundations and charities are increasing.

Figure 2: Trend in the composition of WHO income



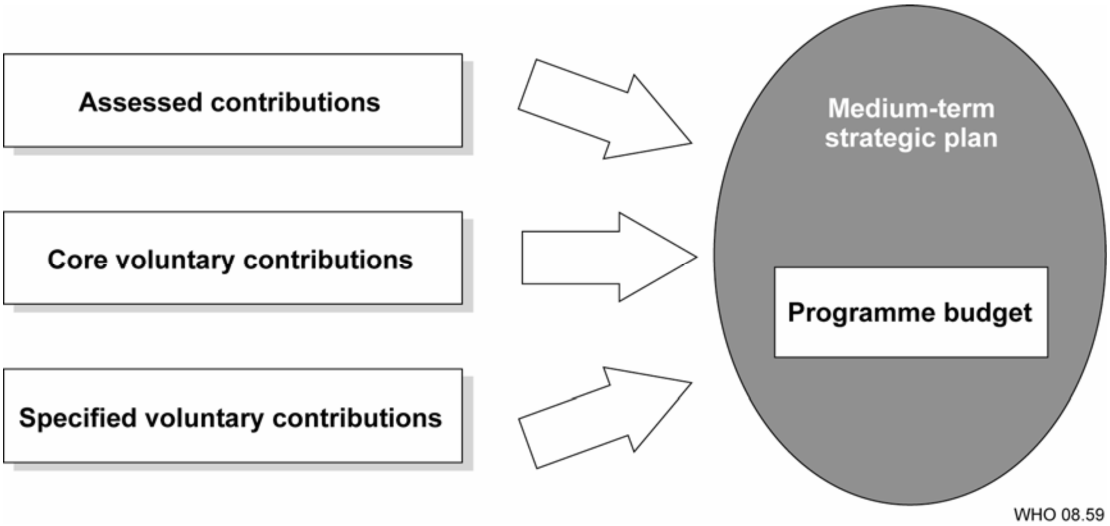
69. This evolving situation has also led to the international health and development community increasingly working through partnerships and other collaborative arrangements in which WHO often plays a key role. Several of these partnerships are hosted by WHO and included in the programme budget. However, their budgets and financing are by nature decided in collaboration with and, not solely by WHO. The income for outbreak and crisis response and for partnerships and collaborative arrangements has grown at a greater pace than the corresponding income for WHO programmes. In the biennium 2006-2007 the income for outbreak and crisis response and for partnerships and collaborative arrangements constituted more than one third of total income (see Figure 2).

70. As the different segments of income have different dynamics and different requirements for budget and resource management, allocations and spending in respect of the budget will be monitored, analysed and reported separately for each of the three, segments. This will start from the biennium 2008–2009, taking full effect from the biennium 2010–2011.

71. Financing the Medium-term strategic plan requires efficient management of the different sources of income in order to ensure that resources are made available where needed, for the purpose needed, and when needed. Although WHO has been fairly successful in mobilizing resources, a key challenge remains, namely: ensuring alignment between the activities planned and the resources mobilized. Despite improvements, additional efforts will be required to avoid situations where funds lie idle, or are underutilized, in one programme or location while resources are acutely needed in another. This will require contributors of voluntary funds to provide their resources in a more flexible and predictable manner, and the Organization to strengthen mechanisms for effective resource allocation and monitoring such as the global management system and the advisory group on financial resources, which recommends to the Director-General the allocation of resources on a corporate basis and in a transparent manner.

72. For the duration of the Medium-term strategic plan, WHO will categorize funds according to the nature of their primary sources: **assessed** contributions, core **voluntary** contributions and specified **voluntary** contributions. The Organization will continue the work with partners and donors to improve the alignment of voluntary contributions with the achievement of results as set out in the programme budget.

Figure 3. Financing the Medium-term strategic plan: three sources of funding



73. **Assessed contribution and miscellaneous income**. WHO is a Member-State organization with global responsibility for normative technical work; it is therefore essential for the Organization's credibility and integrity that a significant portion of its budget should be financed through assessed contributions.

74. Miscellaneous income is derived mainly from interest earned on assessed-contribution funds, collections of arrears of assessed contributions, and assessed contributions remaining unspent at the end of a biennium.

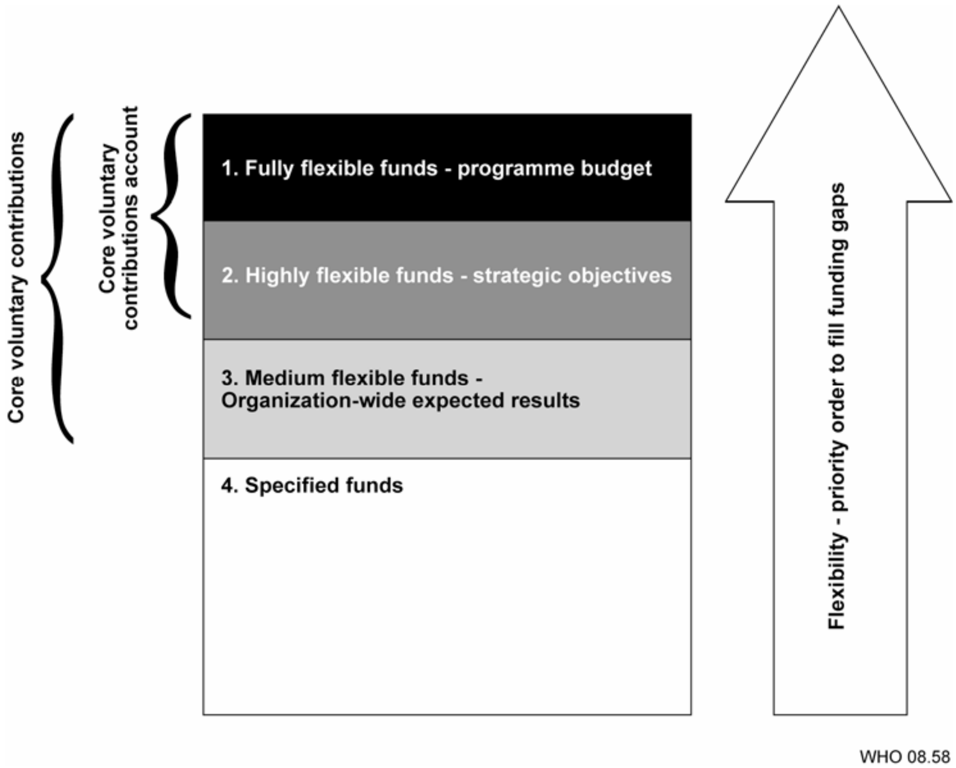
75. The aim is for assessed contributions to continue to be a key source of financing for the Medium-term strategic plan.

76. **Voluntary contributions.** Seventy-one percent of the total expenditures in the biennium 2006-2007 were financed from voluntary contributions. Less than a dozen different sources accounted for more than 75% of all voluntary contributions received, with the remaining contributions coming from more than 400 different sources.

77. Most voluntary contributions are received for development work and humanitarian assistance, and come mainly from bilateral and multilateral development agencies and a few private foundations. Although all resources are welcome and indeed essential to execute WHO's programme of work, the manner in which they are provided can pose a challenge to ensuring proper alignment between the programme budget and its implementation. Further, administering thousands of separate agreements requiring specific reporting significantly increases the transaction costs to the Organization.

78. Working with key partners and donors, WHO is moving towards acquiring a larger share of predictable, unearmarked, **core voluntary contributions**. This would help to align resources to the priorities of the Organization as determined by the governing bodies through the programme budget; to meet critical funding gaps; and to improve implementation of the programme budget.

Figure 4: Stratification of voluntary income by flexibility



79. Core voluntary contributions are those that provide significant flexibility, enabling them to be deployed wherever the most acute financing needs arise. Contributions that are flexible at the programme budget or strategic objective levels and that do not require donor attribution will be managed through the core voluntary contributions account (see Figure 4) overseen by the advisory group on financial resources, which is composed of the Assistant Directors-General and the Directors of Programme Management from the regional offices.

80. The core voluntary contributions account is a key strategic management tool that enables the advisory group on financial resources to improve the alignment between budget and resources, and to optimize delivery of results across the Organization.

81. About 1% of voluntary contributions are provided as fully flexible funds; and between 5% and 6% are provided as highly flexible funds. WHO will seek to at least double the share of these types of funds in financing the Medium-term strategic plan.

82. Contributions that are medium flexible funds, namely those whose application is to a particular Organization-wide expected result, will be managed by Organization-wide technical teams and major offices in accordance with particular needs. Contributions of this type represented about 10% of funding in the biennium 2006-2007.

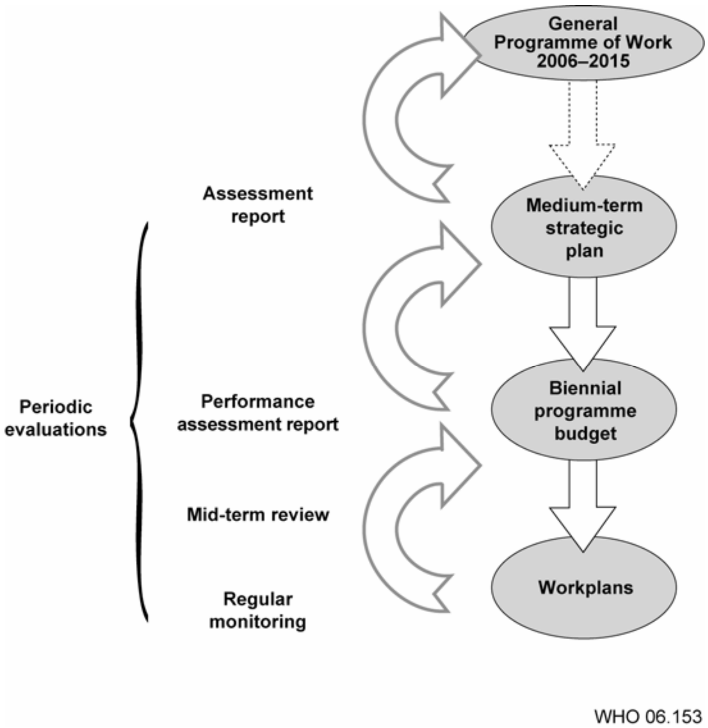
83. **Specified voluntary contributions.** Currently the Organization is financed largely from voluntary contributions intended for a specific purpose. In the biennium 2006-2007 specified contributions constituted about 83% of all voluntary contributions received. Although all these contributions are provided with the aim of achieving the defined expected results and are thus critical for implementation of work plans, their limited flexibility and the large proportion of the total financing that they constitute continue to pose challenges to timely implementation and effective resource management.

84. In order for the Organization to continue to improve the effectiveness of financing, a robust framework is required for management, monitoring and evaluation. Such a framework should enable the different sources of funding to be better integrated, and should allow for more informed decision-making and the continuous fine-tuning of policies, strategies and programmes.

Monitoring, assessment and evaluation

85. A number of instruments within WHO's results-based management framework serve to monitor, assess, evaluate and deal with potential issues related to performance of the Medium-term strategic plan and associated programme budgets.

Figure 5. Monitoring, assessment and evaluation instruments



86. Programmatic and financial implementation is monitored on the basis of operational plans (workplans) at least every six months throughout the biennium. This serves to review and adjust where needed the implementation of specific activities in light of the programmatic and financial situation.

87. An Organization-wide mid-term review is carried out at the end of the first year of each biennium, which assesses progress at each WHO office towards achievement of the specific results for which each is accountable. The mid-term review complements the unaudited financial report.

88. Programme budget performance is assessed at the end of the biennium and complements the audited financial report submitted at the same time. The assessment report provides an Organization-wide summary of the programmatic performance of the Secretariat, including in respect of the achievement of indicator targets, along with the broader lessons learnt across the Organization.

89. The Medium-term strategic plan is monitored through the assessment of programme-budget performance. At the end of the six-year period, the extent to which the 13 strategic objectives have been achieved will be assessed. Data on the strategic-objective indicators will be collected to establish the degree to which the targets have been reached. Performance will be analysed and the main achievements in delivery of the strategic objectives, factors contributing to, or impeding, success, and lessons learnt will be summarized to help in drawing up subsequent strategic plans.

90. The framework also includes the periodic evaluation of WHO's programmes, which assess the outcomes of WHO's work along the lines of thematic, programmatic or country evaluations.

91. Mechanisms such as peer reviews are employed in both the planning and monitoring phases of results-based management so as to ensure a high level of quality throughout the Organization. Collective reviews by senior management, along with the governing bodies, also serve to identify emerging needs, potential performance issues, and ensuing re-prioritization during the six-year period.

92. The General Programme of Work will also be monitored. Priorities will be assessed in depth, and WHO's core functions monitored to ensure their continuing relevance, and the quality and influence of WHO's work.

93. The impact of the work of WHO to the health of the people of Africa and the health of women, to which the Director-General has drawn particular attention,[1] will be monitored specifically.

[1] See paragraph 30.

STRATEGIC OBJECTIVE 1

STRATEGIC OBJECTIVES

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

Indicators and targets

- The mortality rate due to vaccine-preventable diseases. Target: two thirds reduction by 2013
- Coverage of interventions targeted at the control, elimination or eradication of tropical diseases. Target: 80% in 49 at-risk Member States by 2013
- The proportion of countries achieving and maintaining certification of poliomyelitis eradication and destruction or appropriate containment of all polioviruses. Target: 100% by 2013.

ISSUES AND CHALLENGES

The work undertaken under this strategic objective aims at ensuring health security by achieving a sustainable reduction in the health, social and economic burden of communicable diseases. In line with the global health agenda articulated in WHO's Eleventh General Programme of Work 2006-2015, it includes investing in health to reduce poverty; enhancing individual and global health security; harnessing knowledge, science and technology; strengthening health systems; and improving universal access to health services.

Communicable diseases are one of the greatest potential barriers to global health as, excluding HIV/AIDS, malaria and tuberculosis, they account for 20% of deaths in all age groups, 50% of child deaths and 33% of deaths in the least developed countries. Without a reduction in this disease burden, the achievement of other health-related goals, and those in education, gender equality, poverty reduction and economic growth, will be jeopardized. Thus, combating the burden of communicable disease is a key component of two of the Secretariat's strategies for achieving the Millennium Development Goals. These are to devise responses to the diverse and evolving needs of countries, using cost-effective approaches to combating those diseases and the conditions that account for the greatest share of the burden; and to introduce or strengthen integrated surveillance systems and improve the quality of health data.

Epidemics can place sudden and intense demands on health systems. They expose existing weaknesses in health systems and, in addition to their impact on morbidity and mortality, can disrupt economic activity and development. The need for rapid response drains resources, staff and supplies away from previously defined public health priorities and routine disease-control activities, such as childhood immunization.

Lessons learnt

- The prevention, control and surveillance of communicable diseases are all essential components in human security, including health security, economic development and trade.
- Public health emergencies in communicable diseases can cost billions of dollars, not only in direct health-related costs, but also in the impact epidemics can have on trade and finance.
- The prevention of communicable diseases is one of the most cost-effective public health interventions; it can also yield positive economic returns, particularly among the most marginalized and economically disadvantaged population groups.
- The control of vaccine-preventable, epidemic-prone and tropical diseases has proved remarkably successful in reducing inequities by reaching hard-to-reach marginalized, poor, young populations and women, particularly mothers.
- These interventions are among the most effective components of health systems in many countries; they also provide a platform for integrating and disseminating other essential public health services.

WHO has a primary role in preparedness, detection, risk assessment and communications and response to public health emergencies. WHO has verified more than 1000 epidemics of international concern over the past five years.

The International Health Regulations (2005), which came into effect in 2007, impose a binding legal obligation on the Director-General to strengthen the Organization's alert and response capacity in the face of epidemics and public health risks and emergencies and to provide support to Member States in the development and maintenance of minimum core capacities for the detection and assessment of, and response to, those risks and emergencies, most of which are attributable to communicable diseases.

WHO's response to the outbreak of severe acute respiratory syndrome and the threat of an influenza pandemic due to new sub-types of influenza virus demonstrated the importance of coordination, leadership and transparency in dealing with epidemics and pandemics. Development of the global event management system has shown WHO's capacity to detect, assess, confirm, communicate and respond to outbreaks and other public health risks. The poliomyelitis eradication initiative has highlighted the need to couple targeted disease-control measures, such as campaigns, with overall strengthening of health systems, in line with primary health care principles.

To achieve the strategic objective, it will be essential to move beyond vertical and isolated programmes and, on the basis of a thorough assessment of past successes and failures in the creation of strategies for integrated health-systems development, to build on past strengths and success stories and to correct weaknesses.

STRATEGIC APPROACHES

To achieve this objective, Member States will have to invest human, political and financial resources into ensuring and expanding equitable access to high-quality and safe interventions for the prevention, early detection, diagnosis, treatment, and control of communicable diseases among all populations. A key component in the financial and operational sustainability of prevention and control in this context will be the establishment and maintenance by Member States of effective coordination mechanisms with partners and across relevant sectors at the country level, and a willingness to work with the Secretariat in extending these coordination mechanisms to the regional and international spheres. Given that less than 10% of health-research resources globally are spent on health problems that affect 90% of the world's population, increased national involvement in research, through achievement of the objectives for investment in health research, research-capacity strengthening and integration of research into the mainstream of national programmes and plans, will be crucial for improving access to, and use of, research findings.

Lessons learnt

- WHO has a leadership role in setting a global research agenda that will have an innovative and sustainable impact on disease control through the improvement, development and evaluation of new tools, interventions and strategies.

The Secretariat will focus on:

- strengthening its leadership and its collaboration with global health stakeholders, partners and civil society, while working with Member States to articulate ethical and evidence-based policies, and facilitating the expansion of community access to existing and new tools and strategies, including vaccines and medicines, that meet acceptable standards of quality, safety, efficacy and cost-effectiveness, while reducing disparities in access;
- strengthening its capacity to fulfil its obligations to provide technical assistance, build capacity and respond to Member States, in particular, pursuant to Health Assembly resolutions related to communicable diseases and the International Health Regulations (2005). Work will include facilitating national and international resource mobilization and advocacy;
- maintaining and strengthening an effective international system for identifying, assessing and managing risks through alert and response to epidemics and other public health emergencies, with immediate technical support to affected Member States and collective international action for containment and control;
- facilitating public health preparedness for communicable disease response in collaboration with other bodies in the United Nations system and partners, including private and civil-society organizations as appropriate;

The International Health Regulations (2005) require Member States to adopt the necessary legal, administrative, financial, technical and political provisions for activities including the development, strengthening and maintenance of integrated surveillance systems at community/primary, intermediate and national levels, in order to enable them to detect, report on, and respond to public health risks and potential public health emergencies, and to generate information for evidence-based policy decisions on public health interventions.

The Secretariat will focus on:

- providing Member States with tools, strategies and technical support to evaluate and strengthen monitoring and surveillance systems;
- coordinating integrated surveillance activities at global and regional levels in order to inform policy decisions and public health responses;
- shaping the research agenda on communicable diseases and stimulating and supporting the generation, application and dissemination of knowledge for use in the formulation of ethical and evidence-based policy options;
- strengthening the capacity of Member States to undertake health research, especially on the development of tools and strategies for the prevention, early detection, diagnosis, treatment and control of communicable diseases.

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

- that the entry into force of the International Health Regulations (2005) on 15 June 2007 will translate into a renewed commitment by all Member States to strengthen their national surveillance and response systems, and a sustained interest in and support for WHO's activities, including networks and partnerships, on the part of donors and technical partners;
- that the aim of work on developing or strengthening national health systems will continue to be universal access to essential health interventions;
- that there will be effective coordination and harmonization between the increasing number of parties in the global public and private health sectors;
- that open communication will continue to maintain strong and interactive coordination of efforts at the global level.

The risks that could prevent achievement of the strategic objective are:

- that increased pressure diverts resources away from communicable diseases and towards other aspects of health;
- that prevention and control of communicable diseases are neglected or not recognized and visibly maintained as health priorities, particularly in the least developed countries. Such interventions will not remain a priority on national and international health agendas unless harmonized policy messages from the Secretariat and international partners support this item on the global health agenda;
- that financial and political investment in implementation of the International Health Regulations (2005) is insufficient, and the approach of governments towards their implementation is fragmented. These risks can be countered through development of, and adherence to, regional commitments, such as the Kabul Declaration on Regional Collaboration in Health (2006);
- that private-sector and unilateral efforts are inadequate to secure funding to meet the shortfall in investment in research. Without promotion and coordination of policies and actions based on the premise of global public goods, the return on the investment will not be maximized;

- that transmission of polioviruses will not be interrupted by the end of 2009. This will necessitate additional supplemental immunization activities and intensified active surveillance and strengthening of routine immunization, and will also incur extra costs. The risk can be mitigated through the use of new tools and approaches to accelerate interruption of transmission of wild-type poliovirus, as well as heightened advocacy and social mobilization efforts at all levels;
- that an influenza pandemic causes unprecedented morbidity and mortality, and serious economic harm. Advanced planning for appropriate detection and response strategies, including containment and control strategies and research into the development of vaccines and medicines, is central to minimizing the potentially disruptive impact of a pandemic.

ORGANIZATION-WIDE EXPECTED RESULTS

1.1 Policy and technical support provided to Member States in order to maximize equitable access of all people to vaccines of assured quality, including new immunization products and technologies, and to integrate other essential child-health interventions with immunization.	**INDICATORS**		
	1.1.1 Number of Member States with at least 90% national vaccination coverage (DTP3)	**1.1.2** Number of Member States that have introduced *Haemophilus influenzae* type b vaccine in their national immunization schedule	
	BASELINE 2008		
	114	104	
	TARGETS TO BE ACHIEVED BY 2009		
	130	135	
	TARGETS TO BE ACHIEVED BY 2011		
	140	150	
	TARGETS TO BE ACHIEVED BY 2013		
	150	160	
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009 153 584	Proposed budget 2010–2011 345 100	Estimates 2012–2013 181 000
	JUSTIFICATION		
	In resolution WHA58.15 the Health Assembly welcomed the Global Immunization Vision and Strategy, with its approaches to protecting more people by making immunization available to all eligible people, introducing new vaccines and technologies, and linking immunization to the delivery of other health interventions and overall development of the health sector. It also requested policy and technical support to Member States in implementing the strategy. More than 75% of the resources are for activities at regional and country levels. Global health partnerships, such as the Global Alliance for Vaccines and Immunization, and increasing availability of resources to Member States for implementing immunization programmes through initiatives such as the International Financing Facility for Immunization raise the pressure on the Secretariat to provide policy and technical support to Member States in implementing evidence-based health-system approaches so as to ensure that the resources are used in a financially sustainable way in the long term.		

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

INDICATORS

	1.2.1 Percentage of final country reports demonstrating interruption of wild poliovirus transmission and containment of wild poliovirus stocks accepted by the relevant regional commission for the certification of poliomyelitis eradication	1.2.2 Percentage of Member States using trivalent oral poliovirus vaccine that have a timeline and strategy for eventually stopping its use in routine immunization programmes
BASELINE 2008	63%	0%
TARGETS TO BE ACHIEVED BY 2009	75%	0%
TARGETS TO BE ACHIEVED BY 2011	98%	75%
TARGETS TO BE ACHIEVED BY 2013	100%	100%

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
262 615	478 100	240 000

JUSTIFICATION

Intense transmission of poliovirus in two countries endemic for poliomyelitis and recent outbreaks in poliomyelitis-free areas have delayed eradication of poliomyelitis. It is therefore expected that immunization campaigns in some countries will continue through 2008 and that WHO will need to provide more extensive technical assistance for those campaigns, as well as for the poliomyelitis surveillance infrastructure. Once poliovirus transmission has been interrupted, WHO's costs will decline, but activities will continue through 2013 because of global certification, cessation of use of oral poliomyelitis vaccine and containment of the virus. During this time, the poliomyelitis immunization and surveillance infrastructure will be further integrated into WHO's broader technical assistance to build national capacity for vaccine-preventable and epidemic-prone diseases, including in the context of the implementation of the International Health Regulations (2005).

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

INDICATORS

	1.3.1 Number of Member States certified for eradication of dracunculiasis	1.3.2 Number of Member States that have eliminated leprosy at subnational levels	1.3.3 Number of reported cases of human African trypanosomiasis for all endemic countries	1.3.4 Number of Member States having achieved the recommended target coverage of population at risk of lymphatic filariasis, schistosomiasis and soil-transmitted helminthiases through regular anthelminthic preventive chemotherapy
BASELINE 2008	72	6	11 500	11
TARGETS TO BE ACHIEVED BY 2009	79	10	10 000	15
TARGETS TO BE ACHIEVED BY 2011	82	13	8 500	20
TARGETS TO BE ACHIEVED BY 2013	191	18	7 500	25

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
131 669	191 800	185 000

	JUSTIFICATION *Although cost-effective interventions are available and being implemented, the elimination of many neglected tropical diseases as public health problems requires facilitation of intercountry control programmes by WHO, development of new and improved interventions to combat drug resistance, and support from the private sector. Controlling these diseases is highly cost effective for society and thus interventions in this area can be very effective in alleviating poverty. As attainment of the goals of eliminating/eradicating dracunculiasis and leprosy and halving the mortality rate for rabies approaches, the Secretariat's efforts to reinforce its accomplishments and maintain momentum should be intensified, hence the need for increased resources in 2010-2013. The integrated approach to implementing solutions based on health systems for the control of tropical diseases requires a gradual, sustainable scaling up of support to Member States during the period 2008–2013.*

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

INDICATORS	
1.4.1 Number of Member States with surveillance systems and training for all communicable diseases of public health importance for the country	**1.4.2** Percentage of Member States for which WHO/UNICEF joint reporting forms on immunization surveillance and monitoring are received on time at global level in accordance with established time-lines
BASELINE 2008	
60	115
TARGETS TO BE ACHIEVED BY 2009	
80	135
TARGETS TO BE ACHIEVED BY 2011	
150	150
TARGETS TO BE ACHIEVED BY 2013	
193	165

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
79 668	122 500	87 000

JUSTIFICATION

Surveillance is essential for decisions about the allocation of resources and for the effective and efficient management of public health interventions by health and finance ministries and donors, as well as for ensuring that data are collected on equity of access to interventions by all populations, particularly women and children. WHO plays a key role in the process of integrating vertical surveillance programmes, establishing consensus on critical elements of surveillance, and coordinating partnerships between countries, funding partners and multilateral organizations in order to generate appropriate levels of investment in surveillance systems infrastructure. WHO must take the lead in promoting both integrated disease surveillance as a vital component in fully functioning health systems, and the increased use of data to improve alert and response reactions in public health emergencies, in the monitoring of communicable diseases of public health importance, and as the basis for decision-making. Steps must be taken to build better links between all surveillance mechanisms for communicable diseases, including HIV/AIDS, tuberculosis and malaria, as well as noncommunicable diseases.

1.5 New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed and validated, with scientists from developing countries

INDICATORS	
1.5.1 Number of new and improved tools or implementation strategies, developed with significant contribution from WHO, introduced by the public sector in at least one developing country	**1.5.2** Proportion of peer-reviewed publications based on WHO-supported research where the main author's institution is in a developing country
BASELINE 2008	
None	48%
TARGETS TO BE ACHIEVED BY 2009	
4	55%

increasingly taking the lead in this research.

TARGETS TO BE ACHIEVED BY 2011

9	58%

TARGETS TO BE ACHIEVED BY 2013

124	60%

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
72 334	117 700	42 000

JUSTIFICATION

Even though 85% of the global burden of disability and premature mortality affects the developing world, less than 4% of global research funding is devoted to the disorders that constitute the major burden of disease in developing countries. Increases in funds for research, and the expanding role of public-private partnerships make it essential for the Secretariat to define the global health research agenda, facilitate harmonization of research activities and support countries to make evidence-based policy decisions.

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

INDICATORS

1.6.1 Number of Member States that have completed the assessment and developed a national action plan to achieve core capacities for surveillance and response in line with their obligations under the International Health Regulations (2005)	**1.6.2** Number of Member States whose national laboratory system is engaged in at least one external quality-control programme for epidemic-prone communicable diseases

BASELINE 2008

50	90

TARGETS TO BE ACHIEVED BY 2009

180	135

TARGETS TO BE ACHIEVED BY 2011

	160

TARGETS TO BE ACHIEVED BY 2013

193	193

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
76 485	64 200	120 000

JUSTIFICATION

Under the International Health Regulations (2005) all States Parties have made a commitment to assess their national core capacities for surveillance and response within two years of the Regulations' entry into force in May 2007, and to develop and maintain the same core capacities for five years (with a two-year extension if needed) after that date. The definition of these core capacities includes surveillance and early warning for epidemic-prone diseases and essential diagnostic, response and communication capacities. During the biennium 2008–2009, WHO's technical and financial resources will have to support the national assessments and preparation of action plans. During the period 2010-2013, resources will be applied mainly for implementation and the monitoring and evaluation of achievements.

1.7 Member States and the international community equipped to detect, assess, respond to and cope with major epidemic and pandemic-prone

INDICATORS

1.7.1 Number of Member States having national preparedness plans and standard operating procedures in place for readiness and response to major epidemic-prone diseases	**1.7.2** Number of international coordination mechanisms for supplying essential vaccines, medicines and equipment for use in mass interventions against major epidemic and pandemic-prone diseases

BASELINE 2008

90	4

diseases (e.g. influenza, meningitis, yellow fever, haemorrhagic fevers, plague and smallpox) through the development and implementation of tools, methodologies, practices, networks and partnerships for prevention, detection, preparedness and intervention.

TARGETS TO BE ACHIEVED BY 2009

135	7

TARGETS TO BE ACHIEVED BY 2011

165	8

TARGETS TO BE ACHIEVED BY 2013

193	9

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
61 516	163 300	76 000

JUSTIFICATION

Strong programmes and projects on diseases or specific themes are vital for WHO to ensure that serious threats are dealt with systematically and that WHO maintains its much-needed global expertise in vital areas (e.g. influenza, smallpox, biosafety, epidemics caused by deliberate release of pathogens, and yellow fever). The avian influenza crisis has highlighted the need for the Secretariat to accelerate work with Member States in order to ensure that their ability to detect, assess, respond to and cope with the threat of known epidemic-prone and emerging infectious diseases. The development of standard operating procedures and stockpiling of necessary medicines and vaccines are crucial for mitigating the potential impact of these diseases. Maintaining and expanding existing networks and partnerships providing support to Member States in the different aspects of preparedness and response to specific epidemic risks, and developing new ones where required, are essential elements of WHO's strategy. By the end of 2007, all Member States will have national preparedness plans devised, implemented and tested, thus providing the backbone to the response to a potential pandemic.

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

INDICATORS

1.8.1 Number of WHO locations with the global event-management system in place to support coordination of risk assessment, communications and field operations for headquarters, regional and country offices	**1.8.2** Proportion of requests for assistance from Member States for which WHO mobilizes coordinated international support for disease investigation and containment efforts, characterization of events, and sustained containment of outbreaks

BASELINE 2008

7	90%

TARGETS TO BE ACHIEVED BY 2009

60	100%

TARGETS TO BE ACHIEVED BY 2011

90	100%

TARGETS TO BE ACHIEVED BY 2013

120	100%

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
56 172	60 300	71 000

JUSTIFICATION

WHO faces a continuing and increasing demand to operate an effective global system of epidemic intelligence gathering, verification, risk assessment, information management and rapid field response using innovative information technology, standard operating procedures and the resources of partners in the Global Outbreak Alert and Response Network and other relevant regional networks. This service is mandated and obligated according to the International Health Regulations (2005). WHO is focusing on strengthening its epidemic alert and response operations at country and regional levels, while increasing standardization and coordination of operations across the Organization, and increasing the level of accountability for decision-making especially when these decisions affect travel and trade.

<table>
<tr><td rowspan="14">1.9 Effective operations and response by Member States and the international community to declared emergencies situations due to epidemic and pandemic prone diseases.</td><td colspan="3">INDICATORS</td></tr>
<tr><td colspan="3">1.9.1 Proportion of declared emergency situations due to epidemic and pandemic prone diseases where operations have been implemented in a timely fashion</td></tr>
<tr><td colspan="3">BASELINE 2008</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">TARGETS TO BE ACHIEVED BY 2009</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">TARGETS TO BE ACHIEVED BY 2011</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">TARGETS TO BE ACHIEVED BY 2013</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">RESOURCES (US$ THOUSAND)</td></tr>
<tr><td>Budget 2008–2009</td><td>Proposed budget 2010–2011</td><td>Estimates 2012–2013</td></tr>
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<tr><td colspan="3">JUSTIFICATION</td></tr>
</table>

STRATEGIC OBJECTIVE 2

To combat HIV/AIDS, tuberculosis and malaria

Indicators and targets

- Life years gained in low- and middle-income countries through provision of antiretroviral treatment. Target: 15 million life years since 2002 (baseline: 2 million life years since 2002)
- HIV incidence reduction (proxy). Target: all countries with generalized HIV epidemics (56 countries) having achieved and maintained at least a 25% reduction in HIV prevalence in young people (aged 15-24 years) since the United Nations Declaration of Commitment on HIV/AIDS (2001) (baseline: six countries in 2005)
- Reduction in mother-to-child transmission of HIV. Target: by 2013, reduce percentage of HIV-infected infants born to HIV-infected mothers to 10% (baseline: 25% in 2005)
- Reduction in HIV prevalence in vulnerable populations. Target: by 2013, all (136) countries with low-prevalence or concentrated HIV epidemics having halted or reversed HIV prevalence among most populations with risk behaviours (injecting drug users, sex workers and men who have sex with men) (baseline: no country in 2005)
- Reduction of tuberculosis incidence. Target: by 2013, have halted and begun to reverse the incidence of tuberculosis (baseline: 1990 figure)
- Reduction of tuberculosis prevalence rate. Target: by 2013, 45% reduction (baseline:1990 figure)
- Reduction in tuberculosis mortality rate. Target: by 2013, 45% reduction (baseline: 1990 figure)
- Reduction in mortality due to malaria in countries endemic for the disease. Target: 50% reduction by 2013 (baseline: 1.2 million deaths globally in 2002)
- Elimination of malaria from countries where that objective is currently considered feasible by 2013. Target: by 2013, seven countries certified or enrolled in a WHO certification process for malaria elimination (baseline: no country in 2005).

ISSUES AND CHALLENGES

The pandemics of HIV/AIDS, tuberculosis and malaria claim more than six million lives annually and contribute substantially to national and individual poverty. Controlling HIV/AIDS, tuberculosis and malaria is crucial to achieving many of the Millennium Development Goals and will also greatly reduce poverty and child mortality; improve maternal and newborn health, and other health outcomes; and alleviate the burden on individuals, communities, nations and their health systems.

STRATEGIC APPROACHES

Major impetus will be given to promoting the delivery of, and universal access to, essential interventions for prevention, treatment, care and support in order to halt disease transmission and reduce morbidity and mortality. At the primary-care level, interventions can be harmonized in order to maximize the effectiveness of a given contact of a patient with the health system, and to provide the best entry points. Emphasis will be placed on maximizing prevention; addressing gender inequalities; ensuring that the services are also tailored and delivered to poor people, vulnerable groups, including women and girls, and hard-to-reach populations, including injecting drug users, sex workers and prisoners; meeting the needs of populations in conflict situations and humanitarian

Lessons learnt

- Previous and ongoing initiatives on HIV/AIDS, tuberculosis and malaria (e.g. "3 by 5", Stop TB strategy and Global Plan to Stop TB 2006-2015, Roll Back Malaria, and the Global Fund to Fight AIDS, Tuberculosis and Malaria) have been good catalysts at global, regional and national levels in a longer-term global effort to realize the Millennium Development Goals. The challenge is to move towards universal access to prevention, treatment and care interventions in order to combat the three diseases.
- Interventions against these diseases can be expanded even in the most resource-challenged settings, but sound planning, sustainable financing and well-supported infrastructures are essential.
- Strengthening of health systems, adequate financial support, clear milestones, robust monitoring and evaluation, and enhanced partnership structures with improved coordination are essential ingredients in scaling up interventions against the three diseases so as to reach the goal of universal access.

crises; ensuring relevance to sociocultural contexts; and encouraging use of evidence, norms and standards in policy and programme formulation.

Strengthening and supporting human resources and provider networks and enhancing the public–private mix will be vital, and should include training, and upgrading the skills of, health professionals and community workers; expanding the service-provision networks and pool of providers; strengthening human-resource management capacity; improving engagement of nongovernmental and private-sector institutions; enhancing referral systems; tapping the potential of community health workers, persons living with the diseases and family members; and promoting strategies to retain health-sector human resources. Other crucial approaches will be: facilitating the availability, and promoting proper use, of good-quality, safe and affordable medicines, diagnostic tools, blood and blood products, injections, insecticides, health technologies and commodities; expanding quality-assured laboratory networks; and ensuring well-functioning public and private supply chains.

Monitoring, evaluation and surveillance systems for decision-making, determining progress and ensuring accountability for progress towards HIV, tuberculosis and malaria targets, and effectiveness and efficiency of information systems (with generation and use of age- and sex-disaggregated data) will all be improved. The approaches will also aim at strengthening epidemiological and behavioural surveillance, data collection and analysis capacity (including financial tracking); assessing the impact of interventions and trends of the three diseases in special population groups; and refining indicators for major new interventions (such as the long-term impact of antiretroviral treatment for people with HIV/AIDS and monitoring of drug resistance).

Efforts to ensure sustained political commitment, better engagement of communities and affected persons, and more effective partnerships will also be crucial, including coherence and harmonization of operations with UNAIDS, other organizations of the United Nations system, and partners at all levels. Advocacy for concerted efforts to combat the three diseases will be a major factor for success.

Other essential approaches will be: enabling and promoting research, particularly in areas of safe and effective prevention technologies (such as vaccines and microbicides), medicines (including simplified treatment regimens) and diagnostic tools; and operations research to determine effectiveness of service delivery, within the different contexts.

ASSUMPTIONS, RISKS AND OPTIONS

Enabling prevention and control programmes against HIV, tuberculosis and malaria to be scaled up successfully will require a consistent and strong capacity at all national levels for formulating evidence-based policies, analysing their

Lessons learnt

- Various entry points and opportunities exist for scaling up prevention, treatment and care interventions against HIV/AIDS, tuberculosis and malaria in resource-limited settings, including integrated service delivery.
- Engagement of communities, affected persons, civil-society organizations, the private sector and other relevant stakeholders is essential to ensure local ownership and sustainability.
- Major difficulties remain for scaling up interventions at country level; ensuring sustainable financing and its effective use; steering financial and human resources towards clear public health results; ensuring linkages with relevant programmes and initiatives; building synergies between interventions and service-delivery modes; minimizing competition between the various disease programmes; and development and evaluation of more effective intervention tools.

The Secretariat will focus on:

- formulating policies, strategies and standards for tackling HIV/AIDS, tuberculosis and malaria;
- providing support through technical cooperation and coordination to Member States for the implementation of policies, strategies and standards;
- facilitating availability and proper use of high-quality medicines and commodities;
- measuring progress towards global and regional targets and assessing performance, financing and impact of national programmes and systems;
- facilitating partnerships, advocacy and communications;

effects, and making adjustments as necessary. It will also require substantially increasing resources, reinforcing health systems and building institutional capacity for solving operational constraints. The following assumptions underlie achievement of this strategic objective:

- that prevention and control of HIV/AIDS, tuberculosis and malaria continue to be recognized as priorities in national and international health agendas;
- that strengthening of national health systems in order to attain universal access to essential health services and care will be accorded a higher profile;
- that partnership mechanisms and involvement of stakeholders will be strengthened in order to meet the agreed targets at national and regional levels; and that synergy and coordination among the increasing number of participants working to prevent and control HIV/AIDS, tuberculosis and malaria will become a reality;
- that gender inequalities, discrimination and stigmatization, which currently fuel epidemics of the three diseases, will be tackled as high-priority cross-cutting issues.

The following risks have been identified that may hinder achievement of the strategic objective:

- that raising and sustaining the necessary resources may be difficult, both for the Secretariat and Member States, as more competing priorities emerge;
- that health gains in HIV/AIDS, tuberculosis and malaria may not be sustained in the least developed countries without increased political and financial commitment;
- that WHO's leadership of, and interactions with, the growing number of partners may be difficult to sustain, especially in the face of increasing competition for resources and special problems raised by coordination and harmonization.

The Secretariat will focus on:

- strengthening global, regional, subregional and intercountry initiatives aimed at prevention and control of HIV/AIDS, tuberculosis and malaria;
- contributing as appropriate to devising and implementing mechanisms for resource mobilization and use;
- fostering research and building research capacity in target countries.

ORGANIZATION-WIDE EXPECTED RESULTS

2.1 Guidelines, policy, strategy and other tools developed for prevention of, and treatment and care for patients with, HIV/AIDS, tuberculosis and malaria, including innovative approaches for increasing coverage of the interventions among poor people, and hard-to-reach and vulnerable populations.	**INDICATORS**			
	2.1.1 Number of low and middle income countries that have achieved 80% coverage for antiretroviral therapy and the prevention of mother-to-child transmission services	**2.1.2** Proportion of endemic countries that have achieved their national intervention targets for malaria	**2.1.3** Number of Member States that have achieved the targets of at least 70% case detection and 85% treatment success rate for tuberculosis	**2.1.4** Proportion of high burden Member States that have achieved the target of 70% of persons with sexually transmitted infections diagnosed, treated and counselled at primary point-of-care sites
	BASELINE 2008			
	34	5%	54	28%
	TARGETS TO BE ACHIEVED BY 2009			
	60	50%	100	52%
	TARGETS TO BE ACHIEVED BY 2011			

	TARGETS TO BE ACHIEVED BY 2013			
	131	100%	193	90%
	RESOURCES (US$ THOUSAND)			
	Budget 2008–2009 146 534	Proposed budget 2010–2011 146 800	Estimates 2012–2013 150 000	
	JUSTIFICATION			
	WHO is firmly committed to maximizing access to interventions against HIV/AIDS, tuberculosis and malaria, pursuant to various Health Assembly resolutions, the global health-sector strategy for HIV/AIDS, the Stop TB strategy, the Global Plan to Stop TB 2006-2015, the Global Strategic Plan 2005–2015 to Roll Back Malaria; the Global Strategy for the Prevention and Control of Sexually Transmitted Infections, and the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health; articulation of its contribution to scaling up towards universal access to HIV/AIDS prevention, care and treatment (and the need to advance work done under the "3 by 5" Initiative); and to achieving the Millennium Development Goals and other internationally agreed goals. Most of the resources are for country and regional level activities.			

2.2 Policy and technical support provided to countries towards expanded gender-sensitive delivery of prevention, treatment and care interventions for HIV/AIDS, tuberculosis and malaria, including integrated training and service delivery; wider service-provider networks; and strengthened laboratory capacities and better linkages with other health services, such as those for sexual and reproductive health, maternal, newborn and child health, sexually transmitted infections, nutrition, drug-dependence treatment services, respiratory care, neglected diseases and environmental health.	**INDICATORS**		
	2.2.1 Number of targeted Member States with comprehensive policies and medium-term plans in response to HIV, tuberculosis and malaria	**2.2.2** Proportion of high-burden countries monitoring provider initiated HIV testing and counselling in sexually transmitted infection and family planning services	
	BASELINE 2008		
	HIV/AIDS:80/131 Tuberculosis:50/87	0%	
	TARGETS TO BE ACHIEVED BY 2009		
	HIV/AIDS: 131/131 Tuberculosis: 87/87	25%	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	HIV/AIDS: all countries Tuberculosis: 148 Malaria: 43/43	75%	
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009 258 132	Proposed budget 2010–2011 235 300	Estimates 2012–2013 300 000
	JUSTIFICATION		
	WHO plays a critical role in supporting countries to scale up effective and gender-sensitive interventions to all those who need them; to remove the human resources obstacles to progress; to create or maximize synergies among existing programmes and service-delivery modes and to ensure that vulnerable and high-risk populations benefit from the interventions.		

2.3 Global guidance and technical support provided on policies and programmes in order to promote equitable access to essential medicines, diagnostic tools and health technologies of assured quality for the prevention and treatment of HIV/AIDS, tuberculosis and malaria, and their rational use by prescribers and consumers, and, in order to ensure uninterrupted supplies of diagnostics, safe blood and blood products, injections and other essential health technologies and commodities.	**INDICATORS**				
	2.3.1 Number of new or updated global norms and quality standards for medicines and diagnostic tools for HIV/AIDS, tuberculosis and malaria	**2.3.2** Number of priority medicines and diagnostic tools for HIV/AIDS, tuberculosis and malaria that have been assessed and pre-qualified for United Nations procurement	**2.3.3** Number of targeted countries receiving support to increase access to affordable essential medicines for HIV/AIDS, tuberculosis and malaria whose supply is integrated into national pharmaceutical systems (the number of targeted countries is determined for the six-year period)	**2.3.4** Number of Member States implementing quality-assured HIV/AIDS screening of all donated blood	2.3.5 Number of Member States administering all medical injections using sterile single use syringes
	BASELINE 2008				
	Five global standards	150 products	10 countries	77	115
	TARGETS TO BE ACHIEVED BY 2009				
	10 new global standards	225 products	20 countries	134	154
	TARGETS TO BE ACHIEVED BY 2011				
	TARGETS TO BE ACHIEVED BY 2013				
	20 new global standards	400 products	All targeted countries supported	193	193

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
58 284	73 300	29 000

JUSTIFICATION

Progress against HIV/AIDS, tuberculosis and malaria depends significantly on provision of medicines, diagnostic tools and other essential health technologies. Expanding access to them and ensuring their quality are a major priority for WHO, as reflected in various Health Assembly resolutions. They represent an area of increasing priority for Member States and place an enormous demand on WHO for support. Most of the resources will be used for country and regional level activities.

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

INDICATORS	
2.4.1 Number of Member States providing WHO with annual data on surveillance, monitoring or financial allocation data for inclusion in the annual global reports on control of HIV/AIDS, tuberculosis or malaria and the achievement of targets	**2.4.2** Number of Member States reporting drug resistance surveillance data to WHO for HIV/AIDS, tuberculosis or malaria
BASELINE 2008	
HIV/AIDS: 48 Tuberculosis:185 countries and territories Malaria: 107	HIV/AIDS: 13 Tuberculosis: 120 Malaria: 107
TARGETS TO BE ACHIEVED BY 2009	
HIV/AIDS: 65Tuberculosis: 189Malaria: 107	HIV/AIDS: 40Tuberculosis: 135Malaria: 107
TARGETS TO BE ACHIEVED BY 2011	
TARGETS TO BE ACHIEVED BY 2013	
HIV/AIDS:85 Tuberculosis:193 Malaria: 107	HIV/AIDS:50Tuberculosis:155 Malaria: 107

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
104 598	100 500	150 000

JUSTIFICATION

WHO has a crucial role in supporting and coordinating surveillance of HIV/AIDS, tuberculosis and malaria at the global and regional levels, including synthesis and dissemination of data for informing policy decisions and public health responses; shaping the research agenda; stimulating and supporting the generation, translation, and dissemination of knowledge, evidence and lessons learnt; and supporting countries in undertaking research and using the results for the development of tools and strategies for the prevention, early detection, diagnosis, treatment and control of the three diseases. All three levels of the Organization have a key role to play.

2.5 Political commitment sustained and mobilization of resources ensured through advocacy and nurturing of partnerships on HIV/AIDS, tuberculosis and malaria at country, regional and global levels; support provided to countries as appropriate to develop or strengthen and implement mechanisms for resource mobilization and utilization and

INDICATORS	
2.5.1 Number of Member States with functional coordination mechanisms for HIV/AIDS, tuberculosis and malaria control	**2.5.2** Number of Member States involving communities, persons affected by the diseases, civil-society organizations and the private sector in planning, design, implementation and evaluation of HIV/AIDS, tuberculosis and malaria programmes
BASELINE 2008	
HIV/AIDS: 80 Tuberculosis: 45 Malaria:	HIV/AIDS: 131 Tuberculosis: 65
TARGETS TO BE ACHIEVED BY 2009	
HIV/AIDS: 131 Tuberculosis: 87 Malaria:	HIV/AIDS: 131 Tuberculosis: 87
TARGETS TO BE ACHIEVED BY 2011	

increase the absorption capacity of available resources; and engagement of communities and affected persons increased to maximize the reach and performance of HIV/AIDS, tuberculosis and malaria control programmes.	**TARGETS TO BE ACHIEVED BY 2013**		
	HIV/AIDS: 131 Tuberculosis: 87 Malaria:	HIV/AIDS: 131 Tuberculosis: 87	
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009 35 930	Proposed budget 2010–2011 62 700	Estimates 2012–2013 30 000
	JUSTIFICATION *Resources are required to ensure engagement and coordination with various partners for rapid scaling up of interventions for HIV/AIDS, tuberculosis and malaria, including advocacy, coordination, and collaboration with key partners, networks and stakeholders such as UNAIDS, the Stop TB Partnership including the Global Drug Facility and Roll Back Malaria Partnership, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States' President's Emergency Plan for AIDS Relief, the Malaria Medicines and Supply Service, and AIDS Medicines and Diagnostics Service. They are also needed for promoting funding of work on aspects of HIV/AIDS, tuberculosis and malaria that remain severely underfunded, such as laboratory capacity and human resources. The work cuts across all three levels of the Organization.*		

2.6 New knowledge, intervention tools and strategies developed and validated to meet priority needs for the prevention and control of HIV/AIDS, tuberculosis and malaria, with scientists from developing countries increasingly taking the lead in this research.	**INDICATORS**		
	2.6.1 Number of new and improved tools (e.g. medicines, vaccines and diagnostic tools) receiving internationally recognized approval for use in HIV/AIDS, tuberculosis or malaria	**2.6.2** Number of new and improved interventions and implementation strategies for HIV/AIDS, tuberculosis and malaria, whose effectiveness has been determined and evidence made available to appropriate institutions for policy decisions	**2.6.3** Proportion of peer-reviewed publications arising from WHO-supported research on HIV/AIDS, tuberculosis or malaria and for which the main author's institution is based in a developing country
	BASELINE 2008		
	HIV:1 Tuberculosis:1	2	48%
	TARGETS TO BE ACHIEVED BY 2009		
	HIV: 3 Tuberculosis: 3	4	55%
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	HIV: 5 Tuberculosis: 6	8	60%
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009 103 454	Proposed budget 2010–2011 113 100	Estimates 2012–2013 81 000
	JUSTIFICATION *Appropriately directed research can have a significant impact on the control of HIV/AIDS, tuberculosis and malaria through the improvement, development and evaluation of new tools, interventions and strategies. WHO's facilitative role is crucial to finding the most effective measures for combating the three diseases and building a sustainable base in order to enable developing countries to undertake research of national and local relevance.*		

STRATEGIC OBJECTIVE 3

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

Indicators and targets

- <u>To reduce – over and above current trends – the burden of the major noncommunicable diseases</u>
- <u>To halt and begin to reverse the currently rising trends in the burden of mental, behavioural, neurological, and substance use disorders</u>
- To halt and begin to reverse <u>the currently rising</u> trends <u>in mortality from injuries</u>

ISSUES AND CHALLENGES

Chronic noncommunicable conditions, mental disorders, <u>visual impairment,</u> violence and injuries are currently the major causes of death and disability in almost all countries. In recent years the regional committees, the Health Assembly and the United Nations General Assembly have given WHO an important set of mandates for tackling these issues.

These causes are responsible for 75% of all deaths – a figure that is projected to increase over the next 10 years. Over the period 2006-2015, deaths from communicable conditions, maternal and perinatal conditions and nutritional deficiencies are expected to decrease by 3%; on the other hand, deaths from chronic noncommunicable conditions are expected to increase by 17%, deaths from neuropsychiatric disorders by 14% and those caused by injuries by 12%. The major part of this increasing burden will be borne by low- and middle-income countries, where these causes are already responsible for at least 80% of all deaths.

A full range of interventions for chronic noncommunicable conditions, mental disorders, violence and injuries have been shown to be cost effective and affordable in all regions. For example, an outlay of US$ 7 per capita covers the cost of a basic mental health package at primary health care level; US$ 1 spent on smoke alarms produces a health-cost saving of US$ 21; combination drug therapy for individuals at high risk of a cardiovascular event is estimated to avert 63 million disability-adjusted life years every year worldwide; and cataract surgery generates increased economic productivity that is equivalent during the first year to 1500% of the cost of the intervention.

Lessons learnt

- Traditional single-sector approaches are not sufficient for dealing with the problems caused by chronic noncommunicable diseases, mental health and behavioural disorders, violence and injuries; creative ways of working across government agencies, civil society, the private sector and other partners are therefore needed.
- Public-health problems associated with risk factors for chronic noncommunicable diseases, mental health and behavioural disorders, violence and injuries have the potential to overwhelm health-care systems and cause significant social and economic hardship for individuals, families and communities, especially in the countries and groups least able to afford the health-care costs they engender.
- <u>Scaling up of services for chronic noncommunicable conditions, mental disorders and violence and injuries is urgently needed to respond to the large treatment gap that currently exists.</u>
- Prevention is an essential component of national plans for social and economic development as it leads to improvements in population health and a reduction in inequalities.
- Risk-factor prevention is the most cost-effective approach that low- and middle-income countries can adopt to control <u>the</u> adverse health and social outcomes attributable to <u>these</u> diseases.

STRATEGIC APPROACHES

Tackling chronic noncommunicable conditions, mental disorders, violence and injuries and visual impairment will need to be made a priority for health and for development at both national and international levels. A comprehensive public health approach that includes the fostering of multisectoral collaboration and innovation is essential. Member States should develop strengthened and coordinated responses to chronic noncommunicable diseases, mental disorders and promotion of mental health, and violence and injuries, based on evidence and integrated action. Giving a higher priority to primary prevention, ensuring community participation, and reorienting health systems to provide effective health care for chronic conditions, are critical to successful outcomes in countries.

The Secretariat will focus on:

- placing noncommunicable conditions, mental disorders, violence and injuries and visual impairment higher on the global and national development agendas and integrating their prevention and control into policies across the whole of government;
- establishing and strengthening national policies and plans for the prevention and control of noncommunicable conditions, mental disorders, violence and injuries and visual impairment;
- promoting research into the prevention and control of noncommunicable conditions, mental disorders, violence and injury and visual impairment;
- promoting partnerships for the prevention and control of noncommunicable conditions, mental disorders, violence and injuries and visual impairment;
- monitoring noncommunicable conditions and their determinants, mental disorders, violence and injuries and visual impairment, and evaluating progress at the national, regional and global level.

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

- that a high level of multisectoral cooperation will be sustained between global and national stakeholders, and that it is recognized that multisectoral action is a pre-requisite for success.
- that countries give priority to integrated prevention and management of the conditions, disorders and injuries concerned;
- that it is recognized that countries need to give priority to primary health care over tertiary care when allocating resources.
- that the importance of action at national and local level and synergies between these levels of government is recognized

The risks that could prevent achievement of the strategic objective are:

- that combating the growing threat to health and development posed by chronic noncommunicable conditions, mental and behavioural disorders, violence and injuries continues to be omitted from the high-level development schedule, as set out in the Millennium Development Goals;
- that national programmes for the prevention of noncommunicable diseases, mental disorders, visual impairment, violence and injuries are not given the requisite resources to implement the key policies and interventions.

ORGANIZATION-WIDE EXPECTED RESULTS

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

INDICATORS			
3.1.1 Number of Member States whose health ministries have a focal point or a unit for injuries and violence prevention with its own budget	**3.1.2** *The world report on disability and rehabilitation* published and launched, in response to resolution WHA58.23	**3.1.3** Number of Member States with a mental health budget of more than 1% of the total health budget	**3.1.4** Number of Member States with a unit in the ministry of health or equivalent national health authority, with dedicated staff and budget, for the prevention and control of chronic noncommunicable conditions
BASELINE 2008			
80	No report	140	67
TARGETS TO BE ACHIEVED BY 2009			
110	Draft prepared	150	90
TARGETS TO BE ACHIEVED BY 2011			
TARGETS TO BE ACHIEVED BY 2013			
170	Published in 6 languages	180	160

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
25 837	35 600	20 000

JUSTIFICATION

The resources will be used to raise the profile of, and strengthen commitment for, action to tackle chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities at global, regional and national levels. Resources will also be used to support the creation and initial activities of units in national public health agencies for tackling such conditions. Finally, resources will be used for the elaboration of global tools and the preparation of reports and campaigns that describe the situation and make recommendations for action.

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

INDICATORS			
3.2.1 Number of Member States that have national plans to prevent unintentional injuries or violence	**3.2.2** Number of Member States that have initiated the process of developing a mental health policy or law	**3.2.3** Number of Member States that have adopted a multisectoral national policy on chronic noncommunicable conditions	**3.2.4** Number of Member States that are implementing comprehensive national plans for the prevention of hearing or visual impairment
BASELINE 2008			
40	39	53	67
TARGETS TO BE ACHIEVED BY 2009			
50	48	75	75
TARGETS TO BE ACHIEVED BY 2011			
TARGETS TO BE ACHIEVED BY 2013			
80	60	110	137

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
30 440	31 700	33 000

	JUSTIFICATION
	National plans and policies are essential for coordinated multisectoral responses to chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities. To date, only a few countries have prepared the relevant documents and the resources will therefore be used to support regional and national efforts to develop and begin implementation of national plans.

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

INDICATORS

3.3.1 Number of Member States that have submitted a complete assessment of their national road traffic injury prevention status to WHO during the biennium	**3.3.2** Number of Member States that have a published document containing national data on the prevalence and incidence of disabilities	**3.3.3** Number of low- and middle-income Member States with basic mental health indicators annually reported	**3.3.4** Number of Member States with a national health reporting system and annual reports that include indicators for the four major noncommunicable conditions	**3.3.5** Number of Member States documenting, according to population-based surveys, the burden of hearing or visual impairment
BASELINE 2008				
0	60	80	100	32
TARGETS TO BE ACHIEVED BY 2009				
130	90	100	120	38
TARGETS TO BE ACHIEVED BY 2011				
TARGETS TO BE ACHIEVED BY 2013				
180	140	140	160	50

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
23 987	22 000	35 000

JUSTIFICATION

Resources will be used to support countries 'and regions' efforts to improve documentation of the public health impact and costs of chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities. More specifically, the resources will be used to set up data collection systems, and support data analysis and dissemination. Resources will also be used to monitor and provide feedback on global trends.

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

INDICATORS

3.4.1 Availability of evidence-based guidance on the effectiveness of interventions for the management of selected mental, behavioural or neurological disorders including those due to use of psychoactive substances	**3.4.2** Availability of evidence-based guidance or guidelines on the effectiveness or cost-effectiveness of interventions for the prevention and management of chronic noncommunicable conditions
BASELINE 2008	
None published and disseminated	2 published and disseminated
TARGETS TO BE ACHIEVED BY 2009	
Published and disseminated for 4 interventions	2 published and disseminated

	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	Published and disseminated for 12 interventions	6 published and disseminated	
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	23 700	21 700	30 000
	JUSTIFICATION		
	Resources will be used to support further research in low- and middle-income countries on the cost-effectiveness of interventions. This will include training and workshops to refine methodology, studies, and compilation of results at national, regional and global levels, including through documents on best practices and focused dissemination strategies. Resources will also be used to provide policy-makers at country level with information and support their use of such information for priority-setting.		

3.5 Guidance and support provided to Member States for the preparation and implementation of multisectoral, population-wide programmes to promote mental health and to prevent mental and behavioural disorders, violence and injuries, together with hearing and visual impairment, including blindness.	**INDICATORS**		
	3.5.1 Number of guidelines published and widely disseminated on multisectoral interventions to prevent violence and unintentional injuries	**3.5.2** Number of Member States that have initiated community-based projects during the biennium to reduce suicides	**3.5.3** Number of Member States implementing strategies recommended by WHO for the prevention of hearing or visual impairment
	BASELINE 2008		
	4	0	67
	TARGETS TO BE ACHIEVED BY 2009		
	10	17	75
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	18	37	137
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	21 476	21 600	69 000
	JUSTIFICATION		
	Resources will be used to support the implementation of prevention programmes at local, national and regional levels, including provision of the necessary training and workshops. Resources will also be used for global and regional guidelines and documents on best practices, and for global coordination and monitoring of country experiences and lessons learnt.		

3.6 Guidance and support provided to Member States to improve the ability of their health and social systems to prevent and manage chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities together with visual impairment, including blindness.	**INDICATORS**				
	3.6.1 Number of Member States that have incorporated trauma-care services for victims of injuries or violence into their health-care systems using WHO trauma-care guidelines	**3.6.2** Number of Member States implementing community-based rehabilitation programmes	**3.6.3** Number of low- and middle-income Member States that have completed an assessment of their mental health systems using the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS)	**3.6.4** Number of low- and middle-income Member States implementing primary health-care strategies for screening and managing cardiovascular risk	**3.6.5** Number of Member States with tobacco cessation support incorporated into primary health care, as defined in the WHO Report on the Global Tobacco Epidemic, 2008: *the MPOWER package*
	BASELINE 2008				
	3	0	48	Precise data on current baseline unavailable	35
	TARGETS TO BE ACHIEVED BY 2009				
	8	10	72	12	37
	TARGETS TO BE ACHIEVED BY 2011				
	TARGETS TO BE ACHIEVED BY 2013				
	20	40	120	60	45

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
32 664	29 200	43 000

JUSTIFICATION

Resources will be used for the provision of documents, training, workshops and direct support for the strengthening of health and rehabilitation services in low- and middle-income countries, in order to ensure that such countries improve their response to chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities.

STRATEGIC OBJECTIVE 4

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

Indicators and targets

- Coverage with skilled care for childhood. Target: 154 countries in which 85% of births or more are attended by skilled birth attendants.
- Maternal mortality ratio. Target: less than 50 countries with maternal mortality ratio above 100 per 100 000 live births
- Under-five mortality rate. Target: at least 154 countries having met or on track to meet Millennium Development Goal Target 5 (reduce by two thirds, between 1990 and 2015, the under-five mortality rate)
- Access to reproductive health services, as measured by unmet need for family planning and contraceptive prevalence rate, adolescent birth rate and antenatal care coverage. Target: at least 154 countries having met or on track to meet their national targets for all four indicators
- Adolescent health, as measured by fertility proportions, HIV prevalence in young people aged 15–24 years, obesity and overweight, tobacco use and injury rate. Target: at least 50 countries having met or on track to meet their national targets for two of the five indicators and showing no deterioration in the three other indicators

All indicators will be disaggregated by age and, where relevant, sex.

ISSUES AND CHALLENGES

This strategic objective is aimed at strengthening the core service components of primary health care and reducing an enormous burden of disease, while intensifying action towards reaching key health-related Millennium Development Goals (especially 4 and 5) and other international commitments such as universal access to sexual and reproductive health care. Globally, the situation is worsening for some markers (e.g., the incidence of sexually transmitted infections and fertility among adolescents) and is stagnating for others (e.g., maternal and neonatal mortality), while for others still progress is very slow (e.g., under-five mortality). The unmet need for contraception and other sexual and reproductive health commodities is vast and growing in many settings. At present, many countries are not on track to achieve the internationally agreed goals and targets.

Political will is flagging and resources are insufficient. Those who are most affected (e.g., poor women and children in developing countries) have limited influence on decision-makers and often cannot access care. Some issues are politically and culturally sensitive and do not draw the attention that they deserve despite the burden they place on public health. Efforts to improve the quality of necessary health care and to increase coverage are insufficient. Competing health priorities, vertical programme and

Lessons learnt

- The interventions that need to be scaled up are cost effective and can be so expanded even in resource-constrained settings, when sufficient attention is placed on developing an enabling policy environment and strengthening health systems, with a focus on human resources.
- The programmes concerned contribute to reducing inequities because they reach out to the most vulnerable and marginalized populations and serve as a critical entry point and platform for other key public health programmes.
- WHO is expected to lead work on defining strategic and technical approaches to attaining the Millennium Development Goals 4 and 5 and securing international commitments related to reproductive health, and should continue advocating for increased investment in these areas.

disease-oriented approaches and lack of coordination between governments and development partners result in programme fragmentation, missed opportunities and an inefficient use of the limited resources that are currently available. Lack of attention to gender inequality and health inequities undermine ongoing efforts to decrease mortality and morbidity globally. This pattern can be changed through concerted action by all involved.

Technical knowledge and programme experience indicate that effective interventions exist for most of the health problems covered by this strategic objective and that basic interventions are feasible and affordable even in resource-constrained settings. The Health Assembly set out agreed actions in resoluton WHA58.31 on working towards universal coverage of maternal, newborn and child health interventions. To this end, adopting a life-course approach that recognizes the influence of early life events and intergenerational factors on future health outcomes will serve to bridge gaps in, and build synergies between, programme areas while providing support to implementation of resolution WHA58.16 on strengthening active and healthy ageing.

Maternal and child health services, and some other reproductive health services, have long served as the backbone of primary health care and a platform for other health programmes, especially for poor and marginalized populations; but they are now overburdened, overstretched and under-resourced. Scaling-up implies the strengthening of a health system that maintains a suitable infrastructure, provides a reliable supply of essential medicines and commodities, operates functional referral systems, and retains competent and well-motivated health workers.

Lessons learnt

- Effective partnerships of all stakeholders at national, regional and international levels are crucial to avoiding duplication of effort and fragmentation of programmes and to increasing and sustaining momentum towards reaching internationally agreed goals.

STRATEGIC APPROACHES

Approaches to achieving this strategic objective will require a country-led planning and implementation process for scaling up towards universal access to, and coverage by, maternal, newborn, child, adolescent, sexual and reproductive health care, while reducing gender inequality and health inequities, which fuel the high levels of mortality and morbidity.

Programmes and interventions must be integrated and harmonized at the service-delivery level. A continuum of care must be ensured that runs through the life course and spans the home, the community and different levels of the health system. These activities need to occur within the broader framework for strengthening health systems in order to ensure adequate and equitable financing and delivery of good-quality health-support services, with priority given to marginalized and underserved groups. Of particular relevance to all the strategic approaches is the need to resolve the crisis in human resources for health.

The Secretariat will focus on:

- providing technical guidance for the formulation and implementation of effective, evidence-based policies and interventions, aiming for universal access to care, with due attention to reducing gender inequality and health inequities;
- building countries' capacity for service delivery, with particular attention to strengthening human resources for health, and the provision and rational use of essential medicines, safe blood, health technologies and commodities;
- aligning the technical content of programmes and creating synergy between programme areas (including nutrition, HIV/AIDS, tuberculosis and malaria), with attention paid to the specific needs of all age groups, while ensuring a continuum of care at all stages of life from the home to the first-level health facility and referral facilities;
- encouraging the necessary research and development of technologies and interventions, while providing the necessary evidence on determinants, causes and the effectiveness of the programmes;

Community-based interventions also have to be promoted in order to increase the demand for services and to support appropriate care in the home across the life course. The different roles and needs of women and men should be given due attention in order to optimize health outcomes. The sexual health of women and men outside the reproductive process and beyond reproductive age will also receive attention.

In addition, it will be necessary to design, implement and evaluate policies and programmes that promote healthy and active ageing and the highest attainable standard of health and well-being for older citizens.

Member States and partners must commit resources and prioritize national action, with intensified advocacy and the mobilization of all partners around one concrete plan at the country level. The Secretariat will intensify its technical support to countries accordingly. The workplan and budget assume that most growth and most resources will be applied at the country level, with support from the regional offices.

The Secretariat will focus on:

- contributing to countries' monitoring of their health situation by age and sex and assessment of progress towards internationally agreed goals and targets relevant to this objective, and monitoring and evaluating programmes to ensure optimal coverage with effective services;
- working through partnerships in order to mobilize political leadership and resources for improving sexual and reproductive, maternal, newborn, child and adolescent health, while working towards healthy ageing.

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie attainment of this strategic objective:

- that health systems will be strengthened overall, with the development and maintenance of a suitable infrastructure, a reliable supply of essential medicines and commodities, functional referral systems and a competent and well-motivated health workforce;
- that international and national actions will be undertaken to deal with the crisis affecting human resources for health;
- that key processes will be pursued, such as the improved harmonization of the work of bodies of the United Nations system at the country level and the integration of health issues into national planning and implementation instruments – for instance, poverty-reduction strategy papers and medium-term expenditure frameworks;
- that the potential for raising new resources for WHO's work in these areas will be realized. The considerable political interest in making progress towards the Millennium Development Goals is likely to increase with the support of global partnerships and initiatives, including the Partnership on Maternal, Newborn and Child Health, as 2015 approaches.

The following risks have been identified that may hinder achievement of this strategic objective:

- the continued spread of HIV, setbacks in malaria control and, in some countries, increasing poverty, natural crises, political instability and food insecurity may reverse the direction of some indicators.

ORGANIZATION-WIDE EXPECTED RESULTS

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

INDICATORS

4.1.1 Number of targeted Member States that have an integrated policy on universal access to effective interventions for improving maternal, newborn and child health	**4.1.2** Number of Member States that have developed, with WHO support, a policy on achieving universal access to sexual and reproductive health
BASELINE 2008	
10	20
TARGETS TO BE ACHIEVED BY 2009	
20	30
TARGETS TO BE ACHIEVED BY 2011	
40	40
TARGETS TO BE ACHIEVED BY 2013	
68	50

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
36 032	38 100	75 000

JUSTIFICATION

Achievement of targets will require: advocacy and coordination of effective international efforts and the strengthening of collaboration with partners (e.g., through the Maternal Newborn and Child Health Partnership); promotion of key initiatives and approved actions such as the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health, the Global Strategy for the Prevention and Control of Sexually Transmitted Infections, the strategy for child and adolescent health and development, the Global Strategy for Infant and Young Child Feeding, the integrated management of pregnancy and childbirth, the integrated management of childhood illness, and the Child Health Policy Initiative; promotion of national policies and laws that conform to international human-rights norms and standards and that will help to remove inequities; strengthening of health systems, with particular attention paid to human resources and the provision and rational use of essential medicines, safe blood, health technologies and commodities; stronger links between maternal and child health services and other programmes (including those for nutrition, HIV infection, tuberculosis and malaria); and contribution to health management systems for monitoring progress towards national targets and benchmarks relevant to Millennium Development Goals 4 and 5 and sexual and reproductive health goals.

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

INDICATORS

4.2.1 Number of research centres that have received an initial grant for comprehensive institutional development and support	**4.2.2** Number of completed studies on priority issues that have been supported by WHO	**4.2.3** Number of new or updated systematic reviews on best practices, policies and standards of care for improving maternal, newborn, child and adolescent health, promoting active and healthy ageing or improving sexual and reproductive health
BASELINE 2008		
None	None	None
TARGETS TO BE ACHIEVED BY 2009		
8	16	20
TARGETS TO BE ACHIEVED BY 2011		
16	32	40

	TARGETS TO BE ACHIEVED BY 2013
	24 / 48 / 60
	RESOURCES (US$ THOUSAND)
	Budget 2008–2009: 72 497 / Proposed budget 2010–2011: 68 300 / Estimates 2012–2013: 80 000
	JUSTIFICATION
	Country-led identification of research priorities and opportunities for strengthening national research capacity will have to be given greater attention, and the setting of those research priorities, done in close consultation with national research partners and other stakeholders, will have to be improved. Support will be needed for use of research findings in informing policies and programmes.

4.3 Guidelines, approaches and tools for improving maternal care applied at the country level, including technical support provided to Member States for intensified action to ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods, particularly for poor and disadvantaged populations, with progress monitored.	**INDICATORS**
	4.3.1 Number of Member States implementing strategies for increasing coverage with skilled care for childbirth
	BASELINE 2008
	10
	TARGETS TO BE ACHIEVED BY 2009
	25
	TARGETS TO BE ACHIEVED BY 2011
	50
	TARGETS TO BE ACHIEVED BY 2013
	75
	RESOURCES (US$ THOUSAND)
	Budget 2008–2009: 65 389 / Proposed budget 2010–2011: 70 800 / Estimates 2012–2013: 130 000
	JUSTIFICATION
	Attention needs to be paid to strengthening human resources capacity, providing a supportive environment to ensure skilled care for every birth, and ensuring a continuum of care between communities and facilities, with referral care at all times in particular for marginalized populations and communities in order to enhance their participation in designing approaches that improve access to essential health services and referral care. Further, attainment of these results will need monitoring and auditing systems that identify maternal deaths and detect failures of the system to meet needs, especially those of marginalized and underserved populations.

4.4 Guidelines, approaches and tools for improving neonatal survival and health applied at country level, with technical support provided to Member States for intensified action towards universal coverage, effective interventions and monitoring of progress.	**INDICATORS**
	4.4.1 Number of Member States implementing strategies for increasing coverage with interventions for neonatal survival and health
	BASELINE 2008
	20
	TARGETS TO BE ACHIEVED BY 2009
	40
	TARGETS TO BE ACHIEVED BY 2011
	55

	TARGETS TO BE ACHIEVED BY 2013		
	75		
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	50 790	31.3	115 000
	JUSTIFICATION		
	Achievement of this expected result will require a continuum of care between maternal, newborn and child health services and strengthened links between these and other programmes such as immunization, family planning, nutrition, HIV/AIDS, syphilis elimination and malaria control. Furthermore, it will need community involvement and promotion of contact between mothers, their families and health workers, a continuum of care between communities and health facilities, provision of suitable facilities for maternal and newborn care at community and primary-care levels, especially for low birth-weight infants and systems for monitoring trends in neonatal survival, disaggregated by sex, that allow the detection of subpopulations at high risk.		

4.5 Guidelines, approaches and tools for improving child health and development applied at the country level, with technical support provided to Member States for intensified action towards universal coverage of the population with effective interventions and for monitoring progress, taking into consideration international and human-rights norms and standards, notably those stipulated in the Convention on the Rights of the Child.	**INDICATORS**		
	4.5.1 Number of Member States implementing strategies for increasing coverage with child health and development interventions	**4.5.2** Number of Member States that have expanded coverage of the integrated management of childhood illness to more than 75% of target districts	
	BASELINE 2008		
	20	10	
	TARGETS TO BE ACHIEVED BY 2009		
	40	30	
	TARGETS TO BE ACHIEVED BY 2011		
	40	45	
	TARGETS TO BE ACHIEVED BY 2013		
	75	60	
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	41 776	58 400	93 000
	JUSTIFICATION		
	Achievement of this expected result will depend on the following: a continuum of care from mothers and newborns to children, and between different levels of the health system; capacity building at all levels; links with work on addressing the underlying social, environmental and behavioural determinants of ill-health and poor nutrition; promotion of child development and healthy lifestyles; enhanced building of community capacity and involvement in support of the integrated management of childhood illness; and systems for monitoring trends in child survival, disaggregated by age and sex, that allow the detection of subpopulations at high risk.		

4.6 Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, and for the scaling up of a package of prevention,	**INDICATORS**
	4.6.1 Number of Member States with a functioning adolescent health and development programme[1]
	BASELINE 2008
	30
	TARGETS TO BE ACHIEVED BY 2009
	50
	TARGETS TO BE ACHIEVED BY 2011
	75

treatment and care interventions in accordance with established standards.	**TARGETS TO BE ACHIEVED BY 2013**		
	100		
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	34 632	31 200	74 000
	JUSTIFICATION		
	Achievement of this expected result will depend on capacity being built at the country level for collecting and disseminating the data necessary for programme implementation and for health services, with the participation of young people, the engagement of community structures and a focus on particularly vulnerable groups and settings, in order to respond to the priority health needs of adolescents and to increase their access to services. Moreover, the policy environment will need to be supportive in order to ensure that the health sector provides evidence on effective interventions and examples of good practice. Systems will be needed to monitor trends in adolescent health and development, with data disaggregated by age and sex, and to allow the detection of subpopulations at high risk.		

[1] A country with "an adolescent health and development programme" is defined as one that has officially established a programme focusing on the health of adolescents or young people, whether a stand-alone programme or a clearly-demarcated component of a health issue-specific programme such as the HIV programme. To be identified as "functioning", the programme should have in place (a) a national-level plan of action, (b) a budget for activities, and (c) a record of activities undertaken during the past year.

4.7 Guidelines, approaches and tools made available, with provision of technical support to Member States for accelerated action towards implementing the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health, with particular emphasis on ensuring equitable access to good-quality sexual and reproductive health services, particularly in areas of unmet need, and with respect for human rights as they relate to sexual and reproductive health.	**INDICATORS**		
	4.7.1 Number of Member States implementing the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health agreed at the 1994 International Conference on Population and Development (ICPD), its five-year review (ICPD+5), the Millennium Summit and the United Nations General Assembly in 2007	**4.7.2** Number of targeted Member States having reviewed their existing national laws, regulations or policies relating to sexual and reproductive health	
	BASELINE 2008		
	20	3	
	TARGETS TO BE ACHIEVED BY 2009		
	30	8	
	TARGETS TO BE ACHIEVED BY 2011		
	40	12	
	TARGETS TO BE ACHIEVED BY 2013		
	50	15	
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	48 064	48 300	113 000
	JUSTIFICATION		
	Achievement of this result will depend on capacity being built at the country level for collecting, analysing and disseminating the data necessary for programme implementation; stronger links between sexual and reproductive health services and other health programmes, such as those on HIV/AIDS and nutrition; and monitoring and evaluation of sexual and reproductive health programmes within and outside the health system, along with the establishment of accountability mechanisms.		

<table>
<tr><td rowspan="14">4.8 Guidelines, approaches, tools, and technical assistance provided to Member States for increased advocacy for consideration of ageing as a public health issue, for the development and implementation of policies and programmes aiming at maintaining maximum functional capacity throughout the life course and for the training of health-care providers in approaches that ensure healthy ageing.</td><td colspan="3">INDICATORS</td></tr>
<tr><td colspan="3">4.8.1 Number of Member States with a functioning active healthy ageing programme consistent with WHA58.16 “Strengthening active and healthy ageing”</td></tr>
<tr><td colspan="3">BASELINE 2008</td></tr>
<tr><td colspan="3">None</td></tr>
<tr><td colspan="3">TARGETS TO BE ACHIEVED BY 2009</td></tr>
<tr><td colspan="3">15</td></tr>
<tr><td colspan="3">TARGETS TO BE ACHIEVED BY 2011</td></tr>
<tr><td colspan="3">20</td></tr>
<tr><td colspan="3">TARGETS TO BE ACHIEVED BY 2013</td></tr>
<tr><td colspan="3">25</td></tr>
<tr><td colspan="3">RESOURCES (US$ THOUSAND)</td></tr>
<tr><td>Budget 2008–2009</td><td>Proposed budget 2010–2011</td><td>Estimates 2012–2013</td></tr>
<tr><td>10 653</td><td>7 800</td><td>22 000</td></tr>
<tr><td colspan="3">JUSTIFICATION
Achievement of this expected result will depend on building the capacity of health services to support active and healthy ageing; support for the establishment of age-friendly primary health-care centres; ensuring the participation of older persons in the national policy development and programme planning process, with an emphasis on their contribution to society; and support for multisectoral initiatives that promote active ageing, such as “age-friendly cities”.</td></tr>
</table>

STRATEGIC OBJECTIVE 5

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

Indicators and targets

- Crude daily mortality. Target: daily mortality of populations affected by major emergencies maintained below 1 per 10 000 during initial emergency response phase
- Access to functioning health services. Target: 90% of affected populations with levels of access similar to, or better than, pre-emergency conditions within one year
- Weight for height. Target: less than 10% of the affected population with a weight-for-height measurement that is below 80% of the standard value.

ISSUES AND CHALLENGES

This strategic objective is designed to contribute to human security by minimizing the negative effect on health of emergencies, disasters, conflicts and other humanitarian crises and by responding to the health and nutrition needs of vulnerable populations affected by such events.

Each year, one Member State in five experiences a crisis that endangers the health of its people. According to the United Nations International Strategy for Disaster Reduction, 2005 saw an 18% rise in the number of natural disasters. A series of political and social crises created almost 25 million internally displaced people and more than nine million refugees worldwide.

Emergencies place sudden and intense demands on health systems, whose weaknesses may be exposed as a result. They can also hinder economic activity and development. In countries with weak health infrastructures, responding to an emergency can disrupt routine health services and humanitarian programmes for many months.

STRATEGIC APPROACHES

As part of the United Nations humanitarian reform process, WHO has been asked to ensure the coordination, effectiveness and efficiency of activities concerning preparedness, response and recovery in relation to health action in crises. WHO leads the United Nations Inter-Agency Standing Committee Health Cluster.

Health-sector involvement in emergency and humanitarian action should be comprehensive. Emergency response needs to be improved in a wide range of areas, including mass-casualty management; water, sanitation and hygiene; nutrition; communicable and noncommunicable diseases;

Lessons learnt

- Preparedness is a prerequisite for effective emergency response. Building national capacity to manage risk and reduce vulnerability calls for the following: updated policies and legislation, appropriate structures, information, plans and procedures, resources and partnerships.
- Health-sector involvement in emergency and humanitarian action should be comprehensive. The response must be improved in several areas, including management of mass casualties, nutrition, maternal and newborn health, mental health, pharmaceutical supplies, logistics, and restoration of health infrastructure. Strong technical guidance and leadership and better coordination will be needed to ensure that there are no shortcomings in those areas in future emergencies.
- The private sector and the armed forces are frequently involved in disaster-response operations. Criteria and procedures should be agreed for collaboration involving non-local personnel.
- The right people with the right skills need to be found immediately after a disaster; the faster the response, the better the outcome. It is important to build capacity and compile a roster of appropriately trained experts on call.
- Recovering from the disastrous effects of major and complex emergencies and crises takes much longer than perceived by the international community; the impact of such calamities on health services and on the health status of populations persists for years.

maternal and newborn health; mental health; pharmaceuticals; health technologies; logistics; health information services; and restoration of the health infrastructure.

Ensuring funding for health-related aspects of emergency preparedness and response is a major concern. In this regard it is essential for needs analysis and project formulation to be connected with wider processes within both the United Nations system and WHO; partnerships and coordination are therefore needed in order to attract a greater and more predictable flow of funds, especially for dealing with chronic complex emergencies.

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

- that national health systems are strong, well designed and adequately funded. Investing in in-country response programmes is therefore crucial to WHO's work in these fields. Providing health-related action in crises and mounting an effective response to health emergencies are integral parts of WHO's mandated work.

The risks that could prevent achievement of the strategic objective are:

- that work in the area of emergency preparedness and response may be wrongly perceived as an additional responsibility that is secondary to the Organization's regular normative and developmental work;
- that insufficient work will be done to ensure that mechanisms, preparedness and competencies across WHO permit effective and expeditious work in emergency situations;
- that funding of the core functions needed for emergency preparedness and response will not be sufficient to enable the Organization to fulfil its mandate as leader of the United Nations Inter-Agency Standing Committee Health Cluster.

The Secretariat will focus on:

- supporting Member States' efforts to build capacity in the field of emergency preparedness and response through multisectoral, multidisciplinary and all-hazard approaches;
- building and maintaining national and international operational capacity for rapid response and for leading coordinated action involving multiple stakeholders during crises that include environmental and food-safety public-health emergencies, disasters and conflicts;
- developing the necessary knowledge bases and competencies in order to prepare for and respond to emergencies;
- developing partnerships and coordination mechanisms with governments and civil society as well as with networks of collaborating and other centres of excellence in order to ensure timely and effective interventions when needed;
- developing technical and operational capacities across WHO in support of countries in crises, particularly for conducting health assessments, coordinating health action, tackling shortcomings, providing guidance and monitoring the performance of humanitarian action in relation to the health and nutrition of affected populations;
- harnessing the wide array of skills available across the Organization in response to emergencies, including in the areas of mental health, nutrition, water and sanitation, food safety, medicines, violence and injury prevention, mass-casualty management, communicable diseases, and maternal and child health.

ORGANIZATION-WIDE EXPECTED RESULTS

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

INDICATORS

5.1.1 Proportion of Member States with national emergency preparedness plans that cover multiple hazards	**5.1.2** Number of Member States implementing programmes for reducing the vulnerability of health facilities to the effects of natural disasters
BASELINE 2008	
25%	20
TARGETS TO BE ACHIEVED BY 2009	
60%	40
TARGETS TO BE ACHIEVED BY 2011	
TARGETS TO BE ACHIEVED BY 2013	
70%	60

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
45 614	49 900	51 000

JUSTIFICATION

Efforts will be intensified in the biennium 2010–2011 and again in the biennium 2012–2013.

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

INDICATORS

5.2.1 Operational platforms for surge capacity in place in regions and headquarters ready to be activated in acute-onset emergencies	**5.2.2** Number of global and regional training programmes on public health operations in emergency response
BASELINE 2008	
50%	5
TARGETS TO BE ACHIEVED BY 2009	
100%	16
TARGETS TO BE ACHIEVED BY 2011	
TARGETS TO BE ACHIEVED BY 2013	
100%	20

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
67 796	18 500	74 000

JUSTIFICATION

Efforts will be intensified in the biennium 2010–2011 and again in the biennium 2012–2013.

5.3 Norms and standards developed and capacity built to enable Member States to assess needs and for planning interventions during the transition and recovery phases of conflicts and disasters.	**INDICATORS**		
	5.3.1 Number of humanitarian action plans with a health component formulated for ongoing emergencies	**5.3.2** Number of countries in transition that have formulated a recovery strategy for health	
	BASELINE 2008		
	6	8	
	TARGETS TO BE ACHIEVED BY 2009		
	12	25	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	18	20	
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	46 465	19 900	65 000
	JUSTIFICATION		
	Efforts will be intensified in the biennium 2010–2011 and again in the biennium 2012–2013.		

5.4 Coordinated technical support provided to Member States for communicable disease control in natural disaster and conflict situations.	**INDICATORS**		
	5.4.1 Proportion of acute natural disasters or conflicts where communicable disease-control interventions have been implemented, including activation of early-warning systems and disease-surveillance for emergencies		
	BASELINE 2008		
	60%		
	TARGETS TO BE ACHIEVED BY 2009		
	100%		
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	100%		
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	22 948	13 200	53 000
	JUSTIFICATION		
	Efforts will be intensified in the biennium 2010–2011 and again in the biennium 2012–2013.		

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

INDICATORS	
5.5.1 Proportion of Member States with national plans for preparedness, and alert and response activities in respect of chemical, radiological and environmental health emergencies	**5.5.2** Number of Member States with focal points for the International Food Safety Authorities Network and for the environmental health emergencies network
BASELINE 2008	
30%	50
TARGETS TO BE ACHIEVED BY 2009	
60%	75
TARGETS TO BE ACHIEVED BY 2011	
TARGETS TO BE ACHIEVED BY 2013	
70%	100

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
19 190	11 500	18 000

JUSTIFICATION

Efforts will be intensified in the biennium 2010–2011 and again in the biennium 2012–2013.

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

INDICATORS	
5.6.1 Proportion of Member States affected by acute-onset emergencies and those with ongoing emergencies and a humanitarian coordinator in which the Inter-Agency Standing Committee Humanitarian Health Cluster is operational in line with IASC cluster standards in line with IASC cluster standards	**5.6.2** Proportion of Member States with ongoing emergencies and a humanitarian coordinator having a sustainable WHO technical presence covering emergency preparedness, response and recovery
BASELINE 2008	
30%	30%
TARGETS TO BE ACHIEVED BY 2009	
60%	60%
TARGETS TO BE ACHIEVED BY 2011	
TARGETS TO BE ACHIEVED BY 2013	
100%	90%

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
16 400	13 700	17 000

JUSTIFICATION

Efforts will be intensified in the biennium 2010–2011 and again in the biennium 2012–2013.

<table>
<tr><td rowspan="14">**5.7** Acute, ongoing and recovery operations implemented in a timely and effective manner.</td><td colspan="2">**INDICATORS**</td></tr>
<tr><td>**5.7.1** Proportion of acute-onset emergencies for which WHO mobilizes coordinated national and international action</td><td>**5.7.2** Proportion of interventions for chronic emergencies implemented in accordance with humanitarian action plans' health components</td></tr>
<tr><td colspan="2">**BASELINE 2008**</td></tr>
<tr><td>60%</td><td></td></tr>
<tr><td colspan="2">**TARGETS TO BE ACHIEVED BY 2009**</td></tr>
<tr><td>80%</td><td>100%</td></tr>
<tr><td colspan="2">**TARGETS TO BE ACHIEVED BY 2011**</td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">**TARGETS TO BE ACHIEVED BY 2013**</td></tr>
<tr><td>100%</td><td>100%</td></tr>
<tr><td colspan="2">**RESOURCES** (US$ THOUSAND)</td></tr>
<tr><td colspan="2">Budget 2008–2009 / Proposed budget 2010–2011 / Estimates 2012–2013
  / - / </td></tr>
<tr><td colspan="2">**JUSTIFICATION**</td></tr>
<tr><td colspan="2"></td></tr>
</table>

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	-	

STRATEGIC OBJECTIVE 6

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

Indicators and targets

- Proportion of Member States reporting a 10% reduction in the prevalence rate of tobacco use. Target: 50% of Member States reporting a 10% reduction by the end of 2013
- Number of Member States with a stabilized or reduced level of harmful use of alcohol. Target: 10% increase in number of Member States reporting a stabilized or reduced level by the end of 2013
- Number of Member States that have reduced prevalence of obese adults. Target: Three Member States having a stabilized or reduced prevalence of obese adults by the end of 2013, compared with levels during 2007-2010.

ISSUES AND CHALLENGES

The six major risk factors that this strategic objective aims to tackle are responsible worldwide for more than 60% of mortality and at least 50% of morbidity. They have important gender dimensions and particularly affect poor populations in low- and middle-income countries. Although emphasis has been placed on treating the adverse effects of these risk factors, much less attention has been devoted to prevention and gender-responsive ways of dealing effectively with these health determinants, and to reaching low socioeconomic groups in the population.

Tobacco use is a risk factor for six of the eight leading causes of death globally. Tobacco use is the leading cause of preventable deaths worldwide, with at least 70% of tobacco-attributable deaths occurring in developing countries. Tobacco use and poverty are closely linked and prevalence rates are higher among the poor. Fortunately, measures that are both successful and cost effective are available for reducing tobacco use, yet only 5% of the world's population is completely covered by any one of the core demand-reducing policies. The WHO Framework Convention on Tobacco Control is an evidence-based treaty designed to help to reduce the burden of disease and death caused by tobacco use.

Every year, alcohol consumption is linked to 2.3 million deaths globally and 60 million years of life lost. In developing countries with low overall mortality, alcohol use is the leading risk factor, accounting for 6.2% of the total burden of disease. In a growing number of countries, injecting drug use is the driving force behind the rapid spread of HIV infection. Despite evidence of the substantial burden on health and society arising from alcohol and other

Lessons learnt

- Preventing or reducing risk factors is an essential component of national, social and economic development plans as it improves the health of the population in general and reduces inequalities between groups.
- Traditional public health approaches are not sufficient to deal with the problems caused by these risk factors and there is a need for creative ways of working that involve government agencies, civil society, the private sector and other partners.
- The public health problems caused by these risk factors have the potential to overwhelm health-care systems, causing significant social and economic hardship for individuals, families and communities. This is particularly true for the countries and groups least able to afford the health-care costs that such problems engender.
- Health-promotion programmes have been shown to be cost effective; these include, educational strategies designed to reduce the demand for salt in processed foods, and advertising bans and price increases in the case of tobacco control.

psychoactive substance use, there are limited resources at WHO and in countries for preventing and treating substance use disorders, even though US$ 1 invested in treatment produces at least US$ 7 of savings in health and social costs.

Globally, 17% of the population are estimated to be physically inactive and an additional 41% to be insufficiently active to benefit their health. It has been estimated that the resultant annual death toll is 1.9 million.[1] Each year at least 2.7 million people die as a result of low fruit and vegetable consumption. In addition, 2.6 million people die as a result of obesity.

WHO's Global Strategy on Diet, Physical Activity and Health, endorsed by Member States in 2004[2], provides all stakeholders with recommendations and policy options for tackling risk factors related to unhealthy diets and physical inactivity. As many of the determinants of healthy diets and physical activity lie outside the health sector, a major challenge for WHO and stakeholders is to facilitate multisectoral actions in order to scale up implementation of the Global Strategy at country level.

Unsafe sexual behaviour significantly increases the burden of disease through unintended pregnancy, sexually transmitted infections (including HIV), and other social, emotional and physical consequences that have been seriously underestimated. WHO estimates that unsafe sex is the second most important global risk factor to health in countries with high mortality rates. Each year, 80 million women have an unwanted pregnancy, 46 million opt for termination, and 340 million new cases of sexually transmitted infections and five million new HIV infections are reported. Risky behaviour does not often occur in isolation but as part of a cluster, for example, hazardous use of alcohol and other drugs and unsafe sex frequently go together. It is important to understand the underlying social and environmental determinants of risky behaviour and to recognize factors that create vulnerability to individual risks, such as social and cultural determinants, including gender, low education, poverty, and other inequities. For that reason, WHO recognizes the need for a comprehensive, integrated approach to health promotion, together with effective preventive and protective strategies that build the resilience of individuals and strengthen community capacity for improving health.

In addition, global estimates show that three billion people, or half of humanity, now live in urban areas. As a determinant of the major risk factors, urbanization has both positive and negative implications for health. With an increasing number of people living in towns and cities, where the impact of social, economic, environmental and technological change is greatest, new public health issues and problems are emerging.

Lessons learnt

- Preventing and controlling risk factors is the most cost-effective approach that low- and middle-income countries can adopt for tackling the adverse health and social outcomes with which these risk factors are associated.
- Evidence from multilevel research shows that initiatives empowering women, men and communities to alter unhealthy behaviours can lead to improved health; these are separate interventions and should be recognized as such. It demonstrates that empowerment is a viable public health strategy. The integration of empowering interventions for women into the economic, educational and political sectors has had a profound impact on the quality of life, autonomy and authority of women, and has led to policy changes and improved child and family health.

The Secretariat will focus on:

- providing global leadership, coordination, communication, collaboration and advocacy for health promotion in order to improve health, reduce health inequalities, control major risk factors and contribute to national development objectives;
- providing countries with guidance for evidence-based ethical policies, strategies and technical health matters, together with support for the development and maintenance of national systems for surveillance including appropriate mechanisms for disaggregation of data by sex and age, monitoring and evaluation, especially in countries with high burdens of lifestyle-related conditions and to those in which the burdens are increasing;
- encouraging increased investment at all levels and building capacity within the Secretariat, especially in regional and country offices, to meet WHO's needs in relation to health promotion, and prevention or reduction of the occurrence of risk factors associated with lifestyle;

[1] *The world health report 2002. Reducing risks, promoting healthy life.* Geneva, World Health Organization, 2002.
[2] *Resolution WHA57.17.*

The global burden of death, disease and disability due to conditions associated with the major risk factors is substantial. Nevertheless, there is a continuing lack of awareness of the differential impacts of this burden on women and men, girls and boys, together with an absence of political commitment to vigorously promoting health, and preventing or reducing the occurrence of risk factors. In order to reduce the burden, significant additional investment in financial and human resources is urgently needed at all levels of the Secretariat and in Member States in order to build capacity and strengthen interventions at national and global levels.

STRATEGIC APPROACHES

Taking a gender-responsive, integrated approach to health promotion and preventing or reducing major risk factors will enhance synergies, improve the overall efficiency of interventions and broaden the scope and effectiveness of existing vertical approaches.

In countries, it is essential to strengthen institutions and build national capacities for surveillance (including appropriate disaggregation by sex and age**,** and where possible, by socioeconomic group) and prevention or reduction in respect of the common risk factors and the health conditions with which they are associated. Furthermore, strong leadership and stewardship by health ministries are necessary to ensure that all sectors of society participate effectively. Action at the multisectoral level is vital because the main determinants of the major risk factors lie outside the health sector. The process of urbanization (in all its aspects: physical, social and economic) also needs to be supported to ensure that it produces positive health outcomes. The urbanization related determinants need to be effectively addressed in the strategies for risk factor reduction. Therefore, links to environmental health promotion should be established where appropriate (see also strategic objective 8), particularly the promotion of environments supportive to physical activity, for example through cycling and walking.

In the area of health promotion, significant efforts are required: to strengthen leadership and build capacity to take account of increased needs and activities across all relevant health programmes, as well as the recommendations made at the 6th Global Conference on Health Promotion (Bangkok, 7–11 August 2005); to address the determinants of health in the global development agenda, across the whole of government and in communities and civil society; and to make health promotion a requirement for good corporate practice.

In order to ensure lasting success there is a need for comprehensive approaches that use a combination of strategies to resolve policy issues and build capacities at individual, family and community levels.

The Secretariat will focus on:

- supporting countries to build multisectoral national capacities in order to integrate gender and equity perspectives into the mainstream of work on promoting health and preventing lifestyle-related conditions; and to strengthen institutional knowledge and competence in relation to the major risk factors;
- supporting the establishment of multisectoral partnerships and alliances within and among Member States and building international collaboration for the generation and dissemination of research findings;
- leading effective action to overcome policy and structural barriers, build capacity at family and community levels and ensure access to education and information in order to promote safer sexual behaviours and manage the consequences of unsafe sexual behaviours and practices;
- providing direct technical assistance for the implementation of the WHO Framework Convention on Tobacco Control, in collaboration with the Convention Secretariat, including provision of support to strengthen tobacco-control policies as outlined in the *WHO Report on the Global Tobacco Epidemic 2008: the MPOWER package.*

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

- that there is additional investment in financial and human resources to build capacity for health promotion and for preventing risk factors;
- that effective partnerships and multisectoral and multidisciplinary collaborations are established in relation to equitable policies, mechanisms, networks and actions and with the involvement of all stakeholders at city, national, regional and international levels;
- that there is a commitment to comprehensive and integrated policies, plans and programmes addressing common risk factors, together with a recognition that equitable, integrated approaches to preventing major risk factors result in a wide range of health benefits;
- that investment in research, especially to find effective population-based prevention strategies, is increased.

The risks that could prevent achievement of the strategic objective are:

- that working or interacting with industry will expose efforts to the competing interests of the private sector, including the tobacco, alcohol, sugar, processed-food and non-alcoholic drinks industries. Guidelines for appropriate conduct must be followed in all cases and the primacy of public health safeguarded;
- a lack of recognition of the acknowledged importance of action at national and local level, as well as of synergistic action by national and local governments to promote health in all policies;
- that health promotion and prevention efforts with regard to the risk factors may be adversely affected by the low priority afforded to this area and the scarcity of resources allocated to it as a result by the Secretariat and countries. Continued advocacy for increased investment is essential in order to minimize this risk;
- that integrated approaches to prevention or reduction of risk factors may compromise the capacity of both the Secretariat and countries to provide expertise in relation to specific diseases and risk factors. In order to avoid that outcome, adequate resources for integrated approaches, as well as a critical mass of expertise in major areas, must be maintained.

ORGANIZATION-WIDE EXPECTED RESULTS

6.1 Advice and support provided to Member States to build their capacity for health promotion across all relevant programmes, and to establish effective multisectoral and multidisciplinary collaborations for promoting health and preventing or reducing major risk factors.	**INDICATORS**	
	6.1.1 Number of Member States that have evaluated and reported on at least one of the action areas and commitments of the Global Conferences on Health Promotion.	**6.1.2** Number of cities that have implemented healthy urbanization programmes aimed at reducing health inequities
	BASELINE 2008	
	24	6
	TARGETS TO BE ACHIEVED BY 2009	
	30	12
	TARGETS TO BE ACHIEVED BY 2011	
	42	24
	TARGETS TO BE ACHIEVED BY 2013	
	52	48

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
38 879	60 900	66 000

JUSTIFICATION

The 7th Global Conference on Health Promotion, to be held in Africa in 2009, will provide an opportunity to review progress and revise WHO's global health-promotion approach. During 2010-2013, the work will focus on cementing WHO's leadership role in health promotion and ensuring that mechanisms are in place at country level so that policies and strategies are kept up to date. In order to meet these objectives, a significant increase in resources will be required to ensure that developments in global, regional and national health promotion make an effective contribution to reducing the burden of disease and death associated with these major risk factors.

6.2 Guidance and support provided in order to strengthen national systems for surveillance of major risk factors through development and validation of frameworks, tools and operating procedures and their dissemination to Member States where a high or increasing burden of death and disability is attributable to these risk factors.	**INDICATORS**	
	6.2.1 Number of Member States with a functioning national surveillance system for monitoring major risk factors to health among adults based on the WHO STEPwise approach to surveillance	**6.2.2** Number of Member States with a functioning national surveillance system for monitoring major risk factors to health among youth based on the Global school-based student health survey methodology
	BASELINE 2008	
	25	25
	TARGETS TO BE ACHIEVED BY 2009	
	50	50
	TARGETS TO BE ACHIEVED BY 2011	
	60	60
	TARGETS TO BE ACHIEVED BY 2013	
	75	75

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
23 807	14 600	31 000

JUSTIFICATION

Much of the work has already begun, but a substantial number of Member States have yet to implement reliable systems for the surveillance of risk factors and of efforts to control them; many will therefore require WHO's support in the future. Furthermore, Member States that completed surveys previously will require technical support for repeat surveys; additional surveillance tools may also be required. It is expected that the level of effort – and consequently resources – that will be required for development, modification, validation and dissemination of standards and operating procedures will increase significantly.

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

INDICATORS

6.3.1 Number of Member States having comparable adult tobacco prevalence data available from recent national representative surveys, such as the Global Adult Tobacco Survey (GATS) or STEPS	**6.3.2** Number of Member States with smoke-free legislation covering all legislative elements, types of places and institutions as defined in the *WHO Report on the Global Tobacco Epidemic, 2008*	**6.3.3** Number of Member States with bans on tobacco advertising, promotion and sponsorship as defined in the *WHO Report on the Global Tobacco Epidemic, 2008*
BASELINE 2008		
44	16	20
TARGETS TO BE ACHIEVED BY 2009		
50	18	23
TARGETS TO BE ACHIEVED BY 2011		
65	22	30
TARGETS TO BE ACHIEVED BY 2013		
75	26	40

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
38 466	55 200	72 000

JUSTIFICATION

The Secretariat will be working closely with the Conference of the Parties and the Convention Secretariat to provide the necessary support to States Parties as they develop comprehensive tobacco-control policies and programmes and surveillance systems that will allow them to fulfil their obligations under the Convention, and under its future protocols. The Health Assembly, in resolution WHA59.17, called for continued support for and, where appropriate, strengthening of the Secretariat's work.

6.4 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease or death associated with alcohol, drugs and other psychoactive substance use, enabling them to strengthen

INDICATORS

6.4.1 Number of Member States that have developed, with WHO support, strategies, plans and programmes for combating or preventing public health problems caused by alcohol, drugs and other psychoactive substance use	**6.4.2** Number of WHO strategies, guidelines, standards and technical tools developed in order to provide support to Member States in preventing and reducing public health problems caused by alcohol, drugs and other psychoactive substance use
BASELINE 2008	
25	5
TARGETS TO BE ACHIEVED BY 2009	
35	8
TARGETS TO BE ACHIEVED BY 2011	
50	10

institutions in order to combat or prevent the public health problems concerned.	**TARGETS TO BE ACHIEVED BY 2013**		
	60	15	
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	20 978	17 100	33 000
	JUSTIFICATION		
	In order to be credible, the Organization's response to public health problems attributable to use of alcohol, drugs and other psychoactive substances must be commensurate with the burden of disease and death with which such behaviours are associated. Significant additional investment is urgently needed, therefore, for work that includes capacity building and institutional strengthening at all levels of the Secretariat, including WHO collaborating centres, with particular emphasis on regional and country offices for effective responses to Member States' needs, and support for the implementation of relevant resolutions of the Health Assembly. A comprehensive and integrated approach to prevention and reduction efforts in respect of this group of risk factors will be encouraged, but provision of a substantial increase in resources remains a necessity.		

6.5 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed and technical support provided to Member States with a high or increasing burden of disease or death associated with unhealthy diets and physical inactivity, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.	**INDICATORS**		
	6.5.1 Number of Member States that have adopted multisectoral strategies and plans for healthy diets or physical activity, based on the WHO Global Strategy on Diet, Physical Activity and Health	**6.5.2** Number of WHO technical tools that provide support to Member States in promoting healthy diets or physical activity	
	BASELINE 2008		
	29	9	
	TARGETS TO BE ACHIEVED BY 2009		
	50	14	
	TARGETS TO BE ACHIEVED BY 2011		
	65	16	
	TARGETS TO BE ACHIEVED BY 2013		
	75	18	
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	20 347	15 300	31 000
	JUSTIFICATION		
	WHO's guidelines on interactions with external stakeholders will be revised and updated to provide a better reflection of the current environment, especially in relation to the food and the alcoholic and non-alcoholic beverage industries, thus ensuring that public health objectives are highlighted. WHO needs to strengthen its normative work on physical activity, and most of the work related to the revision of guidelines will involve consultations with Member States. Interactions also need to include international and national nongovernmental organizations and community groups.		

<table>
<tr><td rowspan="15">6.6 Evidence-based and ethical policies, strategies, interventions, recommendations, standards and guidelines developed and technical support provided to Member States to promote safer sex and strengthen institutions in order to tackle and manage the social and individual consequences of unsafe sex.</td><td colspan="3">INDICATORS</td></tr>
<tr><td>6.6.1 Number of Member States generating evidence on the determinants or consequences of unsafe sex</td><td colspan="2">6.6.2 Number of Member States generating comparable data on unsafe sex indicators using WHO STEPS surveillance tools</td></tr>
<tr><td colspan="3">BASELINE 2008</td></tr>
<tr><td>4</td><td colspan="2">0</td></tr>
<tr><td colspan="3">TARGETS TO BE ACHIEVED BY 2009</td></tr>
<tr><td>8</td><td colspan="2">2</td></tr>
<tr><td colspan="3">TARGETS TO BE ACHIEVED BY 2011</td></tr>
<tr><td>10</td><td colspan="2">5</td></tr>
<tr><td colspan="3">TARGETS TO BE ACHIEVED BY 2013</td></tr>
<tr><td>12</td><td colspan="2">8</td></tr>
<tr><td colspan="3">RESOURCES (US$ THOUSAND)</td></tr>
<tr><td>Budget 2008–2009</td><td>Proposed budget 2010–2011</td><td>Estimates 2012–2013</td></tr>
<tr><td>18 580</td><td>14 000</td><td>30 000</td></tr>
<tr><td colspan="3">JUSTIFICATION</td></tr>
<tr><td colspan="3">Significant additional resources are required to continue and expand urgently needed interventions to tackle unsafe sex, whose consequences constitute the second most common cause of death and disability in high-mortality countries. The actions required range from generating relevant evidence to providing countries with support to implement policies, strategies and interventions. Investments to achieve this expected result, will also help efforts to reach the goals for other risky behaviours. More resources will be made available for generating and building an evidence base and strengthening WHO's normative role.</td></tr>
</table>

STRATEGIC OBJECTIVE 7

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

Indicators and targets

- Proportion of national health indicators disaggregated by sex and age and at least two other determinants (ethnicity, place of residence, and/or socioeconomic status) and available for exploratory research
- Number of social and economic indicators on conditions favourable to health disaggregated by sex, ethnicity and place of residence (e.g. education levels, agricultural production, infrastructure, housing and employment conditions, criminal or violent events, community development, and household income)
- Number of policies and workplans of priority non-health sectors (e.g. agriculture, energy, education, finance, transport) that have incorporated health targets
- Number of health-related policies and legislation (e.g. national constitutions and health-sector strategies) that explicitly address and incorporate gender equality, human rights and equity in their design and implementation
- Extent to which national development and poverty reduction plans set out ways in which the right to enjoyment of the highest attainable standard of health without discrimination will be progressively realized (explicit responsibilities of stakeholders, targets, time frame, and budget allocation).

ISSUES AND CHALLENGES

Equity in health is an overarching principle of the Organization. In recent decades, gaps in health equity between countries and among social groups within countries have widened, despite medical and technological progress. WHO and other health and development actors have defined tackling of health inequities as a major priority and aim to provide support to countries in more effective action geared to meeting the health needs of vulnerable groups. Meeting this goal will require attending to the social and economic factors that determine people's opportunities for health. An intersectoral approach, though often politically difficult, is indispensable for substantial progress towards health equity. The Millennium Development Goals underscore the deeply interwoven nature of health and economic development processes, the need for coordination among multiple sectors to reach health goals, and the importance of addressing poverty and gender inequality.

This situation raises challenges for ministries of health, which must work in innovative ways to foster intersectoral collaboration on the social and economic determinants of health even as they align key health-sector specific programmes to respond better to the needs of vulnerable populations. Effective means to promote health gains for vulnerable groups include integration into health-sector policies and programmes

Lessons learnt

- The history of intersectoral action for health is not indifferent: as a key component of the Alma-Ata Declaration, it was judged by many to be among the least successful aspects of the Health For All process in the 1980s and 1990s.
- On the other hand, examples of promising innovation in this area exist in WHO, for example, the community-based initiatives in the Eastern Mediterranean Region. Further evaluation is required to assess the potential for expanding these initiatives.
- Policy innovations under way in countries that are partners of the Commission on Social Determinants of Health and the work of the Commission may provide examples of good practice and generate a better understanding of ways to tackle the political challenges connected with action on social determinants.

of equity-enhancing, pro-poor, gender-responsive, ethically sound approaches. Human rights offer a unifying conceptual framework for these strategies and standards by which to evaluate success.

The crucial challenges are, first, to develop sufficient expertise regarding the social and economic determinants of health, gender analysis and actions, and ethics and human rights at global, regional and country levels to be able to provide support to Member States in collecting and acting on relevant data on an intersectoral basis; secondly, to ensure that all levels of the Organization reflect the perspectives of social and economic determinants (including gender and poverty), gender equality, ethics, and human rights in their programmes and normative work; and thirdly, to adopt the correct approach to measuring effects. This final challenge is especially great because results in terms of greater health equity will seldom be rapidly apparent or easily attributed to particular interventions. Distinctive modes of evaluation are required for assessing processes, that is, ways in which policies and interventions are designed, vetted and implemented. One must assess whether the steps taken are known to be effective in bringing about change, rather than measuring health outcomes themselves. The relationship of the health sector as a whole with other parts of government and society is also an important indicator.

Lessons learnt

- Assuring adoption of integrated policies, plans and programmes at national level is made more difficult by the "responsibility gap". Although social and economic determinants concern both government as a whole and the general public, no one actor is accountable for them.
- Success will depend on overcoming the insularity of the policy-making process, and on developing and maintaining effective partnerships that involve a wide range of stakeholders at national, regional and global levels (including organizations of the United Nations system, other international partners, and nongovernmental organizations).

STRATEGIC APPROACHES

The structural determinants of health encompass a country's political, economic and technological context; patterns of social stratification, by differentiating factors such as employment status, income, education, age, gender and ethnicity; the legal system; and public policies in areas other than health. Fostering collaboration across sectors is therefore essential.

Achieving this strategic objective will require policy coherence among all ministries, based on an approach involving government as a whole, that assures the right of everyone to enjoy the highest attainable standard of health as a common goal across sectors and social constituencies in light of a shared responsibility.

National strategies and plans should take into account all forms of social disadvantage and vulnerability that impact on health, and should involve civil society and relevant stakeholders through, for example, community-based initiatives. Principles of human rights and ethics should guide policy making so as to ensure the fairness, responsiveness, accountability, sustainability and coherence of health-related policies and programmes while overcoming social exclusion.

Redressing the root causes of health inequities will need WHO – both Secretariat and Member States – to ensure that the perspectives of gender equality, poverty, ethics and

The Secretariat will focus on:

- providing technical and policy support to Member States to develop and maintain national systems for the collection and analysis of health-related data on a disaggregated basis, and to develop, implement and monitor health policies based on the "whole-government" approach to health;
- ensuring that gender equality, a pro-poor focus, ethics, and human rights are incorporated in the work of the Organization at all levels, including by devising common terminology, tools and advocacy materials; enlarging the knowledge base and implementation capacity; and ensuring coherent strategies;
- using the recommendations of the Commission on Social Determinants of Health to support policy action on the underlying causes of health inequities such as social exclusion, lack of educational and work opportunities as well as inequalities based on gender, age, disability, or ethnicity.

human rights are incorporated into preparation of health guidelines, policy making and programme implementation.

The Secretariat will focus on:

- developing partnerships with other organizations and bodies of the United Nations system and, where appropriate, civil society and the private sector, in order to advance health as a human right and human rights as a tool for improving health and reducing inequities; to address macroeconomic factors relevant to health, including trade; and to support institutions that improve ethical decision-making on health-related policies, programmes, and regulations.

ASSUMPTIONS, RISKS AND OPTIONS

The principal assumptions that underlie achievement of this strategic objective are:

- that in many settings, ministries of health, provided with adequate information and political and technical backing, will be willing and able to take leadership on the broader determinants of health, moving towards a "whole-government" approach to health;
- that throughout all levels of the Organization it will be possible to build sustained support for incorporation of the social determinants of health, gender equality and human rights into technical cooperation and policy dialogue with Member States;
- that in many countries, health programme designers and implementers will be willing and able to incorporate into their programmes strategies that enhance equity, and are pro-poor, gender-responsive, and based on human rights, despite technical and political complications.

The main risks that prevent achieving this strategic objective are:

- lack of effective consensus among partners, including organizations of the United Nations system, other international bodies and nongovernmental organizations on policies and framework for action;
- insufficient investment by national governments for building and deploying adequate skills to ensure that tools to analyse human rights, ethical, economic, gender and poverty aspects are widely and effectively implemented.

ORGANIZATION-WIDE EXPECTED RESULTS

7.1 Significance of social and economic determinants of health recognized throughout the Organization and incorporated into normative work and technical collaboration with Member States and other partners.	**INDICATORS**		
	7.1.1 Number of WHO regions with a regional strategy for addressing social and economic determinants of health as identified in the Report of the Commission on the Social Determinants of Health endorsed by the Director-General		
	BASELINE 2008		
	2		
	TARGETS TO BE ACHIEVED BY 2009		
	5		
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	6		
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	17 814	17 500	23 100

JUSTIFICATION

Although essential for achieving lasting health improvements across populations, the underlying determinants of health have received relatively little attention at WHO, necessitating a substantial increase from the baseline. During 2008–2009 the Commission will complete its work; implementation in countries will begin at all levels of the Organization. During 2010–2011 efforts will remain steady; the expenses that had been associated with the Commission will be replaced by greater spending at country level. In 2012–2013 acceleration of work at country level will produce an increase of about 10%.

7.2 Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels to address social and economic determinants of health, including understanding and acting upon the public health implications of trade and trade agreements, and to encourage poverty-reduction and sustainable development.

INDICATORS

	7.2.1 Number of published country experiences on tackling social determinants for health equity	7.2.2 Number of tools to support countries in analysing the implications of trade and trade agreements for health.
BASELINE 2008	2	7
TARGETS TO BE ACHIEVED BY 2009	10	7
TARGETS TO BE ACHIEVED BY 2011		
TARGETS TO BE ACHIEVED BY 2013	38	10

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
16 499	21 900	21 400

JUSTIFICATION

Work across sectors at both global and local levels is essential for addressing the social and economic determinants of health; this requires a very modest increase in WHO activity for 2008–2009 and 2010–2011. In 2012–2013, activity should increase at all levels of the Organization.

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

INDICATORS

	7.3.1 Number of country reports published during the biennium incorporating disaggregated data and analysis of health equity
BASELINE 2008	25
TARGETS TO BE ACHIEVED BY 2009	35
TARGETS TO BE ACHIEVED BY 2011	
TARGETS TO BE ACHIEVED BY 2013	60

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
13 410	11 800	17 500

JUSTIFICATION

Exploratory research on social and economic determinants and on health equity depends on improving the availability of data that have been collected and reported on a disaggregated basis; essential for indicators of all strategic objectives, it will require considerable support from WHO, which will increase over the time period in order to enable countries to reach the targets.

7.4 Ethics- and rights-based approaches to health promoted within WHO and at national and global levels.	**INDICATORS**		
	7.4.1 Number of tools produced for Member States or the Secretariat giving guidance on using a human rights-based approach to advance health	**7.4.2** Number of tools produced for Member States or the Secretariat giving guidance on use of ethical analysis to improve health policies	
	BASELINE 2008		
	20	8	
	TARGETS TO BE ACHIEVED BY 2009		
	28	12	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	45	20	
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	7 423	8 800	9 700
	JUSTIFICATION		
	In addition to normative work on ethics and human rights carried out by core teams, more work will be carried out by staff with relevant background at all levels of the Organization; they will also translate global documents into actions at country level. This growth in expertise and activity across the Organization accounts for the modest biennium-to-biennium budget increase.		

7.5 Gender analysis and responsive actions incorporated into WHO's normative work and support provided to Member States for formulation of gender-responsive policies and programmes.	**INDICATORS**		
	7.5.1 Number of WHO norms and standards developed or updated that are gender responsive	**7.5.2** Number of Member States supported by WHO that have conducted one or more gender-mainstreaming activities in health programmes	
	BASELINE 2008		
	38	83	
	TARGETS TO BE ACHIEVED BY 2009		
	54	107	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	74	155	
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	10 759	11 900	13 900
	JUSTIFICATION		
	The increased support for gender-related activities across WHO in 2008–2009 reflects commitment to the goal of incorporating this area into the mainstream of work throughout the Organization. In subsequent bienniums, growth is accounted for by increased staff and activities at regional and country levels.		

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

Indicators and targets

- Proportion of the urban and rural populations with access to improved water sources and improved sanitation. Targets: by 2013, 94% of urban populations and 78% of rural populations will have access to improved drinking water sources (baselines, 2004 estimates: 95% and 73%, respectively); by 2013, 81% of urban populations and 48% of rural populations will have access to improved sanitation facilities (baselines, 2004 estimates: 80% and 39%, respectively)
- Proportion of the population using solid fuels (as indicator of the unhealthy use of energy sources for cooking and heating). Target: by 2013, 30% of the global population will be using solid fuels (baseline: 52% in 2003)
- Burden of disease (measured in disability-adjusted life years) due to environmental risks in key sectors (e.g. transport, energy, water and agriculture). Targets: by 2013, 2.8% of the global burden of disease will be attributed to transportation (baseline, 2002 estimate: 3.1%) and 3.0% attributable to inadequate access to improved water supply and sanitation (baseline, 2006 estimate: 3.8%)
- Burden of disease measured in disability-adjusted life years from selected occupational risks. Target: by 2013, 1.2% of the global burden of disease will be attributed to selected occupational risks – noise, injuries, back pain, carcinogens, and airborne particles (baseline: 1.5% in 2000)

ISSUES AND CHALLENGES

About one quarter of the global disease burden and one third of that in developing countries could be reduced through available environmental health interventions and strategies. Yet, health systems on the whole identify only a fraction of the environmental determinants of health as part of their remit, and very rarely treat them as a priority when devising ways of improving public health. The few existing data indicate that only about 2% of a typical national health budget is invested in preventive health strategies. Clearly, health institutions face both the challenge of controlling health costs and the opportunity to do so through more effective environmental health strategies and interventions.

Rapid changes in lifestyles, production patterns and energy consumption, coupled with increasing urbanization, climatic change and pressures on ecosystems could, in both the short and long term, have even greater consequences for public health and health costs than is already the case, if the health sector fails to act on currently emerging environmental hazards to health. A case in point is the lack of attention that has been given to the health effects of climate change. While some of the health consequences of climate change cannot be undone, their impacts can be significantly lessened provided prompt action is taken by the health sector.

Lessons learnt

- WHO's work on environmental health provides the basis for global standards in environmental quality and an effective investment for public health (e.g. air quality and drinking-water quality guidelines).
- Tackling environmental health risks can additionally yield many gender- and equity-related benefits in terms of women spending less time fetching fuel or improved attendance rates for girls at school.
- Benefits from environmental health improvements are enjoyed by rich and poor, in developed and developing countries, lowering health costs and lessening conflict over environmental resources.

In order to reduce vulnerability to environmental and health hazards, health sector decision-makers urgently need new information about the epidemiological impacts of these hazards, as well as about the modifiable factors driving them. They also need evidence of the effectiveness of interventions that can prevent or mitigate adverse health outcomes, as well as of those capable of maximizing benefits for health and the environment. Because so many of the root causes of environmental threats to health emanate from activities in sectors other than health, effective environmental health risk management requires action both in the health sector itself and across sectors, including in the specific settings where they occur, namely, homes, schools, workplaces and cities.

Increasingly, health policy-makers are called on to participate in economic development and policy forums whose decisions have profound long-term impacts on pollution, biodiversity, and ecosystems, and thus on environmental health. Health professionals, often trained in treatment of the individual, need to be better equipped with skills and methods for monitoring and synthesizing health and environmental data; proactively guiding strategies for public awareness, protection and prevention; and responding to emergencies.

Although the health sector cannot implement development policies on its own, it can provide the epidemiological evidence and the tools, methods or guidance necessary for assessing the health impacts of development policies, plans and investment activities. Concurrently, non-health sectors must be made aware of hazards to health and thus informed and empowered to act. For this to happen, integrated assessment and cross-sectoral policy development should be encouraged, bringing parties from the health and other sectors together.

The mandate for WHO's action in this area is firmly anchored in the Constitution and the history of public health practice and achievements. In the framework of United Nations reform, WHO has an opportunity to show a more global leadership in public health and the environment, linking health explicitly to the goals of sustainable development.

Integral to this challenge is the understanding that improved policy on, and greater investment in, environmental health will almost always yield some of the greatest benefits among the populations of the world with the poorest health and the greatest need. These include poor people and children; children's health, in particular, is affected by environmental risks and requires a special focus.

STRATEGIC APPROACHES

In order to address the root causes of environmental threats to health, the health sector will need to adopt the following overarching strategies: to provide leadership on the public health aspects of international environment and sectoral policies; to advocate and establish partnerships for coordinated multisectoral activities and integrated policies to

Lessons learnt

- Environmental health issues are key reasons for persuading non-health sectors to consider the public health implications of their policies, not least because of existing requirements worldwide for taking environmental impacts into consideration when policies and investments are defined.
- Communicating about environmental health facilitates understanding of the complex links between economic and social development, environment and ecosystems, and thereby enables key indicators to be defined for assessing progress towards sustainable development.
- The working environment is an entry point for health services, particularly in low-income areas where it is often the only point of contact with those services.
- About half the world's population works and the workplace is the setting for not only reducing occupational risks, but also tackling determinants of health and establishing cooperation with non-health sectors.

The Secretariat will focus on:

- providing support for primary prevention through environmental health-risk reduction, and monitoring its impact;
- providing support for environmental health assessment and management in emergencies, conflicts and disasters, in particular prevention, preparedness, response and planning for post-emergency reconstruction;
- facilitating and promoting the development, sharing and use of knowledge, research and innovation, while enhancing education about emerging environmental risks and equitable solutions among different stakeholders;

reduce health risks from the environment; and to promote development frameworks and strategies that benefit health.

Management of public health risks requires intensifying institutional and technical capacities for assessing and quantifying environmental and occupational and health risks, for evaluating the impacts of policies and interventions intended to address those risks, and for facilitating the implementation of appropriate intervention measures. Preparedness for, and response to, environmental emergencies and disasters and emerging threats deserve particular attention in health sector development. Increased reliance upon environmental health interventions will contribute towards reducing vulnerability and will strengthen the capabilities of environmental health professionals to provide a preventive arm within the health sector**.**

Further work on identifying and responding to inequities in environmental health risks and outcomes related to gender, age, ethnicity and social circumstance is needed in order to ensure that risk management approaches protect and enhance the health of vulnerable populations. Innovative partnerships also need to be established in order to widen the impact of preventive actions. For example, the amount of international development finance provided to developing countries greatly exceeds official development assistance and offers an excellent opportunity for enhancing health by influencing investments in other sectors. Climate change will also increase the opportunities for ministries of health to promote health in all policies. The momentum created by climate change will be recognized and capitalized upon in order to establish initiatives and partnerships, including through communications and outreach activities, help health sector leaders raise the profile and priority of environment and health issues, and increase the capacity of health systems for integrating health and environmental issues into traditional health-sector agendas.

The Secretariat will focus on:

- promoting global environmental health partnerships;
- articulating policy positions in order to influence international trends in sectoral policies;
- gathering knowledge and providing guidance on the assessment and management of environmental and occupational health risks, including anticipating emerging issues such as the health impacts of climate change;
- contributing to strengthening the capacity to set and implement policies on health and the environment, including through development of norms and standards;
- monitoring and assessing environmental hazards to health.

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie the achievement of this strategic objective:

- that health sector personnel become increasingly cognizant of the mounting burden of disease from environmental health risks in light of new evidence;
- that decision-makers (such as policy-makers, international finance institutions and civil society) in sectors of the economy with the greatest influence over the environmental determinants of health will increasingly prioritize health and put the health costs and benefits of their actions at the centre of their decision-making processes;
- that development partners (banks, multilateral and bilateral aid agencies, foundations and recipient countries) will increasingly recognize that reducing environmental hazards to health will makes a major contribution to sustainable

development goals, and that failure to do so may actually undermine the achievement of the relevant Millennium Development Goals;

- that the climate remains favourable, in the context of United Nations system reform, for WHO to show more global leadership in matters related to public health and the environment, and that it will be able to raise the profile of health more explicitly in humanitarian response and as one of the objectives of environmental sustainability and economic development.

Because hazards to environmental health come primarily from actions in non-health sectors, risk reduction depends on intervention beyond the direct control of the health sector. The health sector, therefore, must encourage those other sectors to pay more attention to environmental health and exert enough leverage to effect the desired changes. In that context, the risks that may prevent achievement of this strategic objective include the following:

- that expectations from other sectors for quick results and reductions of environmental health risks may exceed the capacity of the health sector to provide support for their actions. This pitfall can be avoided by selecting realistic, achievable aims;
- that information about the best options for sectoral interventions to improve occupational and environmental health is inaccessible. This danger can be overcome through investment by health agencies in analysis and documentation of the most effective and cost-beneficial interventions;
- that global leaders and partners in the arenas of development and/or the environment show weak or transient commitment to addressing and reducing environmental threats to health. Investments in partnerships, outreach and more strategic global communications on environmental health issues (such as flagship reports on global environmental health and prospects) and the identification of solutions that benefit health, development and the environment can help to overcome this problem;
- that health systems continue to respond weakly in reducing the range of occupational and environmental health risks and rooting out their causes, and that the lack of ownership of ministries of health in addressing environmental impacts on public health also continues.

ORGANIZATION-WIDE EXPECTED RESULTS

8.1 Evidence-based assessments made, and norms and standards formulated and updated on major environmental hazards to health (e.g., poor air quality, chemical substances, electromagnetic fields, radon, poor-quality drinking-water and waste-water reuse)

INDICATORS	**8.1.1** Number of Member States that have conducted assessments of specific environmental threats to health or have quantified the environmental burden of disease with WHO technical support during the biennium	**8.1.2** Number of new or updated WHO norms, standards or guidelines on occupational or environmental health issues published during the biennium
BASELINE 2008		5
TARGETS TO BE ACHIEVED BY 2009		10
TARGETS TO BE ACHIEVED BY 2011		12 per year
TARGETS TO BE ACHIEVED BY 2013		15

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
32 960	38 100	35 000

JUSTIFICATION

In order to expand the Secretariat's solid experience in risk assessment, burden of disease, norms and guidance and servicing of environmental agreements in order to add further value, the following are needed: harmonization of risk assessment for all types of hazard; provision of information on risk assessments to support WHO guidelines and joint FAO/WHO pesticide specifications; provision of risk assessments of chemicals in food (both additives and pesticide residues) for the Codex Alimentarius Commission; construction of an interactive library of risks assessment, norms and burden of disease information, expanding the International Programme on Chemical Safety's Chemical Safety Information from Intergovernmental Organizations and other databases; global monitoring and reporting of progress towards achievement of environmental Millennium Development Goals linked to health; provision of health inputs to the Strategic Approach to International Chemicals Management and enhancing health-sector inputs into the Stockholm Convention on Persistent Organic Pollutants and the Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade.

8.2 Technical support and guidance provided to Member States for the implementation of primary prevention interventions that reduce environmental hazards to health, enhance safety and promote public health, including in specific settings

INDICATORS	**8.2.1** Number of Member States implementing primary prevention interventions for reducing environmental risks to health, with WHO technical support, in at least one of the following settings: workplaces, homes or urban settings
BASELINE 2008	
TARGETS TO BE ACHIEVED BY 2009	
TARGETS TO BE ACHIEVED BY 2011	

(e.g. workplaces, homes or urban settings) and among vulnerable population groups (e.g. children)	**TARGETS TO BE ACHIEVED BY 2013**		
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	35 208	30 800	29 000
	JUSTIFICATION		
	Following successes in tackling occupational environmental health hazards in specific settings in close connection with local partners, there is a strong demand for the Secretariat to revitalize and extend its support to developing and implementing primary prevention interventions in specific settings and to reducing the major risks. New global initiatives have been planned to support interventions for reducing risks and promoting health in the workplace, school, municipality, home and health-care settings, and to document and inform about costs and benefits of different interventions.		

8.3 Technical assistance and support provided to Member States for strengthening national occupational and environmental health risk management systems, functions and services	**INDICATORS**		
	8.3.1 Number of Member States that have implemented national action plans/policies for the management of occupational health risks, such as in relation to the Global Plan of Action on Workers' Health (2008–2017), with support from WHO		
	BASELINE 2008		
	TARGETS TO BE ACHIEVED BY 2009		
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	21 224	19 800	33 000
	JUSTIFICATION		
	The ability of health systems to deal with occupational and environmental health risks is limited and not commensurate with the great potential for primary prevention of disease through better working and living environments. The planned work will strengthen the health sector's ability to plan and deliver good-quality occupational and environmental health services and expand interventions and surveillance through a better evidence base, logistical and technical support, the engagement of a range of organizations in executing initiatives to reduce risks and promote health, for instance among workers in the informal economy.		

8.4 Guidance, tools and initiatives created in order to support the health sector in influencing policies in other sectors to allow policies that improve health, the environment and safety to be identified and adopted	**INDICATORS**
	8.4.1 Number of Member States that have expressed interest in adopting healthy other sector policies or frameworks proposed by WHO.
	BASELINE 2008
	TARGETS TO BE ACHIEVED BY 2009
	TARGETS TO BE ACHIEVED BY 2011

TARGETS TO BE ACHIEVED BY 2013

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
21 000	14 900	32 000

JUSTIFICATION

The health sector is only poorly able to influence policies in other sectors to promote occupational and environmental health and lacks the tools, knowledge and skills to engage other sectors. New activities will build on institutional experience with health impact assessment, cost-benefit analysis and environmental health in other sectors in order to create, and provide access to, a substantial knowledge base on the impacts on occupational and environmental health of sectoral policies, on the costs and benefits of sectoral interventions and on experiences of implementing sectoral change. Work will include the development of global initiatives – using networks, partnerships, communities of practice and strategic communication – to encourage the targeted sectors to change their policy-making culture so that the prevention of risks to occupational and environmental health is considered and included as a priority. The Secretariat will provide technical assistance and support to countries for strengthening institutions through skills-building in order to enhance the ability of the health sector to lead change in other sectors. The Secretariat will also facilitate setting baselines for, and evaluating, performance and policy change towards the adoption of healthy sector policies.

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

INDICATORS

8.5.1 Number of studies or reports on new and re-emerging occupational and environmental health issues published or co- published by WHO	**8.5.2** Number of reports published or jointly published by WHO on progress made in achieving water and sanitation objectives of major international development frameworks, such as the Millennium Development Goals	**8.5.3** Number of high-level regional forums on environment and health issues organized or technically supported by WHO biennially
BASELINE 2008		
		3
TARGETS TO BE ACHIEVED BY 2009		
		5
TARGETS TO BE ACHIEVED BY 2011		
TARGETS TO BE ACHIEVED BY 2013		
		6

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
20 064	19 000	23 000

JUSTIFICATION

Environmental and occupational health risks are directly linked to patterns of consumption and production and to policies in different sectors of the economy; at present, however, there is no consensus on the trends in these patterns and policies or their implications for risks to health. The consequence is short-term thinking and responses to environmental risks to health and inadequate prevention and responses. The Secretariat's work will put in place a global, multi-year strategy for outreach and communication; produce strategic analyses; result in high-impact publications (including reports on the global outlook for environmental health); provide approaches to

	knowledge management; and engage governments and high-level stakeholders in the response to the issues through global and regional forums and links with networks of practitioners. It will build on existing economic and environmental analyses, reviewing the potential impacts of social and economic trends, monitoring the impact of policies, disseminating information on good practice and making recommendations for action that improves equity in occupational and environmental health.

8.6 Evidence-based policies, strategies and recommendations developed, and technical support provided to Member States for identifying, preventing and tackling public health problems resulting from climate change	**INDICATORS**	
	8.6.1 Number of studies or reports on the public health effects of climate change published or co- published by WHO	**8.6.2** Number of countries that have implemented plans to enable the health sector to adapt to the health effects of climate change
	BASELINE 2008	
	TARGETS TO BE ACHIEVED BY 2009	
	TARGETS TO BE ACHIEVED BY 2011	
	TARGETS TO BE ACHIEVED BY 2013	

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	24 100	

JUSTIFICATION

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

Indicators and targets

- Proportion of stunted children under five years of age. Target: 22% (baseline: 30%)
- Proportion of overweight children under five years of age. Target: 8% (baseline: 8%)
- Proportion of overweight and obese school-age children and adolescents under 20 years of age. Target: 10% (baseline: 10%)
- Under-five mortality caused by specific foodborne diarrhoeal diseases. Target: 5% reduction on 2009 baseline

ISSUES AND CHALLENGES

This strategic objective is intended to address some major determinants of health and disease: malnutrition in all its forms, unsafe foods, that is, foods in which chemical, microbiological, zoonotic and other hazards pose a risk to health, and household food insecurity. Nutrition, food safety and food security are cross-cutting issues that permeate the entire life-course from conception to old age. They apply equally to stable and emergency situations, and should be specifically addressed in the context of HIV/AIDS epidemics.

About 800 million people are undernourished and about 170 million infants and young children are underweight. Each year, more than five million children die from undernutrition and a further 1.8 million from food- and water-borne diarrhoeal diseases. Thousands of millions of people are affected by foodborne and zoonotic diseases, some of which are fatal or have severe sequelae. Micronutrient deficiencies (so-called “hidden hunger”), especially of iron, vitamin A, iodine and zinc, are a major problem worldwide. Undernutrition is the main threat to health and well-being in middle- and low-income countries, as well as globally. Childhood obesity is also becoming a recognized problem, even in low-income countries. More than a thousand million adults worldwide are overweight, of whom 300 million are obese. These issues are still perceived to be separate, but in most countries both are often rooted in poverty and co-exist in communities.

Despite the impact of all forms of malnutrition on mortality, morbidity and national economies, only 1.8% of the total resources for health-related development assistance is allocated to nutrition. Only 0.7% of the World Bank’s total assistance to developing countries is for nutrition and food security. At country level, the financial commitment is even lower. To achieve the strategic objective set out above,

Lessons learnt

- Reducing poverty and achieving the Millennium Development Goals are global priorities. Poverty reduction goals are likely to be met, but targets related to hunger and child underweight are less likely to be attained, thus seriously compromising achievement of other Goals.
- An increase in income does not automatically lead to an improvement in nutrition, food safety and food security, nor does it necessarily reduce micronutrient deficiencies. Direct programme investment is necessary in these areas.
- Nutrition and food safety are not sufficiently prominent in national development plans, and the synergies that could be achieved in linking the two are not often appreciated.
- Lack of adequately trained human resources in nutrition and food safety is perhaps the most serious constraint. Building capacity with an emphasis on leadership at national, public-health levels in nutrition and food safety is a priority.
- The demand for expanding and strengthening WHO’s presence and influence in nutrition and food safety in countries is increasing.
- Closer collaboration and joint work throughout the United Nations system is urgently needed. WHO should catalyse a shared vision and a common agenda among partners. A coordinated advocacy and communications strategy and strong partnerships will be crucial in advancing the agenda.
- Financial commitment to nutrition and food safety has been historically low. Renewed and coordinated support from development partners is crucial.

necessary financial, human and political resources will be required to build, promote and implement a nutrition, food-safety and food-security agenda at global, regional and country levels, in both stable and emergency situations, that is intersectoral, science-based, comprehensive and integrated. Such an agenda should focus on the attainment of the Millennium Development Goals and other international commitments related to nutrition and food safety, including the prevention of foodborne, zoonotic and diet-related chronic diseases and micronutrient malnutrition.

Despite declining prevalence of underweight children in most regions, the fall is not sharp enough to allow attainment of the target for reduction of child malnutrition set out in the first Millennium Development Goal. Furthermore, in Africa the rates continue to rise. The link between poverty, hunger and child undernutrition is loose, so that increased wealth does not automatically lead to the alleviation of hunger and child undernutrition. Hence, direct programme investment is necessary to reduce child undernutrition. Successful efforts to alleviate most forms of malnutrition should ensure that benefits are concentrated mainly among the poor. Unless more progress is made in eliminating hunger and malnutrition, it will be difficult to achieve many of the other Millennium Development Goals. There are critical interactions between undernutrition and most of the following Goals: child mortality (Goal 4), maternal health (Goal 5) and HIV/AIDS and malaria (Goal 6). Although less direct, the interactions between undernutrition and poverty (Goal 1), education (Goal 2) and gender equality (Goal 3) are equally important. Unless nutrition and food safety are recognized as being central to public health and economic development, and a special effort is made to tackle the hunger and child undernutrition targets set out in the first Millennium Development Goal, achievement of all of the other Goals will be compromised.

Actions at national, subnational and community levels to promote, protect and support nutrition, food safety and food security for the benefit of individuals and families are essential for achieving successful outcomes. Such actions are also crucial in promoting interactions between actors in the fields of health, the environment and development to ensure safe and sustainable agricultural-production methods that minimize occupational health risks and maximize long-term health in terms of nutrition, food safety and food security.

It will be essential to ensure that all future nutrition, food safety and food security planning and policies include human rights' and gender perspectives.

STRATEGIC APPROACHES

To achieve this strategic objective, food safety and food security must play a central role in national development policies, in agricultural development, and in animal- and food-production processes, with special emphasis on

The Secretariat will focus on:

- promoting policy development through broad-based alliances and multisectoral approaches to achieve comprehensive and effective national food safety and nutrition policies and action plans; based on national priorities;
- enhancing WHO's presence at regional and country levels and its nutrition and food-safety capacity in order to provide the requisite support to Member States;
- promoting recognition of nutrition and food safety issues as a centrepiece of public health and economic development;
- working with national governments to develop national food-control systems and providing tools to aid this process; supporting national and regional control programmes for zoonotic and non-zoonotic foodborne diseases in order to ensure development of sustainable food production;
- communicating effectively the need for integrated policies to improve nutrition and food safety while ensuring that access to safe and nutritious food includes a human rights perspective;
- increasing coordination and working more closely with organizations of the United Nations System in order to promote the integration of nutrition, food-safety and food-security programmes at country level and incorporate them into national development policies;
- maximizing WHO's convening role and devising new approaches in order to strengthen its normative function, address knowledge gaps through the development of scientifically sound norms, standards, recommendations and technical guidance, and engage relevant partners to ensure wider dissemination and use of WHO's information products;
- strengthening global linkages between policy-makers in the fields of health, agricultural development, water resources, trade and the environment, so as to ensure that nutrition, food-safety and food-security interventions are planned and executed in an integrated manner with the involvement of all stakeholders, thus making sustainable health gains.

reaching the most biologically and socially vulnerable populations. Key actions should include developing and implementing ethically and culturally acceptable essential interventions, and improving access to those interventions; creating synergies and strengthening linkages between programmes and avoiding duplication at the level of service delivery; and promoting better understanding at individual, household and community levels of the role of good nutrition, healthy eating practices and food safety in overall health and well-being. Other necessary conditions include establishment of supportive regulatory and legal frameworks based on existing international regulations and mechanisms; cooperation with the actors involved in food production, manufacturing and distribution so as to improve the availability of healthier foods; and promotion of a balanced diet, including ensuring compliance with the International Code of Marketing of Breastmilk Substitutes and the FAO/WHO Codex Alimentarius. The strengthening of national capacity to generate evidence through surveillance and research will complement essential public-health interventions.

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

- that access to adequate nutrition and safe food are acknowledged to be human rights and necessary, even fundamental, prerequisites for health and development;
- that individual behaviour will be backed up by efficient preventive systems and a supporting environment to assist the public to make informed choices in relation to malnutrition and unsafe food.

The major risk factors that could prevent achievement of the strategic objective are the current low level of human and financial investment and a lack of leadership in the development and implementation of integrated policies and effective interventions. Without more investment at all levels its achievement will be seriously compromised.

ORGANIZATION-WIDE EXPECTED RESULTS

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

INDICATORS	
9.1.1 Number of Member States that have functional institutionalized coordination mechanisms to promote intersectoral approaches and actions in the area of food safety, food security or nutrition	**9.1.2** Number of Member States that have included nutrition, food-safety and food-security activities and a mechanism for their financing in their sector-wide approaches or Poverty Reduction Strategy Papers
BASELINE 2008	
30	44
TARGETS TO BE ACHIEVED BY 2009	
60	60
TARGETS TO BE ACHIEVED BY 2011	
TARGETS TO BE ACHIEVED BY 2013	
80	80

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
16 975	20 900	10 000

JUSTIFICATION

Partnership and leadership building, advocacy and communication activities will be carried out at regional and country levels and will be concentrated in the biennium 2008–2009. The expected result establishes the basic requirements for enhancing the building of efficient national intersectoral nutrition and food-safety systems during the entire period. The resources required for 2008–2009 will be used to carry out workshops and field missions, to devise joint programmes with other organizations of the United Nations system in the context of the reform process, and to develop and implement communication strategies. During the bienniums 2010–2011 and 2012–2013, it is expected that fewer resources will be needed.

9.2 Norms, including references, requirements, research priorities, guidelines, training manuals and standards, produced and disseminated to Member States in order to increase their capacity to assess and respond to all forms of malnutrition, and zoonotic and non-zoonotic foodborne diseases, and to promote healthy dietary practices.

INDICATORS	
9.2.1 Number of new nutrition and food-safety standards, guidelines or training manuals produced and disseminated to Member States and the international community	**9.2.2** Number of new norms, standards, guidelines, tools and training materials for prevention and management of zoonotic and non-zoonotic foodborne diseases
BASELINE 2008	
None	None
TARGETS TO BE ACHIEVED BY 2009	
15	3
TARGETS TO BE ACHIEVED BY 2011	
TARGETS TO BE ACHIEVED BY 2013	
50	10

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
30 031	28 500	30 000

JUSTIFICATION

WHO's work on food and nutritional norms, standards and recommendations will continue in 2008–2009 in order to close gaps in essential areas such as micronutrients and macronutrients (carbohydrates and fats and oils), and to prevent and manage microbiological and chemical hazards. Such work will require full expert consultations to be carried out in partnership with other organizations of the United Nations system. Most of the resources will be used at headquarters, as the expected result entails cooperation between WHO and the Codex Alimentarius bodies and activities for the provision of scientific advice, for example meetings of the Joint FAO/WHO Expert Committee on Food Additives, the Joint FAO/WHO Meeting on Pesticide Residues and the Joint FAO/WHO Expert meetings on Microbiological Risk Assessment. Guidelines and training tools on nutrition and HIV/AIDS, school-based nutrition interventions, nutrition in emergencies, infant and young-child feeding, food safety and the prevention of foodborne and zoonotic diseases will also be produced. The resources required are expected to remain the same for the 2010–2011 and 2012–2013 bienniums since the normative work is a continuing process.

9.3 Monitoring and surveillance of needs and assessment and evaluation of responses in the area of nutrition and diet-related chronic diseases strengthened, and ability to identify best policy options improved, in stable and emergency situations.

INDICATORS

9.3.1 Number of Member States that have adopted and implemented the WHO Child Growth Standards	**9.3.2** Number of Member States that have nationally representative surveillance data on major forms of malnutrition
BASELINE 2008	
20	90
TARGETS TO BE ACHIEVED BY 2009	
50	100
TARGETS TO BE ACHIEVED BY 2011	
TARGETS TO BE ACHIEVED BY 2013	
100	150

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
18 509	16 700	15 000

JUSTIFICATION

Most resources will be used at regional and country levels. The resources required for 2008–2009 will be used to organize regional workshops, develop nationally representative surveys, and carry out missions from headquarters and the regional offices to provide support to countries in assessing their responses. There is a close link between this expected result and the previous one as monitoring, surveillance and assessment of responses provide the support needed for efforts to include nutrition, food-safety and food-security issues in sector-wide approaches, Poverty Reduction Strategy Papers and/or development policies, plans and budgets. During the bienniums 2010–2011 and 2012–2013 the resources required are expected to be the same, since monitoring and evaluation are continuing processes.

9.4 Capacity built and support provided to target Member States for the development, strengthening and implementation of nutrition plans, policies and programmes aimed at improving nutrition throughout the life-course, in stable and emergency situations.	**INDICATORS**				
	9.4.1 Number of Member States that have implemented at least three high-priority actions recommended in the Global Strategy for Infant and Young Child Feeding	**9.4.2** Number of Member States that have implemented strategies to prevent and control micronutrient malnutrition	**9.4.3** Number of Member States that have implemented strategies to promote healthy dietary practices for preventing diet-related chronic diseases	**9.4.4** Number of Member States that have included nutrition in their responses to HIV/AIDS	**9.4.5** Number of Member States that have national preparedness and response plans for nutritional emergencies
	BASELINE 2008				
	60	40	40	65	30
	TARGETS TO BE ACHIEVED BY 2009				
	90	70	70	65	45
	TARGETS TO BE ACHIEVED BY 2011				
	TARGETS TO BE ACHIEVED BY 2013				
	120	80	80	80	70
	RESOURCES (US$ THOUSAND)				
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013		
	24 314	21 800	40 000		
	JUSTIFICATION				
	Most resources will be used at regional and country levels. WHO's presence in nutrition and food safety at these levels will also be substantially enhanced. In 2008–2009 resources will be used adequately to staff regional, subregional and country offices and to support the effective implementation of nutrition interventions according to countries' needs and demands. During the bienniums 2010–2011 and 2012–2013, the amount of resources required is expected to fall slightly. Enhancement of countries' programmes could lead to a reduction in the demand for direct technical support.				

9.5 Systems for surveillance, prevention and control of zoonotic and non-zoonotic foodborne diseases strengthened; food-hazard monitoring and evaluation programmes established and integrated into existing national surveillance systems, and results disseminated to all key players.	**INDICATORS**		
	9.5.1 Number of Member States that have established or strengthened intersectoral collaboration for the prevention, control and surveillance of foodborne zoonotic diseases	**9.5.2** Number of Member States that have initiated a plan for the reduction in the incidence of at least one major foodborne zoonotic disease	
	BASELINE 2008		
	20	50	
	TARGETS TO BE ACHIEVED BY 2009		
	20	50	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	40	70	
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	17 032	14 800	30 000

JUSTIFICATION

Most resources will be used at regional and country levels. The resources required for 2008–2009 will be used to further develop activities related to the Global Salm-Surv network for building national and regional capacities in surveillance, prevention and control of foodborne and zoonotic diseases. This expected result and the next one are linked, as the monitoring and surveillance of responses are essential support activities in the building of efficient food-safety systems. During the bienniums 2010–2011 and 2012–2013 the resources required are expected to be the same since surveillance and control of foodborne and zoonotic diseases are continuing processes.

9.6 Capacity built and support provided to Member States, including their participation in international standard-setting in order to increase their ability to assess risk in the areas of zoonotic and non-zoonotic foodborne diseases and food safety, and to develop and implement national food-control systems, with links to international emergency systems.

INDICATORS

9.6.1 Number of selected Member States receiving support to participate in international standard-setting activities related to food, such as those of the Codex Alimentarius Commission	**9.6.2** Number of selected Member States that have built national systems for food safety with international links to emergency systems
BASELINE 2008	
90	30
TARGETS TO BE ACHIEVED BY 2009	
90	30
TARGETS TO BE ACHIEVED BY 2011	
TARGETS TO BE ACHIEVED BY 2013	
110	80

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
20 073	16 200	30 000

JUSTIFICATION

Most resources will be used to support the effective participation of countries in international standard-setting activities and for building effective food-safety, nutritional and veterinary systems. The resources that will be required during the three bienniums to support participation in standard-setting activities will be gradually reduced as more countries should be able to support themselves. The resources for building systems are expected to remain the same, in keeping with the expected level of need.

STRATEGIC OBJECTIVE 10

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

Indicators and targets

- Reduction in the coverage gap for an integrated set of interventions and services in at least eight out of 10 countries
- Improved leadership and governance of health systems evaluated on regionally agreed benchmarks in 2 out of 5 countries
- Reduction of 25% in the number of countries facing critical health-workforce shortages, and an increase in the equitable distribution of the workforce
- Increase of 25% in health-research funding spent on priority health problems in at least 10 low- and middle-income countries, within overall target of dedicating 2% of health budget to research by 2013
- Internationally accepted standards for health-information systems obtained in at least seven out of 10 countries
- Reduction in the number of countries in which out-of-pocket payment comprises more than 30% of total health spending
- Knowledge management and eHealth strategies to strengthen health systems being designed and implemented in at least 70 countries.

ISSUES AND CHALLENGES

Despite government commitments to improving health, all too often people do not receive the preventive and curative services they need and rightfully expect. Most often, this affects the poor and vulnerable. Reasons vary from country to country: staff and supplies may be lacking; services may be inaccessible, inconvenient, of poor quality or unaffordable; social exclusion may prevent access, often by those most in need; providers (private and public) may fail to adapt to the population's care-seeking behaviour. When service delivery does not live up to legitimate expectations, this often signals problems in the way health systems are financed, organized and governed.

Health decision-makers have to manage multiple objectives and competing demands, often in a context where essential resources – financing, people, infrastructure, supplies, information, political support – are wanting. Often they have to rely on weak institutions that have poor access to crucial knowledge and evidence bases, and are therefore ill-equipped to inform such key questions as ways in which to raise funds, to improve use of existing funds in order to ensure more accessible, affordable and efficient delivery across a range of priority services and outcomes, or to retain and motivate health workers.

Assuming responsibility for leading, governing and steering the health system (sometimes referred to as "governance" or "stewardship") effectively requires an available, competent, responsive and productive workforce with access to appropriate and safe medical technologies and tools; effective management of public and nonpublic providers; fair, adequate and

Lessons learnt

- Health systems with a strong primary health care orientation are important to maximizing health outcomes and to ensure equitable access, financial fairness, and high quality care.
- In judging the quality of health services populations do not merely look at the effectiveness of the interventions provided. They also attach value to other features: continuity of prevention and care; integration; a patient-centred, close-to-client approach; safety; respect; and choice. Whether care is provided by public or nonpublic services, these characteristics – or the absence thereof – strongly influence demand, uptake and coverage. For service delivery to meet the expectations of populations and professionals, the choice of contextually appropriate organization and management models is as important as proper resourcing.

sustainable financing that provides social protection; and system intelligence rooted in information systems, research, and knowledge management in order to inform the framing of health policy and development of the system.

Governing health systems also entails responsibility for the overall organization of service delivery, because the way services are organized and managed affects access, coverage and outcomes. Although there is no single universal model for organizing service delivery, there are some well-established principles. First, measures should be taken to prevent exclusion and ensure access to integrated services that include prevention care and ensures well as social protection; second, the full range of providers, both public and private, have to be taken into account; third, unnecessary duplication and fragmentation needs to be avoided; and fourth, effective accountability mechanisms that involve civil society and include communities should be in place. In addition, experience has shown that countries across the development spectrum are struggling to ensure that the health care provided to patients is safe.

Many countries lack the human resources needed to deliver essential health interventions for a number of reasons. Production capacity may be limited in many developing countries as a result of years of underinvestment in health education institutions. "Push" and "pull" factors may incite health workers to leave their workplaces, resulting in geographical imbalances between urban and rural areas within countries, and between countries and regions. The migration of health workers to developed countries has dire consequences for the health systems in developing countries.

Development of the health workforce may be hampered by such factors as a poor mix of skills and gender imbalances; a training output that is poorly aligned with the health needs of the population; unsafe working conditions; a weak knowledge base; a narrow focus on the public sector; and lack of coordination between sectors. Health workers need to be close to communities and also have the appropriate technical skills founded on evidence-based safety and quality standards.

The way in which the health system is financed is a key determinant of population health and well-being, to the extent that health financing is central to the policy debate in most countries. Although many of the poorest countries need more resources, building up the health system also involves doing more with existing resources, finding ways to secure more predictable funding, encouraging innovation and judgments about sequencing change, working with an increasing array of partners, and ensuring that benefits reach the poor and other marginalized groups, especially women.

The principles of primary health care remain as valid today as ever; the context in which they have to be operationalized are complex. However, ensuring universal access to quality

Lessons learnt

- Governance and leadership are necessary for health systems to be both efficient and effective. Improved capacity for framing policy, regulating, managing and collaborating with stakeholders translates into better service delivery. More intensive interinstitutional and intercountry collaboration is needed, together with more systemic knowledge on the effectiveness of various approaches to strengthening capacity for governing the health sector.
- Women and men of different ages have unequal interactions with the health system. Gender-based inequalities continue to be important factors affecting health-seeking behaviour and health-system responsiveness.
- Well-trained and adequately skilled health-workers are a key factor for delivering good quality health services that respond to the population's needs.
- Building knowledge and databases on the health workforce requires coordination across sectors.
- Heavy reliance on user-charges and other out-of-pocket payments means that some people cannot afford health services, and could result in financial catastrophe and impoverishment for some users. Prepayment, by taxation, insurance, or a mix, can protect people from the consequences of out-of-pocket payments.
- Raising more funds for health in poor countries is a necessary, but insufficient, condition for improving health. Ways of using funds more efficiently and equitably are crucial, as is the development of appropriate prepayment mechanisms.
- Against the backdrop of increased demand for information it is possible to strengthen health-information systems in low- and middle-income countries. Many partners need to be involved in a well-resourced network in order to provide support.

services, financial fairness, and responsive systems requires renewed attention to developing primary health care approaches that can also mobilize society to address risk factors and socioeconomic determinants of health. They also need to be capable of rapidly adapting to new challenges and contexts.

In many countries, the capacity to maintain health-information systems, to conduct nationally relevant research for health, and to translate research findings into policy and practice is limited. Increased international demand for health information and evidence presents an opportunity and challenge to countries, and needs special attention and efforts in order to match national needs. Information, evidence and research are not only critical components of country health systems but also required for the development, monitoring and evaluation of global policies and programmes. Monitoring progress towards global goals such as the Millennium Development Goals is severely hampered by the lack of recent comparable health statistics.

Lessons learnt

- Progress in health research, including health-systems research, has been piecemeal, and requires strong leadership and coordination from WHO and its partners in order to enhance evidence-based health decision-making.
- Rapid changes in information technology provide an unprecedented opportunity to bring about major changes in the way societies and individuals deal with data, information, and knowledge for health.
- To first "do no harm", health care workers must be equipped with knowledge and measurement tools to ensure the health care they provide is safe.

Governing health systems in such circumstances relies on building institutional capacities in such diverse areas as analysing, formulating and implementing policy, bridging the gaps between knowledge and practice; optimizing the allocation and use of resources; building collaboration across government sectors and with public and private stakeholders outside government; aligning and fitting policies with organizational structure and culture; regulating the behaviour of health-system actors; and establishing effective mechanisms to ensure accountability and transparency.

These are considerable challenges for Member States. Major institutional hurdles need to be overcome in order to develop more effective working relationships across programmes and departments and surmount the current fragmented organization of health systems.

STRATEGIC APPROACHES

WHO's approach to country support will be tailored to the political, cultural and social context of which the health system is part. Its actions will be underpinned by agreed international principles that include Health For All; a primary health care strategy, specific Health Assembly resolutions and the Paris Declaration on Aid Effectiveness.

At country level, WHO will provide support for diagnosis of health-system constraints; engage in collaborative sector reviews and financing, framing of health workforce policy, and design of investment strategies that fit with broader national development policies; contribute to building national capacity in health policy, system analysis and research; and provide support for countries' monitoring of trends in health systems and their performance.

The Secretariat will focus on:

- diagnosing health-system constraints through use of consistent approaches that incorporate a system-wide perspective, yet are sufficiently flexible to be used by programme and systems groups with different entry points;
- working with countries to renew and reinvigorate health systems based on primary health care, to promote more equitable health;
- producing and communicating norms, standards and guidelines on health and health systems; developing standardized methods, such as for national health accounting in low- and middle-income countries, and cost-effectiveness tools; and defining a set of measurements that capture the status and performance of a health system;
- assuring more systematic approaches to understanding which interventions are effective and why, including better evidence on health systems, in order to inform the health-research agenda currently in preparation;

WHO and its partners will contribute to providing a global response to difficulties related to the health workforce. It will address specifically the need for adequate financing for health workers, expanding capacities of education and training institutions, and strengthening advocacy at global and country levels to sustain effective development of the workforce.

WHO's international work in the field of information, evidence and research will draw on its direct engagement with countries, and produce global public goods including tools, methods and metrics for monitoring health and health systems performance, guide and set standards for health research and the formulation of evidence-based policies, and provide tools and policy options for strengthening health services and systems.

WHO will use its convening power and authority to shape the environment of international health aid for the health sector.

Patient safety has become part of the global health agenda. WHO will provide norms and guidelines as support to Member States in estimating and tracking the nature and the size of the problem. WHO will also provide evidence-based guidelines for improving safety in priority areas. The Secretariat and Member States must work together to improve safety and coordinate international expertise. The Secretariat will provide support to Member States in setting up mechanisms, procedures and incentives that encourage all stakeholders - including public and non-public providers and provider organizations - to work together to improve service delivery and eliminate exclusion from access to care following the principles of primary health care. It will support efforts to establish and promote effective accountability mechanisms that protect nationally agreed priorities.

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

- that a basic consensus exists that governments have a responsibility for the health of their entire population, even though other actors may be involved in the financing and provision of health care;
- that changes will be made in the financing channels and modus operandi of external partners, in line with the Paris Declaration on Aid Effectiveness;
- that effective partnerships are formed with key national, regional and global stakeholders, such as regional and international financial institutions, information agencies, professional associations, civil society organizations, private providers, ministries of finance, and international expert groups such as ACHR;
- that governance and strategic planning improve across all government sectors relating to health;

The Secretariat will focus on:

- producing evidence-based policy briefs on topical issues such as ways to reduce financial catastrophe, or increase health worker productivity, and providing support for approaches to more informal learning, using new information technology, and promoting eHealth networks within and between countries;
- contributing to framing of health-sector policy and development of evidence-based health-sector strategies and costed plans linked to the macroeconomic framework, and to strengthening the capacity of health ministries to frame health-sector policies that fit with broader national development policies and priority-setting and to allocate resources in line with policy objectives;
- providing policy advice in specific aspects of systems, such as health workforce strategies and investment plans, development of information systems, health-financing policy options and so forth that are based on principles outlined in specific Health Assembly resolutions;
- providing support for development of national health leadership at central and peripheral levels in order to mobilize resources for health and formulate, implement, monitor and evaluate policies and plans in light of health needs, with emphasis on strengthening national systems, including public and non-public components, engaging communities, and ultimately improving access to, and availability of, essential health services that include prevention as well as treatment;
- providing support for countries' monitoring of trends in health systems and performance, backed up by relevant research and eHealth platforms;

- that basic economic, social and political stability prevails, although WHO would continue to provide support to health systems even in the absence of these conditions;
- that international and national investments in information and research are adequate to meet increasing demands.

The risks that could prevent achievement of the strategic objective are:

- that donor financing for specific health outcomes and short-term results makes it more difficult to share resources and skills and to develop the required support systems and institutions common to all basic services and programmes that would help to reduce unnecessary waste, fragmentation and duplication;
- that governments focus only on the public-sector network, and fail to steer and regulate the entire health system;
- that governments focus only on primary or first-contact care at the expense of secondary and tertiary care, or vice versa, <u>and not on integrated networks of care that include all levels;</u>
- that international and national investment in this area is insufficient to meet increasing demand, particularly in the area of health-workforce development;
- that global market forces will continue to favour migration from countries already lacking sufficient health workers;
- that countries continue to be subject to internationally set caps on public spending, impinging thus on the national capacity to recruit and retain an adequate health workforce;
- that there is a preference for investing in short-term, unsustainable solutions to close gaps in information, evidence and research.

The Secretariat will focus on:

- providing support for building of national health-information systems for generating, analysing and using reliable information from population-based sources (such as surveys and vital registration, including gender-disaggregated data), and clinical and administrative data sources, through collaboration with partners, giving priority to effective communication of internationally agreed concepts, language and metrics on health systems, and improved national information systems that capture health-system inputs, services and outcomes;
- continuing to work with the OECD Development Assistance Committee and others to increase donor accountability in health, with global health partnerships to bring to bear the “best practice” principles of the Paris Declaration on Aid Effectiveness, with development banks and financing partnerships to advocate more, and more predictable, financing for health, and with such partnerships as the Health Metrics Network, the Global Health Workforce Alliance and the Alliance for Health Policy and System Research;
- <u>drawing on the strengths of international nongovernmental organizations with an interest in health systems, and conveying clarity as to messages, costing and impact;</u>
- <u>supporting member states in their efforts to make health care safer.</u>

ORGANIZATION-WIDE EXPECTED RESULTS

<table>
<tr><td rowspan="16">10.1 Management and organization of integrated, population-based health-service delivery through public and nonpublic providers and networks improved, reflecting the primary health care strategy, scaling up coverage, equity, quality and safety of personal and population-based health services, and enhancing health outcomes.</td><td colspan="3">INDICATORS</td></tr>
<tr><td colspan="2">10.1.1 Proportion of Member states that show increased coverage, access and quality of personal (preventive, diagnostic, treatment and rehabilitation) and population-based services</td><td>10.1.2 Number of Member states that show progress in embedding disease-specific programmes in general health services</td></tr>
<tr><td colspan="3">BASELINE 2008</td></tr>
<tr><td colspan="3">To be established</td></tr>
<tr><td colspan="3">TARGETS TO BE ACHIEVED BY 2009</td></tr>
<tr><td colspan="2">15 % increase</td><td>20 % increase</td></tr>
<tr><td colspan="3">TARGETS TO BE ACHIEVED BY 2011</td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td colspan="3">TARGETS TO BE ACHIEVED BY 2013</td></tr>
<tr><td colspan="2">25 % increase</td><td>35 % increase</td></tr>
<tr><td colspan="3">RESOURCES (US$ THOUSAND)</td></tr>
<tr><td>Budget 2008–2009</td><td>Proposed budget 2010–2011</td><td>Estimates 2012–2013</td></tr>
<tr><td>73 379</td><td>130 400</td><td>96 000</td></tr>
<tr><td colspan="3">JUSTIFICATION</td></tr>
<tr><td colspan="3">The management and organization of service delivery presents challenges for many countries, particularly where management of health systems is fragmented, and for WHO, which will need to adjust its way of operating. Progress towards this objective will be measured in terms of results and improvement in institutional arrangements, specifically the integration of programme and system development. The former will use composite indicators that are being operationalized. The latter will assess evolution over time against country or region-specific benchmarks that take regional context into account. As WHO’s way of working evolves and its capacity for support expands, demand for support is expected to grow, which will require increased funding.</td></tr>
</table>

<table>
<tr><td rowspan="4">10.2 National capacities for governance and leadership improved through evidence-based policy dialogue, institutional capacity-building for policy analysis and development, strategy-based health system performance assessment, greater transparency and accountability for performance, and more effective intersectoral collaboration.</td><td colspan="4">INDICATORS</td></tr>
<tr><td>10.2.1 Proportion of Member states that, against regionally agreed benchmarks, show evidence of improving institutional processes, structures and capacities for policy analysis, policy formulation, strategic planning, regulation, interinstitutional coordination and implementation of reform</td><td>10.2.2 Proportion of Member states that, against regionally agreed benchmarks, show evidence of improved accountability for performance and greater participation of civil society, community, consumers and professional organizations in shaping, implementing and reporting on policies</td><td>10.2.3 Proportion of Member states that, against regionally agreed benchmarks, show evidence of improved performance in law development and enforcement, policy formulation, policy implementation and regulation</td><td>10.2.4 Proportion of Member states that, against regionally agreed benchmarks, establish effective intersectoral cooperation mechanisms to improve health-systems’ performance for better health outcomes</td></tr>
<tr><td colspan="4">BASELINE 2008</td></tr>
<tr><td>To be established in 2007-2008</td><td></td><td></td><td></td></tr>
</table>

	TARGETS TO BE ACHIEVED BY 2009			
	Significant improvement compared to 2007-2008 country-specific baseline in at least 10%			
	TARGETS TO BE ACHIEVED BY 2011			
	TARGETS TO BE ACHIEVED BY 2013			
	Significant improvement compared to country-specific baseline in 50%			

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
87 484	55 100	108 000

JUSTIFICATION

The measures that need to be taken to improve the way in which national health systems are governed, steered and regulated are in essence country specific, but have to be informed by evidence, based on enhanced institutional capacities, and should result in improved policy formulation, for which appropriate accountability mechanisms are in place. Progress needs to be assessed objectively, using country- or region-specific benchmarks, and should cover key policy and strategy issues, with a focus on the articulation of service-delivery mechanisms, essential public-health functions, and policies governing pharmaceuticals, technologies, infrastructure development, human-resources, financing, and coordination of the contributions of all major stakeholders in the health sector.

Improving capacities and practices will require systematic collaborative policy reviews that serve to build the evidence bases, create tools, determine benchmarks and norms, and incorporate them in the work of national institutions. The scope of capacity building is likely to expand over time as problems and their solutions are increasingly identified and documented. As WHO's own capacity increases, particularly at regional and country levels, demand for support is expected to grow and the level of support would have to increase accordingly.

10.3 Coordination of the various mechanisms (including donor assistance) that provide support to Member States in their efforts to achieve national targets for health-system development and global health goals improved.	**INDICATORS**
	10.3.1 Number of Member states where the inputs of major stakeholders are harmonized with national policies, measured in line with the Paris Declaration on Aid Effectiveness
	BASELINE 2008
	To be established
	TARGETS TO BE ACHIEVED BY 2009
	Increase by 20% from 2008 baseline
	TARGETS TO BE ACHIEVED BY 2011
	TARGETS TO BE ACHIEVED BY 2013
	Increase by 30% from 2008 baseline

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
15 801	14 700	17 000

	JUSTIFICATION
	Few Member States have mechanisms for coordination, harmonization and alignment of donor and other inputs in the health sector. In order to accelerate progress towards achievement of the Millennium Development Goals, WHO will continue to provide support to governments in their efforts to lead effectively interactions with partners.

10.4 Country health-information systems that provide and use high-quality and timely information for health planning and for monitoring progress towards national and major international goals strengthened.	**INDICATORS**		
	10.4.1 Proportion of low- and middle-income countries with adequate health statistics and monitoring of health-related Millennium Development Goals that meet agreed standards		
	BASELINE 2008		
	30%		
	TARGETS TO BE ACHIEVED BY 2009		
	35%		
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	66%		
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	34 352	34 500	58 000
	JUSTIFICATION		
	The increasing demand for health information is likely to continue, and only through a major effort will countries' health-information systems become stronger. Through major partnerships, notably the Health Metrics Network, more resources have become available in 2006-2007. It is expected that growth will continue modestly beyond 2010 because strengthening health-information systems in countries will take many years, especially for some neglected areas such as vital registration systems.		

10.5. Better knowledge and evidence for health decision-making assured through consolidation and publication of existing evidence, facilitation of knowledge generation in priority areas, and global leadership in health research policy and coordination, including with regard to ethical conduct.	**INDICATORS**		
	10.5.1 Proportion of countries for which high quality profiles with core health statistics are available from its open-access databases	**10.5.2** Number of countries in which WHO plays a key role in supporting the generation and use of information and knowledge, including primary data collection through surveys, civil registration or improvement or analysis and synthesis of health facility data for policies and planning	**10.5.3** Effective research for health coordination and leadership mechanisms established and maintained at global and regional levels
	BASELINE 2008		
	66%	20	Mechanisms operating at global and some regional levels
	TARGETS TO BE ACHIEVED BY 2009		
	80%	30	Mechanisms operating at global and all regional levels
	TARGETS TO BE ACHIEVED BY 2011		

TARGETS TO BE ACHIEVED BY 2013		
Over 90%	45	Mechanisms operating at global and all regional levels

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Programme budget 2010–2011	Estimates 2012–2013
36 484	44 400	38 000

JUSTIFICATION

WHO's contribution to better knowledge and evidence for health decision-making will expand modestly, maintaining and strengthening WHO's position as a world and regional leader in monitoring the health situation. The continuation of the Organization's normative work on classifications in a new era of information technology is expected to lead to a full revision in 2011 of the International Statistical Classification of Diseases and Related Health Problems. A moderate increase in budget is expected in order to meet the demand for WHO's work in this area.

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

INDICATORS

10.6.1	10.6.2
10.6.1 Proportion of low- and middle-income countries in which national health-research systems meet internationally agreed minimum standards	**10.6.2** Number of Member states complying with the recommendation to dedicate at least 2% of their health budget to research (Commission on Health Research for Development, 1990)
BASELINE 2008	
10%-15% (to be refined)	Less than 25% (to be refined)
TARGETS TO BE ACHIEVED BY 2009	
25%	10% increase from baseline 2008
TARGETS TO BE ACHIEVED BY 2011	
TARGETS TO BE ACHIEVED BY 2013	
50%	25% increase from baseline 2008

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
21 088	20 000	38 000

JUSTIFICATION

In view of the current situation in many Member States and globally, overcoming the limitations of national health research for health-system development will be a gradual and long-term process. An increasing number of Member States should become involved during the next decade. The Alliance for Health Policy and Systems Research will play an important role in generating and channelling resources to finance high-priority health-systems research.

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

INDICATORS

10.7.1	10.7.2	10.7.3
10.7.1 Number of Member states adopting knowledge management policies in order to bridge the "know-how" gap particularly aimed to decrease the digital divide	**10.7.2** Number of Member states with access to electronic international scientific journals and knowledge archives in health sciences as assessed by the WHO Global Observatory for eHealth biannual survey	**10.7.3** Proportion of Member states with eHealth policies, strategies and regulatory frameworks as assessed by the WHO Global Observatory for eHealth biannual survey

	BASELINE 2008		
	15	60	15
	TARGETS TO BE ACHIEVED BY 2009		
	30	90	30
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	70	120	70

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Budget 2008–2009
39 064	27 400	39 064

JUSTIFICATION

WHO's work in knowledge management and eHealth policies and strategies will initially be largely normative, but will gradually shift to provision of support to Member States for implementation. Continued investment will be needed during the coming years and a moderate increase of the budget is required in order to include and provide support to an increasing number of Member States.

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

INDICATORS

10.8.1 Number of countries reporting two or more national data points on human resources for health within the past five years, reported in the Global Atlas of the Health Workforce	10.8.2 Number of Member states with an national policy and planning unit for human resources for health
BASELINE 2008	
63	40
TARGETS TO BE ACHIEVED BY 2009	
75	50
TARGETS TO BE ACHIEVED BY 2011	
TARGETS TO BE ACHIEVED BY 2013	
96	60

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
76 216	46 400	67 000

JUSTIFICATION

Availability of skilled health workers contributes to improved health outcomes, such as maternal, infant and child survival. Yet development of the health workforce cannot be dealt with in isolation. Dialogue between stakeholders and work across sectors are required in order to analyse human-resources constraints and to identify and implement effective solutions. The knowledge base in human resources for health needs to be further developed. Data and information needs to be collected and analysed in order to determine appropriate indicators with which to monitor global and regional situations and trends in the health workforce. Research needs to be supported and further stimulated in order to expand knowledge and to identify and promote best practices in health-workforce development. These efforts should eventually be reflected in increased capacity of countries to promote health-workforce development, assure political commitment, and create an environment that enables formulation of national policies and plans and pursuit of their implementation, in order to reduce shortages and redress the maldistribution of health workers. Capacity of WHO at all levels needs to be strengthened in order to provide support for health-workforce development in countries.

10.9 Technical support provided to Member States, with a focus on those facing severe health-workforce difficulties in order to improve the production, distribution, skill mix and retention of the health workforce.	**INDICATORS**	
	10.9.1 Proportion of 57 countries with critical shortage of health workforce, as identified in *The world health report 2006* with a multi-year HRH plan	**10.9.2** Proportion of 57 countries with critical shortage of health workforce, as identified in *The world health report 2006* which have an investment plan for scaling up training and education of health workers
	BASELINE 2008	
	Less than 10%	Less than 10%
	TARGETS TO BE ACHIEVED BY 2009	
	At least 10%	At least 10%
	TARGETS TO BE ACHIEVED BY 2011	
	TARGETS TO BE ACHIEVED BY 2013	
	At least 50%	At least 50%

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
40 041	66 500	62 000

JUSTIFICATION

Resolutions WHA59.23 and WHA59.27 called for a rapid scaling up of health-workforce production and a further strengthening of nursing and midwifery in order to respond to the global crisis of human resources for health. Shortages and imbalances in the health workforce are at a critical level in 57 countries. National institutions need to be strengthened in order to improve production capacity and quality of education and training of the health workforce. Tools, guidelines and other technical support will be provided so as to ensure that countries can build their health workforce across the continuum of entry, working life and exit. Migration of health workers will be given special attention, and efforts to manage international migration will be renewed, in collaboration with global partners.

10.10 Evidence-based policy and technical support provided to Member States in order to improve health-system financing in terms of the availability of funds, social and financial-risk protection, equity, access to services and efficiency of resource use.	**INDICATORS**	
	10.10.1 Number of Member states provided with technical and policy support to raise additional funds for health; to reduce financial barriers to access, incidence of financial catastrophe, and impoverishment linked to health payments; or to improve social protection and the efficiency and equity of resource use	**10.10.1** Number of key policy briefs prepared, disseminated and their use supported, which document best practices on revenue-raising, pooling and purchasing, including contracting, provision of interventions and services, and handling of fragmentation in systems associated with vertical programmes and inflow of international funds
	BASELINE 2008	
	15	6 technical briefs for policy-makers
	TARGETS TO BE ACHIEVED BY 2009	
	40	12 technical briefs
	TARGETS TO BE ACHIEVED BY 2011	
	TARGETS TO BE ACHIEVED BY 2013	
	90	20 technical briefs

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
31 249	33 200	41 000

JUSTIFICATION

Requests for support from Member States have substantially increased on ways to improve the efficiency and/or equity of their health-financing systems, and to extend financial-risk protection to vulnerable groups. Response requires the assessment and dissemination of experiences and best practices across settings. To meet the rising demand, a significant increase in resources is required for 2008–2009, with modest increases subsequently.

10.11 Norms, standards and measurement tools developed for tracking resources, estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe, impoverishment, and social exclusion, and their use supported and monitored.

INDICATORS

10.11.1 Key tools, norms and standards to guide policy development and implementation developed, disseminated and their use supported, according to expressed need, that comprise resource tracking and allocation, budgeting, financial management, economic consequences of disease and social exclusion, organization and efficiency of service delivery, including contracting, or the incidence of financial catastrophe and impoverishment	**10.11.2** Number of Member states provided with technical support for using WHO tools to track and evaluate the adequacy and use of funds, to estimate future financial needs, to manage and monitor available funds, or to track the impact of financing policy on households

BASELINE 2008

Tools produced and disseminated on national health accounts, costing, financial catastrophe and impoverishment, cost-effectiveness, implications of health-insurance design, and contracting	15

TARGETS TO BE ACHIEVED BY 2009

Additional tools developed for resource tracking, additionally and economic burden; existing tools revised where necessary; framework drawn up for formulation of financing policy	30

TARGETS TO BE ACHIEVED BY 2011

TARGETS TO BE ACHIEVED BY 2013

Tools and frameworks modified, updates and disseminated as necessary	50

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
23 896	18 500	28 000

JUSTIFICATION

Demand is rising for WHO to provide norms or guidelines on methods to estimate the economic impact of illness, to track expenditures on particular diseases, or to identify and monitor households suffering financial catastrophe and impoverishment as a result of out-of-pocket payments for health services. In order to meet this demand capacity needs to be expanded substantially, together with the ability to provide support to policy-makers seeking to use the resulting norms and standards.

<table>
<tr><td rowspan="16">10.12 Steps taken to advocate additional funds for health where necessary; to build capacity in framing of health-financing policy and interpretation and use of financial information; and to stimulate the generation and translation of knowledge to support policy development.</td><td colspan="2">INDICATORS</td></tr>
<tr><td>10.12.1 WHO presence and leadership in international, regional and national partnerships and use of its evidence in order to increase financing for health in low-income countries, or provide support to countries in design and monitoring of Poverty Reduction Strategy Papers, sector-wide approaches, medium-term expenditure frameworks, and other long-term financing mechanisms capable of providing social health protect consistent with primary health care</td><td>10.12.2 Number of Member states provided with support to build capacity in the formulation of health financing policies and strategies and the interpretation of financial data, or with key information on health expenditures, financing, efficiency and equity to guide the process</td></tr>
<tr><td colspan="2">BASELINE 2008</td></tr>
<tr><td>WHO participation in 2 global or regional partnerships on financing options; support provided on long-term financing options in 6 countries</td><td>Technical support provided to 25 countries and annual updates on health expenditure to all 193 Member States</td></tr>
<tr><td colspan="2">TARGETS TO BE ACHIEVED BY 2009</td></tr>
<tr><td>WHO participation in 4 partnerships; country support provided on long-term financing options in 16 countries</td><td>Technical support provided to 55 countries, and annual updates of health expenditures to all Member States, together with information on the incidence of catastrophic expenditures in 90 countries</td></tr>
<tr><td colspan="2">TARGETS TO BE ACHIEVED BY 2011</td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">TARGETS TO BE ACHIEVED BY 2013</td></tr>
<tr><td>WHO participation in 8 partnerships; support provided to 40 countries</td><td>Technical support provided to 90 countries, annual updates of health expenditures to all Member States, and revised and updated information on catastrophic expenditures to an additional 20 countries</td></tr>
<tr><td colspan="2">RESOURCES (US$ THOUSAND)</td></tr>
<tr><td colspan="2">Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013</td></tr>
<tr><td colspan="2">35 000 | 20 100 | 47 000</td></tr>
<tr><td colspan="2">JUSTIFICATION</td></tr>
<tr><td colspan="2">WHO has contributed to international and national efforts to raise additional financing for health in poor countries and for vulnerable groups everywhere. It is important to build up momentum internationally and to provide active support to countries so as to incorporate health into economic plans such as medium-term expenditure frameworks. Capacity of country offices and other levels of WHO needs to be strengthened in support of these efforts.</td></tr>
</table>

<table>
<tr><td rowspan="6">10.13 Evidence based norms, standards and measurement tools developed to support member states to quantify and decrease the level of unsafe health care provided.</td><td colspan="2">INDICATORS</td></tr>
<tr><td>10.13.1 Key tools, norms and standards to guide policy development, measurement and implementation disseminated and their use supported</td><td>10.13.2 Number of Member states participating in global patient safety challenges and other global safety initiatives, including research and measurement</td></tr>
<tr><td colspan="2">BASELINE 2008</td></tr>
<tr><td>1 global safety standards and 10 major supporting tools</td><td>30</td></tr>
<tr><td colspan="2">TARGETS TO BE ACHIEVED BY 2009</td></tr>
<tr><td></td><td>45</td></tr>
</table>

TARGETS TO BE ACHIEVED BY 2011

TARGETS TO BE ACHIEVED BY 2013

100% increase	

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	34 500	

JUSTIFICATION

Patient safety has become a global health agenda. WHO will provide norms and guidelines to support member states in estimating and tracking the nature and the size of the problem. WHO will also provide evidence-based guidelines for improving safety in priority areas. The response of WHO needs to be comprehensive. The Secretariat and Member States must work together to improve safety and coordinate international expertise.

STRATEGIC OBJECTIVE 11

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

Indicators and targets

- Access to essential medical products and technologies, as part of the fulfilment of the right to health, recognized in countries' constitutions or national legislation. Target: such recognition in 50 countries in 2013
- Availability of and median consumer price ratio for 30 selected generic essential medicines in the public, private and nongovernmental sectors. Target: (1) 80% availability of medicines in all sectors and (2) a median consumer price ratio for the selected generic medicines of not more than four times the world market price for those generic products
- Developmental stage of national regulatory capacity. Target: national regulatory authority assessed; 33% of countries with basic-level, 50% with intermediary-level and 17% with high-level regulatory functions in place by 2013
- Proportion of vaccines in use in childhood immunization programmes that are of assured quality. Target: 100% by 2013
- Percentage of prescriptions in accordance with current national or institutional clinical guidelines. Target: 70% by 2013

ISSUES AND CHALLENGES

Successful primary health care, achievement of the health-related Millennium Development Goals and functioning of new global funding mechanisms fully depend on the availability of medicines, medical products, vaccines and health technologies of assured quality. In Member States, about half the overall expenditure on health is on medical products, yet about 27 000 people die unnecessarily every day owing to lack of access to basic essential medicines. Paediatric formulations for many essential medicines are lacking. International market forces do not favour the development of new products for the diseases of poverty, and international trade agreements set prices of future essential medicines out of the reach of most people who need them. Globalization allows for an unprecedented growth in counterfeit medical products. Safety monitoring of new medicines for HIV/AIDS, tuberculosis, malaria and tropical diseases is missing in exactly those geographical areas where they are to be used most.

Medical products and technologies, including devices, save lives, reduce suffering and improve health, but only when they are of good quality, safe, effective, available, affordable, acceptable and properly used by prescribers and patients. In many countries, not all these conditions are met. This failure is often due to lack of awareness of the potential benefits in medical outcomes and economic savings; lack of political will and public investment; commercial and political pressures, including those of donors; and discordant strategies on financing and supply. A balance needs to be struck between short-term gain

Lessons learnt

- Without high-level political support and additional investment, both in WHO and in national health budgets, the large potential of essential medical products and technologies will remain untapped, leading to unnecessary disease, disability, death and economic waste.
- Great potential exists for improvements in quality and economic savings (for example, programmes on rational use of medicines can yield a three-fold economic return and those on prequalification a 200-fold return).
- New global funding programmes pay little attention to the need for national capacity building in quality assurance, procurement and supply management, pharmacovigilance, and rational use of medicines and technologies, which is generally seen as WHO's responsibility; without improvements in these areas much of the new funding may be wasted.
- Demand from Member States for medical product- and technology-related support greatly exceeds what the Secretariat can provide.

through special vertical systems and long-term development of comprehensive national policies and supply systems for medical products and technologies, within comprehensive health systems.

The development and implementation of comprehensive policies on medical products and technology aimed at improving access to essential medical products and technologies of assured quality and improving their use, within a comprehensive health system, would contribute significantly to improving health and reducing morbidity and mortality from, in particular, HIV/AIDS, malaria, tuberculosis, and childhood and maternal diseases.

STRATEGIC APPROACHES

Expanding access to essential medical products and technologies of assured quality and improving their use by health workers and consumers have for many years been priorities for Member States and the Secretariat. This long-term goal can best be achieved through the establishment and implementation of comprehensive national policies on medical products and technologies.

Adequate supply of medical products and technologies of assured quality and their rational use depend largely on market forces but also require public investment, political will and capacity building within national institutions (including regulatory agencies).

Applying evidence-based international norms and standards, developed through rigorous, transparent, inclusive and authoritative processes, and establishing and implementing programmes in order to promote good supply management, quality assurance and rational use of medical products and technologies, including devices, are essential. Attention should focus on reliable procurement, combating counterfeit and substandard products, cost-effective clinical interventions, long-term adherence to treatment, and containing antimicrobial resistance.

Emphasis will also be laid on promoting a public health approach to innovation, providing support to countries for using the flexibilities provided for in the Agreement on Trade-Related Aspects of Intellectual Property Rights, and adapting interventions that have proved successful in high-income countries to the needs and conditions of low- and middle-income countries. The work of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property, as discussed at the Health Assemblies in 2007 and 2008, will be taken into account. In addition, monitoring access, safety, quality, effectiveness and use of products and technologies through independent assessments will be encouraged. The Secretariat will combine its recognized technical leadership role and unique global normative functions with international advocacy, policy guidance and targeted country support.

The Secretariat will focus on:

- developing policy guidance, nomenclatures and reference materials through Expert Advisory Panels and Committees, regional and global consultation processes, or other global or regional normative processes, with particular emphasis on equitable access and rational use of essential products (including paediatric formulations) and technologies, international quality and clinical standards for new essential products and technologies, standards for traditional medicines, and strategies to promote and monitor the use of WHO's standards;
- promoting equitable access to, and rational use of, good-quality products and technologies through provision of technical and policy support to health authorities, professional networks, consumer organizations and other stakeholders, and facilitating needs assessments and capacity building;
- implementing directly high-quality programmes through the WHO/United Nations prequalification programmes for priority vaccines, medicines and diagnostics;
- providing support to countries for producing, using and exporting products of assured quality, safety and efficacy through strengthening of national regulatory authorities and an international programme to combat counterfeits;
- providing support to countries for establishing and implementing programmes to promote good supply management, reliable procurement and rational use of products and technologies;
- providing support to countries for establishing or strengthening systems for post-marketing surveillance, pharmacovigilance, ensuring blood safety and monitoring prescription, and for communicating the outcomes to citizens and other stakeholders in order to promote patient safety;

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

- that achieving universal access to essential products and technologies of assured quality and improving their use by health workers and consumers will remain priorities for Member States and therefore the Secretariat;
- that WHO will resist undue political and commercial pressure and will continue to fulfil its constitutional and international treaty obligations with regard to the development of international pharmaceutical norms and standards for products and technologies;
- that sufficient resources will be available, thereby reversing the trend of the last decade.

The following risks may hinder achievement of the strategic objective:

- that work within national systems and the Secretariat related to medical products and technology will be split between different vertical programmes, instead of being integrated within a comprehensive health system;
- that insufficient recognition by the new global funding programmes of the need for national capacity building in quality assurance, procurement and supply management, rational use and pharmacovigilance and blood-safety systems will result in a large proportion of the new funds being wasted.

The Secretariat will focus on:

- collating in global databases and reviewing reports and information on significant events or global signals on product quality or safety, and disseminating the results;
- stimulating the development, testing and use of new products, tools, standards and policy guidelines to promote better access, quality and use of products and technologies that target the major disease burden in countries.

ORGANIZATION-WIDE EXPECTED RESULTS

11.1 Formulation and monitoring of comprehensive national policies on access, quality and use of essential medical products and technologies advocated and supported.	**INDICATORS**			
	11.1.1 Number of Member States receiving support to formulate and implement official national policies on access, quality and use of essential medical products or technologies	**11.1.2** Number of Member States receiving support to design or strengthen comprehensive national procurement or supply systems	**11.1.3** Number of Member States receiving support to formulate and/or implement national strategies and regulatory mechanisms for blood and blood products or infection control	**11.1.4** Publication of a biennial global report on medicine prices, availability and affordability, based on all available regional and national reports
	BASELINE 2008			
	62	20	46	Report published in 2007
	TARGETS TO BE ACHIEVED BY 2009			
	68	25	52	Report published
	TARGETS TO BE ACHIEVED BY 2011			
	TARGETS TO BE ACHIEVED BY 2013			
	78	35	64	2 reports published (2011 and 2013)

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
39 305	65 200	44 000

JUSTIFICATION

WHO's global policy guidance on access to medical products and health technologies is widely respected. This component of WHO's work promotes equity, sustainability and the integration of the many vertical programmes into one national supply system.

11.2 International norms, standards and guidelines for the quality, safety, efficacy and cost-effective use of medical products and technologies developed and their national and/or regional implementation advocated and supported.

INDICATORS

11.2.1 Number of new or updated global quality standards, reference preparations, guidelines and tools for improving the provision, management, use, quality, or effective regulation of medical products and technologies	**11.2.2** Number of assigned International Nonproprietary Names for medical products	**11.2.3** Number of priority medicines, vaccines, diagnostic tools and items of equipment that are prequalified for United Nations procurement	**11.2.4** Number of Member States for which the functionality of the national regulatory authorities has been assessed or supported
BASELINE 2008			
30 per biennium	8900	150	20
TARGETS TO BE ACHIEVED BY 2009			
30 additional	9100	250	30
TARGETS TO BE ACHIEVED BY 2011			
TARGETS TO BE ACHIEVED BY 2013			
60 additional	9500	500	80

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
69 172	72 200	104 000

JUSTIFICATION

The Secretariat's global normative work in vaccines, medicines, and health technologies is unique and highly appreciated by Member States, other bodies in the United Nations system, and international and nongovernmental organizations. It benefits all Member States and should remain independent of individual donors' decisions. There is an unexpectedly high demand for WHO's prequalification programme in vaccines, priority medicines and diagnostics. The programme has become the main engine of capacity building in national regulatory agencies. Resource requirements are expected to increase by about 30% in response to the full demands for prequalification of vaccines, priority medicines and diagnostics.

<table>
<tr><td rowspan="14">11.3 Evidence-based policy guidance on promoting scientifically sound and cost-effective use of medical products and technologies by health workers and consumers developed and supported within the Secretariat and regional and national programmes.</td><td colspan="3">INDICATORS</td></tr>
<tr><td>11.3.1 Number of national or regional programmes receiving support for promoting sound and cost-effective use of medical products or technologies</td><td colspan="2">11.3.2 Number of Member States using national lists, updated within the past five years, of essential medicines, vaccines or technologies for public procurement or reimbursement</td></tr>
<tr><td colspan="3">BASELINE 2008</td></tr>
<tr><td>5</td><td colspan="2">80</td></tr>
<tr><td colspan="3">TARGETS TO BE ACHIEVED BY 2009</td></tr>
<tr><td>10</td><td colspan="2">90</td></tr>
<tr><td colspan="3">TARGETS TO BE ACHIEVED BY 2011</td></tr>
<tr><td></td><td colspan="2"></td></tr>
<tr><td colspan="3">TARGETS TO BE ACHIEVED BY 2013</td></tr>
<tr><td>20</td><td colspan="2">100</td></tr>
<tr><td colspan="3">RESOURCES (US$ THOUSAND)</td></tr>
<tr><td>Budget 2008–2009</td><td>Proposed budget 2010–2011</td><td>Estimates 2012–2013</td></tr>
<tr><td>25 556</td><td>23 300</td><td>34 000</td></tr>
<tr><td colspan="3">JUSTIFICATION
Most new funding mechanisms, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and UNITAID, pay little attention to promoting the rational use by prescribers and consumers of the medicines they supply, which is generally seen as WHO's responsibility. Without improvements in this area health outcomes cannot be fully attained and much of the new funding may be wasted.</td></tr>
</table>

STRATEGIC OBJECTIVE 12

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

Indicators and targets

- Number of countries implementing health-related resolutions and agreements adopted by the Health Assembly. Target: more than half the Member States by 2013
- Number of countries that have a country cooperation strategy agreed by the government, with a qualitative assessment of the degree to which WHO resources are harmonized with partners and aligned with national health and development strategies. Target: 80 by 2013 (baseline: 3 in 2006-2007)
- Degree of attainment by Official Development Assistance for Health of Paris Declaration benchmarks on harmonization and alignment.[1] Target: 100% of benchmarks met by 2013

ISSUES AND CHALLENGES

The leadership and governance of the Organization is assured by governing bodies – the Health Assembly, Executive Board and regional committees – and through the senior officers of the Secretariat at global and regional levels – the Director-General and the Regional Directors.

The governing bodies need to be serviced effectively, and their decisions implemented in a responsive and transparent way. Clear lines of authority, responsibility and accountability are needed within the Secretariat, especially in a context where resources, and decisions on their use, are increasingly decentralized to locations where programmes are implemented.

At all levels, the Organization’s capabilities need to be strengthened to cope with the ever-growing demand for information on health, appropriately disaggregated by sex and age. The Organization should be equipped to communicate internally and externally in a timely and consistent way at global, region and country levels – both proactively and in times of crises – in order to demonstrate its leadership and commitment to equity in health, provide essential health information, and ensure visibility.

Lessons learnt

- With an increasing number of sectors, actors and partners involved in health, WHO’s role and strengths need to be well understood and recognized. WHO will need to maintain its position in order to achieve its objectives and contribute to eliminating social disparities in health and to reaching the health-related Millennium Development Goals.
- The growing number of others involved in health work has also led to gaps in accountability and an absence of synergy in coordination of action. Global health partnerships offer the potential to combine the different strengths of public and private organizations, along with civil society groups, in tackling health problems and inequities.

[1] Paris Declaration on Aid Effectiveness: Ownership, Harmonisation, Alignment, Results and Mutual Accountability, Paris, 2 March 2005. WHO is working with OECD, the World Bank and other stakeholders to adapt the Paris Declaration to health. The following targets will gradually become more health focused as the process evolves: 50% of Official Development Assistance implemented through coordinated programmes consistent with national development strategies; 90% of procurement supported by such Assistance effected through partner countries’ procurement systems; 50% reduction in Assistance not disbursed in the fiscal year for which it was programmed; 66% of Assistance provided in the context of programme-based approaches; 40% of WHO country missions conducted jointly; 66% of WHO country analytical work in health conducted jointly.

There is a need for strong political will, good governance and leadership at country level. Indeed, the State plays a key role in shaping, regulating and managing health systems and designating the respective health responsibilities of government, society and the individual. This means dealing not only with health-sector issues but with broader ones, for instance social inequities, reform of the civil service or macroeconomic policy, which can have a major impact on the delivery of health services. The Secretariat, for its part, needs to ensure that it focuses its support around clearly articulated country strategies, that these are reflected and consistent with WHO's medium-term plans and programme budgets, and that the Organization's presence is matched to the needs and level of development of the country concerned in order to provide optimal support.

At global level, certain mechanisms should be strengthened to allow stakeholders to tackle health issues in a transparent, equitable and effective way. WHO should help to ensure that national health policy-makers and advisers are fully involved in all international forums that discuss health-related issues. This is particularly important in a time of social and economic interdependence, where decisions on issues such as trade, conflict and human rights can have major consequences for health. The numerous actors in public health, outside government and intergovernmental bodies, whether activists, academics or private-sector lobbyists, need to have forums so that they can contribute in a transparent way to global and national debates on health-related policies; they also play a part in ensuring good governance and accountability.

Lessons learnt

- Expectations of the United Nations system are increasing, as is the need to be more clear on how it adds value. Of particular importance are relations at country level where many changes are taking place as international organizations align their work with national health policies and programmes, and harmonize their efforts so as to reduce the overall management burden. In this context, WHO needs to continue to play a proactive role, and to devise innovative mechanisms for managing or participating in global partnerships in order to make the international health architecture more efficient and responsive to the needs of Member States.

STRATEGIC APPROACHES

Achieving the strategic objective will require Member States and the Secretariat to work closely together. More specifically, key actions should include leading, directing and coordinating the work of WHO; strengthening the governance of the Organization through stronger engagement of Member States and effective Secretariat support; and effectively communicating the work and knowledge of WHO to Member States, other partners, stakeholders and the general public.

In collaborating with countries to advance the global health agenda, WHO will contribute to the formulation of equitable national strategies and priorities, and bring country realities and perspectives into global policies and priorities. The different levels of the Organization would be coordinated on the basis of an effective country presence that reflects national needs and priorities and integrates common principles of gender equality and health equity. At national level the Organization will promote multisectoral approaches for advancing the global health agenda; build institutional capacities for leadership and governance and for health development planning; it will also facilitate technical cooperation among developing and developed countries.

Other actions include promoting development of functional partnerships and a global health architecture that ensures equitable health outcomes at all levels; encouraging harmonized approaches to health development and health security with organizations of the United Nations system, other international bodies, and other stakeholders in health; actively participating in the debate on reform of the United Nations system; and acting as a convener on health issues of global and regional importance.

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of the strategic objective:

- that commitment from all stakeholders to health equity, good governance and strong leadership is maintained; and Member States and the Secretariat comply with the resolutions and decisions of the governing bodies;
- that the current relationship of trust between Member States and the Secretariat is maintained;
- that accountability for actual implementation of action decided on will be strengthened in the context of the results-based management framework;
- that possible changes in the external and internal environment over the period of the medium-term strategic plan will not fundamentally alter the role and functions of WHO; however, WHO must be able to respond and adapt itself to, for instance, changes stemming from reform of the United Nations system.

Among the risks that might affect achievement of the strategic objective consideration could be given to possible consequences of the reform of the United Nations system; opportunities would be increased if WHO takes initiatives and plays a proactive role in this process. Also, the increasing number of partnerships might give rise to duplication of effort between initiatives, high transaction costs to government and donors, unclear accountability, and lack of alignment with country priorities and systems; remedial action would be needed if this development occurs.

ORGANIZATION-WIDE EXPECTED RESULTS

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

	INDICATORS	
	12.1.1 Proportion of documents submitted to governing bodies within constitutional deadlines in the six WHO official languages	**12.1.2** Level of understanding by key stakeholders of WHO's role, priorities and key messages as provided by a stakeholder survey
BASELINE 2008	50%	76% of stakeholders familiar/very familiar with WHO roles and priorities
TARGETS TO BE ACHIEVED BY 2009	75%	86% of stakeholders familiar/very familiar with WHO roles and priorities
TARGETS TO BE ACHIEVED BY 2011		
TARGETS TO BE ACHIEVED BY 2013	90%	96% of stakeholders familiar/very familiar with WHO roles and priorities

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
87 222	156 900	108 128

JUSTIFICATION

This Organization-wide expected result covers a wide range of activities, including the organization of governing body sessions and other intergovernmental health forums. WHO's convening role is expected to increase over the coming years. Emphasis on the strengthening of WHO's institutional integrity, including the oversight functions, will continue to be an essential component in achieving this result.

12.2 Effective WHO country presence[1] established to implement WHO country cooperation strategies that are aligned with Member States' health and development agendas, and harmonized with the United Nations country team and other development partners.

	INDICATORS		
	12.2.1 Number of Member States where WHO is aligning its country cooperation strategy with the country's priorities and development cycle and harmonizing its work with the United Nations and other development partners within relevant frameworks, such as the United Nations Development Assistance Framework, Poverty Reduction Strategy Papers and Sector-Wide Approaches	**12.2.2** Proportion of WHO country offices which have reviewed and adjusted their core capacity in accordance with their country cooperation strategy	**12.2.3** Proportion of country workplans that are consistent with their country cooperation strategy
BASELINE 2008	40	20%	
TARGETS TO BE ACHIEVED BY 2009	80	40%	
TARGETS TO BE ACHIEVED BY 2011			

[1] WHO country presence is the platform for effective collaboration with countries for advancing the global health agenda, contributing to national strategies, and bringing country realities and perspectives into global policies and priorities.

	TARGETS TO BE ACHIEVED BY 2013		
	145	80%	
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	71 128	30 800	87 481
	JUSTIFICATION		
	WHO's commitment to strengthen operations have greater impact at country level will be maintained and may require resources in the coming years in order, for example, to increase ability to collaborate more with country-level partners and harmonization mechanisms.		

12.3 Global health and development mechanisms established to provide more sustained and predictable technical and financial resources for health on the basis of a common health agenda which responds to the health needs and priorities of Member States.	**INDICATORS**		
	12.3.1 Number of health partnerships in which WHO participates that work according to the best practice principles for Global Health Partnerships	**12.3.2** Proportion of health partnerships managed by WHO that comply with WHO partnership policy guidance	**12.3.3** Proportion of countries where WHO is leading or actively engaged in health and development partnerships (formal and informal), including in the context of reforms of the United Nations system
	BASELINE 2008		
	3	0%	Less than 20%
	TARGETS TO BE ACHIEVED BY 2009		
	10	14 %	Over 50%
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	50	100%	To be established by 2009
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	21 030	33 800	26 058
	JUSTIFICATION		
	A slight increase of resources is foreseen in this Organization-wide expected result for the coming years, as it becomes increasingly important to collaborate more actively globally and regionally with other actors in health and development.		

12.4 Essential multilingual health knowledge and advocacy material made accessible to Member States, health partners and other stakeholders through the effective exchange and sharing of knowledge.	**INDICATORS**	
	12.4.1 Average number of page views/visits per month to the WHO headquarters' web site	**12.4.2** Number of pages in languages other than English available on WHO country and regional offices' and headquarters' web sites
	BASELINE 2008	
	28 million/3.5 million	12 733
	TARGETS TO BE ACHIEVED BY 2009	
	48 million/5 million	22 000
	TARGETS TO BE ACHIEVED BY 2011	

TARGETS TO BE ACHIEVED BY 2013	
80 million/7 million	40 000

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
34 964	32 400	43 333

JUSTIFICATION

In line with WHO's work, the activities related to this Organization-wide expected result will slightly increase.

STRATEGIC OBJECTIVE 13

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

Indicators and targets

- Cost-effectiveness of the enabling functions of the Organization, i.e. the share of overall budget spent on this strategic objective relative to the total WHO budget. Target: 12% in 2013 (baseline: 14.5% in 2006-2007)
- Alignment of expenditure with the programme budget, measured by the proportion of strategic objectives that have spent 80% to 120% against the programme budget. Target: 90% of strategic objectives by 2013 (baseline: 60% of areas of work in 2004-2005)
- Effectiveness of managerial and administrative capacity at country level (methodologies to measure this are under development as part of the process of measuring WHO's overall effectiveness at country level).

ISSUES AND CHALLENGES

As highlighted in the Eleventh General Programme of Work, continuous change is today the norm. The Organization must continue to evolve in a flexible and responsive manner in order to respond successfully to evolving global health challenges that in the future may be very different from those of today.

Global public health, within which WHO plays a key role, is increasingly complex. New actors and partnerships continue to emerge, and WHO must be strategic in its relations, in line with its role as the lead international agency for health. Moreover, efforts to harmonize activities in the development community and broader reforms within the United Nations system also influence the way in which global and local actors operate. WHO will participate actively in these developments, and can contribute proactively to reform of the United Nations system, for example through setting an example in its own ways of working.

Investments in health have increased substantially over the past 10 years, leading to a growing demand from countries for technical support from WHO. This increased investment has also impacted on WHO's relations with major partners and contributors, which are expecting increasing transparency and accountability in terms of both measurable results and use of financial resources.

Advances in information technology, increasing dependence on global economic cycles, innovation in managerial techniques and an increasingly competitive job market influence the way WHO can and should be managed.

Within this context, and despite progress in a number of areas, there remain challenges for improving managerial and administrative support throughout the Organization.

Lessons learnt

- Improving managerial effectiveness and efficiency requires time and commitment over the long-term from senior management and staff.
- Robust information systems that provide timely and accurate information globally (including appropriate sex and age disaggregation) are essential for translating managerial reforms into day-to-day practice.
- Efficient management and administration of WHO programmes require the right balance between global policies and systems, and decentralized implementation that recognizes regional and country specificities.
- The drive to emphasize performance management and greater accountability – programmatic and individual – must be sustained and strengthened further.
- More efforts are required to ensure that organizational policies and commitments to gender equality and health equity are communicated, understood and integrated at all levels of the Organization, in particular through learning and development activities.

WHO's results-based management framework has been strengthened through the work needed for preparation of the Eleventh General Programme of Work and the Medium-term strategic plan. More can be done, however, to ensure that the framework builds on lessons learnt, better reflects country needs, encourages greater collaboration and promotes gender equality throughout the Organization.

Financial management continues to be a challenge in a situation in which about 80% of the Organization's resources are voluntary contributions. Regular monitoring of, and reporting on, resources across the Organization has improved. However, more flexibility and less earmarking is required in the financing from partners together with more effective use of funds internally for better alignment of resources with the programme budget and lowering of transaction costs.

Progress has been achieved in implementing far-reaching reforms in human resources management, including streamlining of recruitment and classification procedures, adoption of a global competency model for all staff, establishment of a staff development fund, and launching of a leadership programme for all senior managers. Building on these advances, further efforts are needed to improve planning of human resources and to further strengthen a culture that promotes learning and manages performance. Work will also be required to facilitate the rotation and mobility of staff within the Organization.

Work-life balance needs to be recognized as an issue for staff seeking to balance their roles in the paid workforce with other responsibilities. Gender differences and the demands on people brought about by circumstances need to be taken into consideration, for example, the role many women play in caring for dependent family members, while maintaining a role in the paid workforce.

The twin aims of the newly implemented global management system are to improve the efficiency and effectiveness of the Organization and to enhance the impact of WHO's programmes at country level .The global management system has been supported by administrative, procedural and structural changes, including the establishment of the global service centre in Malaysia. These changes will need to be continuously monitored to ensure that the full potential of the system can be realized across the Organization.

Recognizing the decentralized nature of WHO's work, a key challenge at all levels of the Secretariat has been the alignment between responsibility and authority, which is a prerequisite for sound accountability. Through the implementation of the global management system, alignment has been greatly enhanced. However, further work is required to implement a broader accountability framework for the Organization. Also, particular emphasis should be placed on strengthening the managerial capacity of WHO country offices.

The Secretariat will focus on:

- strengthening a results-based approach in all aspects of WHO's work, an approach that emphasizes the importance of gender equality and health equity, learning, joint planning and collaboration, and that reflects WHO's strengths within the global health and development community;
- instituting a more integrated, strategic and equitable approach to financing the programme budget and managing financial resources throughout the Organization; this includes a more coordinated approach to mobilization of resources;
- creating a culture that embeds learning processes in the work of all staff, fosters ethical behaviour, gender equality and integrity, rewards performance, and facilitates mobility in order to ensure the effective and efficient staffing;
- strengthening operational support throughout the Organization by continuously seeking more cost-effective ways to provide administrative, information and managerial systems and services, including optimization of the location from which such services are delivered; providing a safe and healthy working environment, including attention to work-life balance; managing through clearly defined service-level agreements;
- providing frameworks and tools to implement strong accountability mechanisms in the Secretariat while supporting collaboration and coordination across its different levels.

Over the past two years, the Organization has faced serious challenges in financing investments in major renovation of infrastructure and in meeting United Nations minimum operating security standards. This has mainly been due to increasing operational support needs, as well as to past decisions to defer projects because of a lack of funding. It has therefore become necessary to identify a sustainable mechanism for financing investment in major renovation of infrastructure, security and safety.

STRATEGIC APPROACHES

In order to achieve the strategic objective and respond to the above challenges, broad complementary approaches are required. Over the past years significant efforts have been made in internal reforms to enhance the Secretariat's administrative and managerial capabilities, efforts that are starting to show results. These approaches will be intensified during the coming years, and include the move from an organization managed mainly through tight, overly bureaucratic controls to post facto monitoring in support of greater delegation and accountability; the shift of responsibility for, and decision-making on, the use of resources closer to where programmes are implemented; improvement of managerial transparency and integrity; reinforcement of corporate governance and common Organization-wide systems, while recognizing regional specificities; and strengthening of managerial and administrative capacities and competencies in all locations, in particular at country offices. Successful implementation of these strategic approaches will require active support from Member States through, for instance, timely financing of the Organization's programme budget, including voluntary contributions.

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of the strategic objective:

- that there is support in WHO – both Member States and Secretariat – to continue and further accelerate the reforms under way; improving managerial methods in a sustainable fashion requires strong leadership from senior management and commitment from all staff to ensure that strategies and policies are effectively translated into day-to-day practices and behaviour;
- that communication internally and externally is clear in order to ensure that efforts to meet this objective remain relevant to the changing needs of the Organization;
- that the changes in the external and internal environment likely to occur over the six-year period of the plan will not fundamentally alter the role and functions of WHO; nonetheless, managerial reforms should help shape WHO into a more flexible organization that is able to adapt to change;

- that pressure to contain administrative costs is likely to persist; the Secretariat will therefore continue to minimize costs and ensure that all options are considered, including outsourcing or relocation opportunities.

The strategic objective is inherently linked to the work of the rest of the Organization; increasing workload in other strategic objectives will require increased resources to support that work, even if the relationship is not necessarily linear. Among the risks that might affect its achievement is the impact of changes in ways of working, which must not be carried out to the detriment of institutional knowledge, quality, appropriate controls and accountability.

In provision of a physical working environment that is conducive to the well-being and safety of staff in all locations, serious problems may arise when expenditure on facilities is deferred, as lack of maintenance can lead to breakdowns, which in turn increase the overall need for resources to undertake emergency repairs at a later date and at a higher cost due to the fluctuation of exchange rates and inflation.

ORGANIZATION-WIDE EXPECTED RESULTS

13.1 Work of the Organization guided by strategic and operational plans that build on lessons learnt, reflect country needs, are elaborated across the Organization, and used to monitor performance and evaluate results.

INDICATORS

13.1.1 Proportion of country workplans that have been peer reviewed with respect to their technical quality, that they incorporate lessons learnt and reflect country needs	**13.1.2** Office Specific Expected Results (OSERs) for which progress status has been updated within the established timeframes for periodic reporting
BASELINE 2008	
0%	60%
TARGETS TO BE ACHIEVED BY 2009	
	80%
TARGETS TO BE ACHIEVED BY 2011	
30%	
TARGETS TO BE ACHIEVED BY 2013	
60%	90%

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
36 916	40 800	43 805

JUSTIFICATION

The overall results-based management framework (e.g. joint planning, quality assurance, and peer reviews) needs to be reinforced. Despite the increase in the biennium 2006-2007, more investment is required, especially at regional and country levels in order to ensure a more collaborative and integrated approach. Substantial efforts are required to ensure greater accountability of programme performance, and better governance of planning and of programme implementation throughout the Organization.

13.2 Sound financial practices and efficient management of financial resources achieved through continuous monitoring and mobilization of resources to ensure the alignment of resources with the programme budgets.

INDICATORS

13.2.1 Degree of compliance of WHO with International Public Sector Accounting Standards	**13.2.2** Proportion of voluntary contributions that are classified as “core voluntary contribution”
BASELINE 2008	
Accounting Standards not implemented	
TARGETS TO BE ACHIEVED BY 2009	
International Public Sector Accounting Standards implemented	
TARGETS TO BE ACHIEVED BY 2011	
TARGETS TO BE ACHIEVED BY 2013	

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
60 654	67 800	72 538

JUSTIFICATION

The proposed increase reflects the emphasis being placed on a more coordinated and strategic approach to resource mobilization, which requires corporate support. Some investments will be required to adopt successfully the International Public Sector Accounting Standards and ensure even greater financial accountability and integrity. The above resource requirement includes US$ 20 million dedicated to the exchange-rate hedging mechanism.

13.3 Human resource policies and practices in place to attract and retain top talent, promote learning and professional development, manage performance, and foster ethical behaviour.

INDICATORS

	13.3.1 Proportion of offices[1] with approved human resources plans for a biennium	**13.3.2** Number of staff assuming a new position or moving to a new location during a biennium (delayed until 2010 - 2011 biennium)	**13.3.3** Proportion of staff in compliance with the cycle of the Performance Management Development System
BASELINE 2008	40%		65%
TARGETS TO BE ACHIEVED BY 2009	75%		75%
TARGETS TO BE ACHIEVED BY 2011			
TARGETS TO BE ACHIEVED BY 2013	100%		95%

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
29 630	37 000	35 549

JUSTIFICATION

The proposed increase reflects the need to strengthen capacity at regional level to provide better support to managers and staff at regional and country levels. Significant efforts are required to strengthen the management of human resources further by implementing new policies that reinforce staff mobility and rotation, improve performance management, and so forth.

[1] Offices here refers to country offices (144), regional office divisions (~30) and headquarter departments (~40).

13.4 Management strategies, policies and practices in place for information systems, that ensure reliable, secure and cost-effective solutions while meeting the changing needs of the Organization.

INDICATORS

	13.4.1 Number of information technology disciplines[1] implemented Organization-wide according to to industry-best-practices benchmarks	**13.4.2** Proportion of offices using consistent real-time management information
BASELINE 2008	0	
TARGETS TO BE ACHIEVED BY 2009	3	
TARGETS TO BE ACHIEVED BY 2011	5	
TARGETS TO BE ACHIEVED BY 2013	7	

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
106 228	120 300	127 483

JUSTIFICATION

Resources remain relatively stable in this area resulting from, on the one hand, a decrease in unit costs due to efficiency gains and global sourcing of information technology resources from lower cost locations and, on the other, an increase in costs due to implementation of the new global management system and the overlap with legacy applications that require greater support. By 2012–2013, the Organization will begin the process of upgrading the base of the system upon receiving mandatory new software releases.

[1] This includes, for example, incidence management, configuration management, release management, service-desk function.

<table>
<tr><td rowspan="14">**13.5** Managerial and administrative support services[1] necessary for the efficient functioning of the Organization provided in accordance with service-level agreements that emphasize quality and responsiveness.</td><td colspan="3">**INDICATORS**</td></tr>
<tr><td colspan="3">**13.5.1** Proportion of services delivered by the global service centre according to criteria in service-level agreements</td></tr>
<tr><td colspan="3">**BASELINE 2008**</td></tr>
<tr><td colspan="3">0%</td></tr>
<tr><td colspan="3">**TARGETS TO BE ACHIEVED BY 2009**</td></tr>
<tr><td colspan="3">75%</td></tr>
<tr><td colspan="3">**TARGETS TO BE ACHIEVED BY 2011**</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">**TARGETS TO BE ACHIEVED BY 2013**</td></tr>
<tr><td colspan="3">100%</td></tr>
<tr><td colspan="3">**RESOURCES** (US$ THOUSAND)</td></tr>
<tr><td>Budget 2008–2009</td><td>Proposed budget 2010–2011</td><td>Estimates 2012–2013</td></tr>
<tr><td>149 647</td><td>130 100</td><td>179 217</td></tr>
<tr><td colspan="3">**JUSTIFICATION**
The overall workload is increasing throughout the Organization, and support services must reflect that. At the same time, efforts to find more cost-effective ways of working will lead to some savings. However, over the biennium 2008–2009, the level of resources need to be increased slightly. Costing will be refined over the next few months in the context of a global review of service delivery.</td></tr>
</table>

[1] Includes services in the areas of information technology, human resources, financial resources, logistics, and language services.

<table>
<tr><td rowspan="14">**13.6** Working environment conducive to the well-being and safety of staff in all locations.</td><td colspan="3">**INDICATORS**</td></tr>
<tr><td>**13.6.1** Proportion of planned projects included in the Capital master plan completed for a given biennium</td><td colspan="2">**13.6.2** Proportion of locations that are compliant with Minimum Operating Safety Standards (MOSS)</td></tr>
<tr><td colspan="3">**BASELINE 2008**</td></tr>
<tr><td></td><td colspan="2">65%</td></tr>
<tr><td colspan="3">**TARGETS TO BE ACHIEVED BY 2009**</td></tr>
<tr><td></td><td colspan="2">75%</td></tr>
<tr><td colspan="3">**TARGETS TO BE ACHIEVED BY 2011**</td></tr>
<tr><td></td><td colspan="2"></td></tr>
<tr><td colspan="3">**TARGETS TO BE ACHIEVED BY 2013**</td></tr>
<tr><td></td><td colspan="2">95%</td></tr>
<tr><td colspan="3">**RESOURCES** (US$ THOUSAND)</td></tr>
<tr><td>Budget 2008–2009</td><td>Proposed budget 2010–2011</td><td>Estimates 2012–2013</td></tr>
<tr><td>159 297</td><td>149 600</td><td>181 408</td></tr>
<tr><td colspan="3">**JUSTIFICATION**
The increase for this expected result stems mainly from increased security costs incurred in reaching compliance with Minimum Operating Safety Standards. The overall resource requirement will be refined over the coming months as the capital master plan is drawn up. Resource requirements includes the security fund as well as the Real Estate Fund.</td></tr>
</table>
