SIXTY-FOURTH WORLD HEALTH ASSEMBLY
Provisional agenda item 12.3

A64/7
4 April 2011

Medium-term strategic plan 2008–2013 and Proposed programme budget 2012–2013

PROPOSED PROGRAMME BUDGET 2012–2013

Foreword by the Director-General

The Proposed programme budget for 2012–2013 is a transitional budget that responds to both the new reality of financial austerity and a series of reforms being undertaken to improve the overall performance of WHO. These reforms include an improved results-based management and accountability framework and a more realistic and flexible funding model.

The proposed budget assumes that global economic recovery from the 2008 financial crisis is fragile and that prudence is wise. Bearing this in mind, no increase in income for WHO, compared to the current biennium, is anticipated for 2012–2013.

This is the third and final programme budget within the overarching framework of the Medium Term Strategic Plan for 2008–2013. Proposals have been guided by the outcome of the recent performance assessment of the Programme budget for the biennium 2008–2009. This assessment directed the updating of some indicators and their targets.

Revisions in the budget also respond to recent feedback from Member States and to some clear and challenging requests articulated during the January 2011 session of the Executive Board. Member States expressed their desire for a realistic budget based on income and expenditure, asked for better alignment of resources across the Organization, and requested a further review of indicators and targets.

The budget for 2012–2013 of US$ 4804 million presented to the Executive Board has been revised downward to the currently proposed US$ 3959 million.

The budget proposes that assessed contributions remain at their 2010– 2011 level, representing zero nominal growth. This proposal will provide around 24% of the financing for the programme budget. The remaining 76% will need to be financed through voluntary contributions.

Member States were equally strong in their desire to see certain commitments and priority activities emphasized to the extent possible. Priority areas identified by Member States include activities that support progress towards the health-related Millennium Development Goals, especially those for reducing young-child and maternal mortality, and efforts to address the rise of noncommunicable diseases, especially in low- and middle-income countries. Work on the strengthening of health systems was also identified as an important area of focus.

As requested, an effort has been made to make it easier for reviewers of the budget to see where the Organization’s engagement, based on difficult but necessary strategic decisions, has been scaled down, meaning that certain activities and results will be reduced or no longer delivered. Work in this area will continue during the operational planning phase.

Preparation of the Proposed programme budget for 2012–2013 has been challenging. The revisions attempt to balance the request for a realistic budget with the demands of projecting income in a situation where the largest share of financing comes from voluntary contributions. The budget further aims to match projected income more closely with WHO’s implementation capacity and better align resources across the Organization.

With these challenges in mind, I am pleased to submit this proposed programme budget for 2012–2013 for consideration by Member States. I anticipate that future budgets will benefit more fully from the wide-ranging reforms that are being introduced to improve WHO's results-based management and accountability framework in the near future.

Dr Margaret Chan
Director-General

Geneva, 4 April 2011

CONTENTS

Page

FOREWORD BY THE DIRECTOR-GENERAL

INTRODUCTION 6

STRATEGIC OBJECTIVES 19

1. To reduce the health, social and economic burden of communicable diseases 19
2. To combat HIV/AIDS, tuberculosis and malaria 25
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment 32
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 38
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact 45
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 49
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 55
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. 60
9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development 65
10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research 71
11. To ensure improved access, quality and use of medical products and technologies 79
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 83
13. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively 87

Financial tables

Annex 1 91
Annex 2 92
Annex 3 94

Notes: Throughout the document, references to the Programme budget 2008–2009 and Programme budget 2010–2011 are to the biennial budgets approved by the Health Assembly in resolutions WHA60.12 and WHA62.9 respectively. References to "implementation for 2008–2009" relate to the expenditures and encumbrances reported in the Programme budget 2008–2009 performance assessment.[1]

The introduction and the tables within it have been revised in the light of the Executive Board's expressed wishes during consideration of an earlier version of this document at its 128th session in January 2011.[2] Underlining or strike through of text in the tables of the strategic objectives indicate changes from the information presented in the amended Medium-term strategic plan 2008–2013. These changes arise from discussion by the regional committees and the Board. The elements that were formerly entitled "Targets by 2011" in the amended Medium-term strategic plan 2008–2013 have been replaced in the Proposed programme budget with a new element entitled "Baselines 2012".

Rounding convention. The WHO programme budget is prepared in thousands of US dollars, and presented in millions. Each of the figures shown is correct; however, as a result of rounding in the presentation, there may be a slight discrepancy between the total shown, and the total when calculated by adding the figures as printed. In such a case, the total as shown should be considered correct since it takes into account the underlying figures.

[1] Document EB128/22.

[2] See documents EB128/22 and EB128/2011/REC/2, summary record of the seventh meeting, section 2.

INTRODUCTION

1. WHO's Proposed programme budget 2012–2013 presents the expected results and budget requirements for the biennium 2012–2013 within the broader context of the Organization's Medium-term strategic plan. It indicates the scope of the work that will be undertaken under each strategic objective, identifying for each of the Organization-wide results the targets to be achieved during the biennium, the resources required to deliver results under each strategic objectives, and specific links to other strategic objectives.

2. The biennial programme budget 2012–2013 is the last within the Medium-term strategic plan 2008–2013. The structure of the Medium-term strategic plan – with its 13 strategic objectives remaining unchanged over several bienniums – provides advantages of stability and comparability. However, the importance of **integration** of WHO's action across programmes and levels of the Organization has become increasingly clear. The strategic objectives in the Medium-term strategic plan are intended to provide overall direction and priority.

3. When determining the results to be achieved, care has been taken to ensure that the strategic objectives would not be implemented in isolation from one another. The Proposed programme budget emphasizes both synergies between programmes and the specific links between strategic objectives. Examples are numerous. Work on HIV, tuberculosis and malaria has an impact on child and maternal health. Better nutritional status is an outcome of work under several strategic objectives. Better capacity to manage outbreaks of emerging and epidemic-prone diseases means better capacity to manage the health dimensions of humanitarian crises. WHO's core functions are not exclusive to any one level of the Organization; they interact across different levels of WHO in the interest of achieving better outcomes. The process of fostering better integration, and of continuously seeking to find synergies across all programmes of the three levels of the Organization is ongoing and will continue to be strengthened.

4. Another key theme for this budget is **continuity**. This translates into using lessons learnt from the performance assessment of the Programme budget 2008–2009 and from scaling up interventions that have proved their relevance and effectiveness. Such an approach is particularly important for interventions aimed at improving maternal and child health services.

5. The third theme is **change** – where new directions and priorities have been articulated through the country cooperation strategies, or established by World Health Assembly resolutions. Examples of such changes include the increasing focus and number of intergovernmental processes, shifting from policy to action, as in the programme on health system strengthening, and from research to implementation, as in the programme for noncommunicable diseases.

6. The key programmatic emphases for this programme budget include i) redoubling the Organization's efforts in support of the achievement of the health-related Millennium Development Goals, especially Goals 4 (Reduce child mortality) and 5 (Improve maternal health) ; ii) scaling up our work to address noncommunicable diseases, and iii) the strengthening of health systems to support this work. Furthermore the Proposed programme budget also reflects the Organization's continued efforts to improve its effectiveness and efficiency.

7. As the biennium 2012–2013 begins, there will be just three years left before 2015, the date set for the achievement of the Millennium Development Goals. The outcome document of the High-level Plenary Meeting of the General Assembly on the Millennium Development Goals at its sixty-fifth

session[1] (20–22 September 2010) further informs policy direction, specifies where progress is inadequate and indicates where WHO's energies should be directed. For maternal, newborn and child health, WHO's work will focus on high-burden countries. The method of operation will be through agreed collaboration and division of labour with other United Nations agencies. The work will be conducted in the context of national development plans as well as national health policies and strategies.

8. Success in improving the health of women, newborn infants, and young children will require a continuum of technical interventions across the life course, with concomitant efforts to strengthen health delivery systems and address the broader social and economic determinants of women's health. This work will follow the evidence provided in the publication *Women and Health*,[2] which outlines the consequences and costs of failing to address health issues at the appropriate point in the lives of girls and women. Moreover, to support the recently launched United Nations Secretary-General's Global Strategy for Women's and Children's Health, WHO is facilitating a high-level Commission on information and accountability for women's and children's health. This initiative breaks new ground in terms of global health governance, and will propose, within a six-month timeframe, expedient ways to improve the tracking of financial and other commitments from partners, the measurement of results, and the capacity of developing countries to collect and analyse basic health data.

9. Cardiovascular diseases, cancer, diabetes, chronic lung disease and other noncommunicable diseases are currently responsible for 60% of all deaths. Many of these deaths are premature and occur in low- and middle-income countries. Although affordable, evidence-based interventions exist and can effectively reduce morbidity, disability and premature death even in low-income countries, the global burden of noncommunicable diseases continues to grow, with serious implications for health and socioeconomic development.

10. The action plan for the global strategy for the prevention and control of noncommunicable diseases for the period 2008–2013[3] provides sound guidance for Member States and the Secretariat to address this enormous challenge. To date, significant progress has been made. Sustained advocacy has resulted in high-level political support for the noncommunicable diseases agenda at global and national levels. This was demonstrated recently by the issuance of the Ministerial Declaration during the High-Level Segment of the United Nations Economic and Social Council (Geneva, 6–9 July 2009) and the adoption in consecutive sessions (May and December 2010) by the United Nations General Assembly of resolutions relating to the convening of, and detailed organizational arrangements for, a high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases, with the participation of Heads of State and Government.[4]

11. Awareness of the need for urgent action is increasing. The challenges now are to monitor the trends of noncommunicable diseases and their determinants, to develop and strengthen effective national prevention and control programmes, and to improve the responsiveness of health systems to the essential health-care needs of people with noncommunicable diseases. The Proposed programme budget 2012–2013 responds to this challenge.

12. One of the key lessons learnt from previous bienniums is that the achievement of health goals depends on equitable access to a health system that delivers high quality services. The exact configuration of services will depend on country context, but will in all cases require adequate

[1] See United Nations General Assembly resolution 65/1.

[2] *Women and Health: today's evidence, tomorrow's agenda*. Geneva, World Health Organization, 2009.

[3] See WHA61/2008/REC/1, Annex 3.

[4] United Nations General Assembly resolutions 64/265 and 65/238.

financing of health care with pooling of risk; a well-trained and adequately remunerated workforce; information on which to base policy and management decisions; infrastructure and logistics to get medicines and vaccines to where they are needed; well-maintained facilities organized as part of a referral network; and leadership that provides clear direction and draws on the potential of all stakeholders – with a special focus on communities.

13. A robust national health policy and strategy can ensure the complementarity of all the elements needed to improve health outcomes, and thus accelerate progress towards the Millennium Development Goals. In countries that receive significant levels of external aid, robust national strategies are the best means to align external aid with national priorities. WHO strongly supports the development and implementation of national policies, strategies and plans.

14. The Millennium Development Goals' focus on achieving quantitative, time-bound goals has been a stimulus to measurement of results and progress. This focus has also revealed serious shortcomings in the capacity of countries to generate statistics and other health information. Eighty-five countries, representing 65% of the world's population, do not have reliable cause-of-death statistics. This means that causes of death are neither known nor recorded, and health programmes can only base their strategies on crude and imprecise estimates. WHO will continue to help countries to strengthen information systems and build national analytical capacity.

15. The past decade has seen notable reductions in deaths from HIV/AIDS, tuberculosis, malaria and the vaccine-preventable diseases of childhood. This is progress, not a victory. These gains must be sustained at the same time as efforts are made to tackle other health priorities, including noncommunicable diseases, mental health and disabilities.

16. The pandemic (H1N1) 2009 was the first major test of the International Health Regulations (2005). By the time the Programme budget 2012–2013 begins implementation, the Review Committee on the Functioning of the International Health Regulations (2005) will have completed its assessment of the performance of the WHO Secretariat, Member States and the network of national and international institutions involved in tackling this pandemic. It will be important to protect and reinforce components of the system that are identified as working well. The Committee is also tasked with finding areas of WHO performance that need to be improved. Such recommendations will be taken into account in the operational planning phase of the Proposed programme budget 2012–2013.

17. Both internal and external discussions have emphasized that WHO should be of demonstrable value to all countries, irrespective of their level of economic development, with the level of support being adjusted to individual countries' needs and circumstances. In some but not all countries WHO provides support through a WHO country office. A central concern during the biennium will be the review and realignment of the distribution of functions across the three levels of the Organization. This is currently under discussion within the Secretariat as part of the WHO reform agenda.[1]

18. WHO's budget and financing must be considered in conjunction with questions about priorities and the changing nature of WHO's core business. Member States continue to discuss the strategic issues raised in January 2010 at the initial consultation on the future of financing for WHO in parallel with the preparation of this budget. During the ongoing consultations, normative and standard-setting work as well as technical cooperation with countries were generally seen as being core business and central to maintaining WHO's role as the world's leading technical authority on health issues. Further

[1] See document A64/4.

input on these important considerations for the profile of WHO in both the immediate and longer term future will be forthcoming during the continuing discussion of WHO reform.[1]

Budget overview

19. The preparation of the Proposed programme budget for the biennium 2012–2013 started in early 2010 in order to obtain views from the regional committees later that year. In January 2011, the Executive Board at its 128th session was able to consider the evolving proposal in the light also of the status of implementation of the Programme budget for the biennium 2010–2011 at its half way point.[2] The Director-General decided to adjust the Proposed programme budget for 2012–2013 in view of the Board's comments. The resulting Proposed programme budget for 2012–2013 of US$ 3959 million represents a reduction of some 13% compared with the level of the 2010–2011 biennium (and a reduction of 18% in comparison with the level of the version of the Proposed programme budget 2012–2013 presented to the Board in January 2011). The Proposed programme budget 2012–2013 attempts to match closely the levels of implementation in 2008–2009, and takes into consideration the projections of total income and expenditure for the 2010–2011 biennium. This budget restates the Secretariat's commitment to better alignment of resource management with planned delivery across strategic objectives and major offices, especially with regard to the priority strategic objectives that are underfunded. It maintains the Organization's commitment to strengthening the first-line support to countries and to providing adequate back-up at regional and global levels.

20. Each expected result has Organization-wide baselines and targets. The detailed work of identifying the office-specific targets and actual resource requirements at the Organization-wide expected result level will be undertaken in 2011 during an integrated operational planning and budgeting process. This will enable a better alignment with country priorities, collaboration across the Organization and a more accurate estimate of resource requirements, thus enabling the budget to be used as a stronger management tool with respect to resource mobilization, budget utilization and accountability for results.

21. Formerly, assessed contributions were managed in parallel, but separately from the voluntary contributions budget. Assessed contributions, being flexible, can play an important role in protecting and aligning the core activities of WHO. The allocation of assessed contribution resources by major office is proposed to remain unchanged from the biennium 2010–2011. However, within each major office the assessed contributions will be managed to ensure the best alignment between budget, resources and results within its programme portfolio.

22. During the biennium 2008–2009, a segmentation of the budget was proposed to provide greater transparency in the funding and implementation of the programme budget. In the Programme budget 2010–2011 the budget was broken down into three segments: Base programmes, Special programmes and collaborative arrangements, and Outbreak and crisis response. This segmentation has proved useful in improving transparency, for example as shown in the discussions on partnerships during the Sixty-third World Health Assembly, and in facilitating budget management.

23. **The total Proposed programme budget for 2012–2013 is US$ 3959 million.** The reduction of US$ 581 million compared with the approved budget for 2010–2011 relates mainly to adjusting the Base programmes segment towards realistic estimates of incomes and expenditures. Special programmes and collaborative arrangements and the Outbreak and crisis response figures have been

[1] Document A64/4.

[2] Document EB128/23.

increased slightly in comparison to 2010–2011, according to the realities of their funding and the record of implementation in 2008–2009 (Table 1).

24. **Base programmes:** WHO has exclusive strategic and operational control over the activities concerned, and over the choice of means, location and timing of implementation. The Organization can ensure a balanced growth across the different strategic objectives, reflecting overall health priorities, and an even distribution across major offices. This segment is proposed at a level of US$ 2627 million. This represents a decrease over the approved budget for 2010–2011 of US$ 741 million, but is in line with current estimates of implementation capacity and income. It should be noted that both strategic objectives 12 and 13 are included as part of Base programmes although in fact these strategic objectives serve all three budget segments. Strategic objectives 12 and 13 are financed principally from assessed contributions and programme support cost charges, as well as from limited voluntary contributions. Annex 1 shows the recurrent costs for strategic objective 13. Annex 2 shows the proposed allocation of resources in 2012–2013 by strategic objective, major office and segment.

25. **Special programmes and collaborative arrangements:** these are activities that are fully within WHO's results hierarchy and over which WHO has executive authority. However, the activities in this segment are undertaken in collaboration with partners and thus the magnitude of associated operations is determined by the special nature of the activity and the joint strategic decisions of the collaboration. The budget for this segment has been set at US$ 864 million, i.e., a similar level to the expenditure in 2008–2009 but US$ 42 million above the approved budget for 2010–2011. For a full list of the special programmes and collaborative arrangements for 2012–2013, see Annex 3.

26. **Outbreak and crisis response:** these activities are governed by acute external events. The resource requirements are normally significant and difficult to predict; for this reason, budgeting is an uncertain process. The requirements for the biennium 2012–2013 have been estimated at US$ 469 million, i.e. above the amount budgeted in 2010-2011. (Table 2).

Table 1: Implementation for 2008–2009, approved Programme budget for 2010–2011 and Proposed programme budget 2012–2013 by budget segment (US$ million)

Segment	Implementation[1] 2008–2009		Approved programme budget 2010–2011	Proposed programme budget 2012-2013
	Budget	**Implementation**		
Base programmes	3 742	2 371	3 368	2 627
Special programmes and collaborative arrangements	370	934	822	864
Outbreak and crisis response	116	469	350	469
Total	**4 227**	**3 773**	**4 540**	**3 959**

[1] Compared with the expenditures reported in the Programme budget 2008–2009 performance assessment, US$ 151 million has been shifted from the Base programme segment to the Special programmes and collaborative arrangements segment, and US$ 46 million has been shifted from the Special programmes and collaborative arrangements segment out of the Proposed programme budget altogether.

27. The programme budget approved by the Health Assembly has included an "aspirational" aspect over the past several bienniums to reflect the shared ambition of the Organization of what action should be taken. However, funding and implementation have not always kept pace with the vision of the budget. There have been large funding gaps across strategic objectives and major offices. This has challenged programme planning and implementation, resulting in overexpansion in some programmes in anticipation of income indicated in the approved programme budget. The Independent Expert Oversight Advisory Committee raised a concern in its report[1] to the Programme, Budget and Administration Committee of the Executive Board, in the context of accountability, about the "aspirational" nature of WHO's budget. The Independent Expert Oversight Advisory Committee observed that the actual revenues available often fall well below budgeted levels, which has meant that the budget no longer serves as a basic control document in the way usually expected in a public sector organization. A closer alignment between results, budget, available resources and programme implementation is sought for the biennium 2012–2013.

28. Within the overall budget for 2012–2013 (Table 2) the emphasis will be on strategic objectives 3, 4, 6, and 9 as in 2010–11, and in addition, strategic objective 10 will also be targeted. For strategic objectives 3 and 6 this reflects work planned to implement the action plan for the global strategy for the prevention and control of noncommunicable diseases and the general scaling up of the work in this area; for strategic objectives 4 and 9 this corresponds to the need to accelerate efforts to meet the Millennium Development Goals for child and maternal health; and for strategic objective 10, this responds to the health system strengthening support necessary to achieve the Millennium Development Goals as well as to support the scaling-up of work on noncommunicable diseases.

29. As highlighted earlier, the strategic objectives would not be implemented in isolation of one another, but in a synergistic manner. Public health goals, such as, for example, the Millennium Development Goals, scaling up work on noncommunicable diseases and addressing communicable diseases, are very often achieved through the contribution of a number of interlinked strategic objectives. The critical links and effective collaboration between a number of strategic objectives in support of the achievement of any of the 13 strategic objective are further highlighted later in this document under the sections for each strategic objective.

30. Furthermore, in line with Member States' requests, the Proposed programme budget also reflects the Organization's continued efforts to improve its effectiveness and efficiency. The Director-General aims to increase efficiency in the implementation of strategic objectives 12 and 13 and to limit overall operating costs. The budget for strategic objectives 12 and 13 has been reduced at headquarters and has been capped at levels of 2008–2009 implementation in the regions. In addition, an Organization-wide effort is ongoing to contain costs, through application of bench-marking and standard-setting, and introduction of cost-reduction targets. However, at the same time, these efforts are being challenged by the number and complexity of intergovernmental processes, which demand increasing resources, putting a particular strain on strategic objectives 12 and 13.

[1] See document EBPBAC13/3.

Table 2: Proposed programme budget 2012–2013 by strategic objective and segment, compared with implementation in the biennium 2008–2009 and the approved Programme budget for 2010–2011 (US$ million)

Baselines (all segments)				Proposed programme budget 2012–2013					
		Approved Programme budget 2010–2011							
Strategic Objective	Implementation 2008–2009 (Base programmes)	All segments	Base programmes	Base programmes	% change over expenditure 2008–2009	Special programmes and collaborative arrangements	Outbreak and crisis response	Total	% of grand total
1	407	1 268	542	446	9	679	153	1 278	32
2	386	634	556	446	16	94	0	540	14
3	89	146	146	114	27	0	0	114	3
4	153	333	292	186	22	32	0	218	6
5	55	364	109	65	17	1	316	382	10
6	89	162	149	111	25	11	0	122	3
7	35	63	63	42	21	0.5	0	43	1
8	80	114	113	87	9	0	0	87	2
9	42	120	116	51	23	4	0	55	1
10	265	474	420	322	21	26	0	348	9
11	114	115	115	122	7	16	0	137	3
Subtotal 1–11	**1 715**	**3 793**	**2 621**	**1 992**	**16**	**864**	**469**	**3 325**	**84**
12	260	223	223	258	-1			258	6
13	396	524	524	377	-5			377	10
Subtotal 12–13	**656**	**747**	**747**	**634**	**-3**			**634**	**16**
Grand total	**2 371**	**4 540**	**3 368**	**2 627**	**11**	**864**	**469**	**3 959**	**100**

Note: SO13 represents the administrative cost of the Organization within the programme budget. In addition, US$ 138 million is charged directly to all strategic objectives to recover the costs of administrative services directly attributable to these programmes. This is shown in Annex 1. The full cost of administrative services is therefore US$ 515 million (US$ 377 million plus US$ 138 million cost-recovered from programmes), and the cost when combined with SO12 is US$ 772 million.

Table 3: Budget breakdown of the Proposed programme budget 2012–2013 by major office and budget segment in comparison to implementation in 2008–2009 and the approved Programme budget for 2010–2011 (US$ million)

				Proposed programme budget 2012–2013				
		Approved Programme budget 2010–2011						
	Implementation 2008–2009 (Base programmes)	All segments	Base, including SO12 and SO13	Base programmes, including SO 12 and SO 13	% of total	Special programmes and collaborative arrangements	Outbreak and crisis response	Total
Africa	500	1 263	926	640	25.2	372	81	1 093
The Americas	124	256	245	161	6.3	5	7	173
South-East Asia	245	545	394	279	10.9	74	32	384
Europe	169	262	239	192	7.5	10	11	213
Eastern Mediterranean	189	515	391	232	9.1	150	171	554
Western Pacific	199	310	293	222	8.7	10	13	246
Headquarters	944	1 389	881	900	32.3	242	154	1 296
Total	**2 371**	**4 540**	**3 368**	**2 627**	**100**	**864**	**469**	**3 959**

Note: validation range calculations have been made for Base programmes, including SO12 and 13, but excluding some corporate governance functions from both regions and headquarters, including estimated costs for regional committees and governing body meetings, costs of legal and audit support to the Organization and some intergovernmental working groups.

31. Within this smaller budget envelope, it has been more challenging to align the budgets of all major offices within the validation range. Some corporate governance functions such as governing bodies, the Office of Internal Oversight Services, the Independent Expert Oversight Advisory Committee, the work of the External Auditor, the Office of the Legal Counsel, the Global Service Centre, and the support provided to the several intergovernmental working groups, have been excluded from within the headquarters' budget, as have the regional committees from the regional budgets, for the purpose of allowing comparison among the major offices. In this revised Proposed programme budget all regional offices fall within the validation range and despite the substantial budget reduction for headquarters, it is still slightly above its range (this is because the headquarters implementation rate in 2008–2009 was proportionally very high) (Table 3). This will create the impetus for devolving functions and resources to the regions and countries in order to move towards the 70%–30% principle. However, for this to materialize, efforts to adjust are being made during the biennium 2010–2011.

Financing the programme budget

32. Although it is difficult to predict the future financial situation, it is prudent to show greater caution in efforts to ensure at all times that resources are sufficient to meet programme needs, including obligations to staff salaries and other costs that represent longer-term commitments and are slow in adjusting. The Proposed programme budget for the biennium 2012–2013 is therefore based on realistic assumptions of income and expenditure.

33. The Director-General is proposing a zero nominal growth in the level of the assessed contributions in 2012–2013. The programme budget is anticipated to be funded 24% from assessed contributions and 76% from voluntary contributions with most of the latter being highly specified. This continues the trend of an increasing proportion of the programme of WHO being funded from voluntary resources (Table 4). The high proportion of the total budget funded from specified voluntary contributions poses serious challenges to WHO. This has been articulated in the discussions on the future of financing for WHO, and it is envisaged that in the course of this ongoing critical discussion and the related development of the organizational reform agenda, Member States will increasingly

support predictable and flexible funding for the Organization, and thereby allow a better alignment of resources with agreed priorities.

Table 4: Proposed programme budget 2012–2013 financing compared with actual implementation in 2008–2009 and the approved Programme budget 2010–2011 showing funding by type

	2008–2009		2010–2011		2012–2013	
Type of funding	**Actual implementation**		**Approved Programme budget**		**Proposed programme budget**	
	US$ million	**%**	**US$ million**	**%**	**US$ million**	**%**
Assessed contributions	919		929		929	
Member States non-assessed income	30		15		15	
Total assessed contributions	949	24	944	21	944	24
Full and highly flexible funding	111		300		400	
Medium flexible voluntary funding	196		400		400	
Specified voluntary contributions	2 644		2 896		2 215	
Total voluntary contributions	2 951	76	3 596	79	3 015	76
Total financing	**3 900**	**100**	**4 540**	**100**	**3 959**	**100**

Note: Assessed contributions at zero nominal growth

Assessed contributions

34. It is proposed that the level of assessed contributions remains as in the biennium 2010–2011. Member States non-assessed income may continue to provide support to the budget in line with assessed contributions. Non-assessed income is derived mainly from interest earnings on assessed contributions, collection of arrears of assessed contributions, and unspent assessed contributions at the end of a biennium.

35. A unified budget is proposed, financed from both assessed and voluntary contributions. The allocation of assessed contributions by major offices is proposed to remain the same as for 2010–2011 (Table 5). It is also proposed that the number of appropriation sections be reduced from the present 13 (corresponding to the strategic objectives) to a smaller number to gain a greater degree of flexibility for the use of assessed contributions to ensure optimal alignment between budget, resources and results across the programme portfolio.

Table 5: Proposed financing of a unified programme budget: assessed contributions by major office compared with actual implementation in 2008–2009 and the approved Programme budget 2010–2011 (US$ million)

Major office	2008–2009		2010–2011		2012–2013	
	Actual implementation		Approved Programme budget		Proposed programme budget	
	Total	Assessed contributions	Total	Assessed contributions	Total	Assessed contributions
Africa	984	211	1 263	210	1 093	210
The Americas	137	81	256	81	173	81
South-East Asia	357	103	545	102	384	102
Europe	195	63	262	62	213	62
Eastern Mediterranean	522	91	515	91	554	91
Western Pacific	224	79	310	79	246	79
Headquarters	1 354	322	1 389	320	1 296	320
Total	**3 773**	**949**	**4 540**	**944**	**3 959**	**944**

Note: Assessed contributions at zero nominal growth

Voluntary contributions

36. The core voluntary contributions account, comprising fully and highly flexible funds, is becoming an important component of WHO's financing model. The contributors to the core voluntary contributions account, as well as the Secretariat are learning how to optimize the benefits of using this new financing instrument. For the biennium 2008–2009, US$ 202 million were received for the core voluntary contributions account from 14 donor countries. Thanks to the core voluntary contributions account, less-well-funded strategic objectives and offices are benefiting from a better flow of resources; their implementation bottlenecks, which arise when immediate financing is lacking, are also eased. The core voluntary contributions account thus contributes to both greater alignment and improved efficiency. The core voluntary contributions account, including the required rolling working capital, has now been established. It is envisaged that the ongoing discussions related to the future financing of WHO will lead to further increases in the flexible funding that the Organization receives such as the funds for the core voluntary contributions account.

37. Core voluntary contributions that are flexible at the level of Organization-wide expected result, major office or Organization-wide theme are termed "medium-flexible". They provide an option for contributors who are not able to provide highly or fully flexible funds and thereby increase the quality of their funding. It is foreseen that specified voluntary contributions will continue to constitute the majority of the funding for the Organization in the 2012–2013 biennium. However, it is also anticipated that the combination of the global financial situation and the institutionalization of the core voluntary contributions account will mean that specified voluntary contributions will represent a smaller proportion of overall funding during the biennium 2012–2013.

38. Financing the Proposed programme budget through the provision of US$ 944 million in assessed contributions and US$ 400 million in the form of fully and highly flexible funding will give the Director-General greater flexibility in the allocation of around 34% of the budget. This will allow for better alignment of resources with Member States' priorities. Ideally, the ongoing discussions on the future of financing for WHO will result in at least 50% of the programme budget for the period 2014–2015 being in the form of flexible, predictable funding.

39. Additional efforts in 2012–2013 to raise predictable and flexible voluntary contributions will include a corporate approach aimed at improving donor confidence, and expanding the range of sources of support to include emerging economies and the private sector. Work in this regard will commence during 2011.

Cost recovery

40. The combined costs of strategic objectives 12 and 13 for 2012–2013 are estimated to be US$ 634 million with an additional US$ 138 million derived from post occupancy charges (see Annex 1). In the approved Programme budget for 2010–2011 these objectives were listed as being funded through a separate mechanism.

41. Member States have over the years requested WHO to ensure full cost recovery from activities funded from voluntary contributions. Ensuring cost recovery of both direct and indirect costs is a challenge across the United Nations system. During 2009, WHO undertook an Organization-wide exercise to analyse the constraints in ensuring full cost recovery and investigated alternative solutions. As a result of this work, the post occupancy charge was introduced from 1 January 2010 to recover those costs most closely associated with the level of staffing of programmes and projects. Examples of such costs include: staff development and learning, information and communications technology infrastructure, human resources administration, United Nations common security charges, the Global Service Centre, and office accommodation. The introduction of the post occupancy charge is expected to close the financing gap for strategic objectives 12 and 13 that was projected in the Programme budget 2010–2011.

42. The post occupancy charge is included as a programme direct cost within all strategic objectives and appears in workplans as an integral component of the standard staff cost. These costs are separated out and explicitly shown in Annex 1 in the column “Strategic Objective 13 *bis*- funded through post occupancy charge”. The figure shown is based on the actual costs recovered during the first part of 2010.

Financing safety and security of staff

43. The security situation has continued to deteriorate significantly in certain countries, and the cost of providing security for the Organization’s staff and operations has escalated. WHO has put in place four financing mechanisms: (a) set-up costs will allow for a minimum standard of security staffing and infrastructure to be financed through assessed contributions and other direct funding of strategic objective 13 in the programme budget; (b) costs due to unforeseen circumstances such as emergency evacuation will be financed through the Security Fund; (c) costs directly driven by the number of staff alone such as WHO’s contribution to the United Nations Security Management System will be covered by the newly introduced post occupancy charge; and (d) the costs of doing business at a particular field location as a consequence of programme implementation will be covered from the workplans of each programme and project.

Financing the Capital Master Plan

44. Financing the Capital Master Plan has been for many years a significant challenge for the Organization. In support of establishing a sustainable funding mechanism, the Health Assembly adopted resolution WHA63.7. In this resolution, inter alia, it resolved to appropriate a one-off sum of US$ 22 million from Member States’ non-assessed income to the Real Estate Fund in order to cover the costs of urgently needed renovation, and authorized the Director-General to allocate up to US$ 10 million at the end of each financial period from the same source to partly cover the backlog of needed capital investment projects. For the biennium 2012–2013, the total cost of the Capital Master Plan is estimated at US$ 48 million, mostly attributable to the rectification of the backlog. This is in

addition to the operational expenditures in strategic objectives 1 to 13 and is shown in Annex 1. It is estimated that the funding needs of the Capital Master Plan will be met through a combination of three options, namely, a depreciation charge on all income, an increase in the post occupancy charge and appropriation from Member States' non-assessed income.[1]

Carry forward

45. The Organization routinely carries forward a balance on specified voluntary contributions to meet future commitments for planned salary and activity costs. The value of the funds carried forward contributes to the financing of the programme budget. At present, precise estimation of the opening carry-forward balance at the start of 2012 is difficult: variables include the amount and degree of specification of income received for the remainder of the 2010–2011 biennium, and the extent to which some existing contribution balances can be redeployed to under-funded areas, whilst respecting the donor agreement conditions. It is expected that redeployment will provide useful immediate support but have the longer-term effect of reducing the existing carry-forward by the start of 2012 and possibly even further by the end of 2013. The level of reduction in the carry-forward balance depends in part on the extent to which funds can be redistributed to other planned costs. This redistribution in turn is governed by the flexibility of the funds – the extent to which they are specified by the donors' terms and conditions. The carry-forward balance comprises over 2000 individual voluntary contribution balances, each with specific terms and conditions. The Secretariat will conduct further analysis of this conditionality as part of the operational planning exercise for the 2012–2013 budget.

Operational planning and budgeting

46. The detailed resource allocation is determined closer to the time of implementation of the programme budget, on the basis of specifically planned results and a precise estimate of resource requirements for agreed programme delivery. An integrated operational planning and budgeting process will be conducted in 2011. During this process the expected accomplishments of each entity across the Organization will be agreed, reflecting their respective functions and desirable staffing. Particular attention will be given to clearly identifying the specific health outcomes to be targeted for action by the Secretariat, and the related outputs for which the Secretariat will be accountable. Estimated staff and non-staff resource requirements will be determined. On the basis of the agreed operational plans, detailed budget allocations will be made.

47. A key feature of the operational planning and budgeting process is the alignment of the commitments to specific results and their budget allocations with agreed priorities at the country level. This will allow the identification of certain countries for the Organization-wide expected results, on the basis of the national health and development plans and the WHO country cooperation strategies. This will in turn ensure greater coordination and alignment of the delivery of planned results across the Organization.

48. During the operational planning process for the biennium 2012–2013, the Secretariat will organize its work in accordance with the priorities and emphases outlined in the Proposed programme budget. The Secretariat will clearly define what is expected to be delivered and achieved by each budget centre, on the basis of a resource projection that is realistic at the time of operational planning, and will identify the additional resources to be raised in order to achieve all the expected results outlined in the Proposed programme budget 2012–2013.

[1] See document A63/36.

Monitoring the programme budget

49. Performance monitoring and assessment are essential for the proper management of the programme budget and to inform the revision of policies and strategies. Monitoring of the implementation of the programme budget is conducted at the end of the 12-month period (the mid-term review) and an assessment is made upon completion of the biennium (the programme budget performance assessment).

50. The mid-term review provides a means to track and appraise progress towards the achievement of the expected results. It facilitates corrective action, and the reprogramming and reallocation of resources during implementation. For each Organization-wide expected result, there is an appraisal of the progress made towards achieving the expected results at the mid-term. It is a process that allows the Secretariat to identify and analyse the impediments and risks encountered, together with the actions required to ensure achievement of the expected results.

51. The end-of-biennium programme budget performance assessment is a comprehensive appraisal of the performance of each organizational entity and of the Organization as a whole, including whether the targets set for the expected result indicators have been attained. The assessment focuses on achievements in comparison with planned results, and on lessons learnt, in order to inform planning for the next biennium. The performance assessment for the biennium 2008–2009[1] has highlighted the lessons learnt that have shaped the Proposed programme budget 2012–2013.

52. The Secretariat has further reviewed the set of indicators and targets for all Organization-wide expected results in the amended Medium-term strategic plan 2008–2013 in the light of the performance assessement of the Programme budget 2008–2009. It has introduced additional improvements where appropriate in order to facilitate measurement and reporting. This process of incremental refinement will lead to continuing improvements, and form part of the preparation of the next medium-term strategic plan.

53. The processes of the mid-term review and the programme budget performance assessment each generate a report; both documents are submitted to the governing bodies for their consideration. The timeline for production of these documents established for the biennium 2008–2009 will be maintained. The mid-term review report will be made available for the Programme, Budget and Administration Committee of the Executive Board, the Executive Board, the Health Assembly and regional committee sessions following the first year of the biennium; the assessment report will be submitted to the same bodies at their session following the second year of the biennium.

Management reforms and efficiency gains

54. The Organization will continue its efforts to improve organizational effectiveness and efficiency through results-based management, cost reduction and management reforms. WHO is committed to reducing costs and increasing efficiency, and has focused on the key areas of travel, publications and consolidation of information technologies and platforms; as well as on the relocation to Malaysia of many back office administrative functions. In addition, several management reforms have been initiated to improve internal efficiency and effectiveness in the areas of governance, finance, human resources and system integration.

[1] Document EB128/22.

STRATEGIC OBJECTIVE 1

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

Scope

The work under this strategic objective focuses on prevention, early detection, diagnosis, treatment, control, elimination and eradication measures to combat communicable diseases that disproportionately affect poor and marginalized populations. The targeted diseases include, but are not limited to: vaccine-preventable, tropical, zoonotic and epidemic-prone diseases, excluding HIV/AIDS, tuberculosis and malaria.

Critical links with other strategic objectives

Achievement of this strategic objective requires strong links and effective collaboration with other strategic objectives, in particular:

- Strategic objectives 2, 3, 4, 6 and 9: in connection with integrated disease control, surveillance and harmonized research initiatives
- Strategic objective 5: in connection with mutual support in field operations and health security
- Strategic objective 8: in connection with the adoption of adequate solutions for the management of health-care waste
- Strategic objective 9: in connection with water and sanitation aspects of zoonotic diseases
- Strategic objective 10: in connection with the implementation of programmes through financially sustainable health-system approaches
- Strategic objective 11: in connection with safe and effective vaccines, medicines and interventions, as well as quality assurance of diagnostics and laboratory services.

Key achievements to date

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

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

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

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

Countries are increasingly leading research through networks such as the African network for drugs and diagnostics innovation. Four regional reference research training centres have been established in Colombia, Indonesia, Kazakhstan and Rwanda. The high-level political commitment demonstrated at both the Ministerial Conference on Research for Health in the African Region (Algiers, 23–26 June 2008) and the Global Ministerial

Forum on Research for Health (Bamako,17–19 November 2008), served to raise the priority given to health research.

Key challenges

Achieving or making progress towards eradication of numerous neglected tropical diseases and communicable diseases, as well as poliomyelitis, will involve overcoming impediments such as weak delivery systems. Building the capacity of health systems to implement planned activities in conflict areas presents a particular challenge. In general, interventions to prevent and control vaccine-preventable diseases and respiratory, diarrhoeal and vector-borne diseases, will need to be scaled up, including expanding vaccination coverage to include children who have not been immunized, and introducing new vaccines. Stronger support will be required for the integration of the Global Plan to Combat Neglected Tropical Diseases (2008–2015) in national plans, and to enhance capacity and address emerging, re-emerging and vector-borne diseases that pose a risk to global health security. In addition to ensuring full implementation of the International Health Regulations (2005), research and advocacy will need to be scaled up in order to engage governments and civil society in preventing, controlling and treating communicable diseases.

Priorities and emphasis for 2012–2013

Considerable progress has been made towards the regional elimination of some major vaccine-preventable diseases, such as poliomyelitis, measles and rubella, which affect millions of children every year. It is anticipated that fewer supplementary immunization activities will be needed as eradication or elimination of these diseases is achieved. Some progress has also been made towards reducing the impact of diseases such as hepatitis B, while certain vaccine-preventable diseases, including influenza, remain poorly controlled. It is clear that immunization campaigns work, but the momentum must be maintained. The main emphasis in this area will be on making progress towards regional eradication and elimination of certain diseases – including measles, rubella, and hepatitis B – and on strengthening immunization against others, such as influenza; working with partners to build on the outcome of campaigns until targets are reached and control and prevention interventions are adequately scaled up; increasing the availability of information for assessing and documenting the effectiveness of immunization programmes; and extending vaccination to unimmunized children and age groups beyond infancy. Immunizing older age groups will extend protection and ensure that immunization initiated in infancy is completed. Priority will also be given to supporting low- and middle-income countries to mount immunization campaigns, and to supporting the development of innovative and effective ways to expand immunization coverage through regional pooled vaccine procurement systems, new partnerships and financing arrangements, new vaccines, transfers of vaccine production technologies, and wider access to vaccines.

The persistence of poliomyelitis in four countries and its spread to other countries continue to delay eradication of the disease and increase the risk of re-infection in poliomyelitis-free countries. The main emphasis in this area of work will be on: mobilizing the political, technical and financial backing needed to complete poliomyelitis eradication; working with partners in the Global Polio Eradication Initiative to build on the new Global Polio Eradication Initiative Strategic Plan 2010–2012; implementing vigorous outbreak-control measures and migrant population strategies; and planning for the post-eradication period in terms of the destruction or safe storage and handling of residual stocks of wild poliovirus infectious materials, certification of the interruption of wild poliovirus transmission and final containment of wild poliovirus stocks, as well as the technical and operational feasibility of replacing oral poliomyelitis vaccine with inactivated poliomyelitis vaccine in order to eliminate the occurrence of vaccine-associated paralytic poliomyelitis and circulation of vaccine-derived polioviruses, and verification of the elimination of vaccine-derived polioviruses.

Following the launch of the Global Plan to Combat Neglected Tropical Diseases (2008–2015), progress has been made in the treatment and elimination of leprosy, Chagas disease, rabies, lymphatic filariasis, and dracunculiasis, as well as in reducing the impact of other diseases, including schistosomiasis, human African trypanosomiasis and yaws. Breakthroughs occurred as a result of the alignment of national plans with the Global Plan, as well as the harmonization of multisectoral collaboration, the strengthening of surveillance, and the preparation of elimination plans and global strategies to deal with particular aspects of neglected tropical and zoonotic diseases. Integrated vector and pesticide management strategies have also been developed. WHO supported several countries through training and education programmes and by facilitating access to vital information, specimen banks and databanks. Collaboration was also strengthened with Member States and United Nations agencies, as well as with the Foundation for Innovative New Diagnostics (FIND) and the pharmaceutical industry, which provided large-scale drug donations. The main emphasis in this area will be on: achieving global eradication of

dracunculiasis and regional eradication and elimination of lymphatic filariasis, schistosomiasis, human African trypanosomiasis and yaws; increasing the availability of drugs, particularly for schistosomiasis and soil-transmitted helminthiasis, and supporting integrated national plans to combat neglected tropical diseases under the Global Plan, as well as implementation of a new strategic plan for dengue that includes integrated vector management and provides a road map for the development of national plans.

The implementation of the International Health Regulations (2005) as the framework for preparedness, surveillance, alert, assessment and networks is essential for strengthening global public health security; it will help countries to respond to emerging and re-emerging epidemic, pandemic and vector-borne diseases, diseases related to the interface between humans and animals, and environmental change. Implementation of the Regulations is proving particularly complex in fragile States and areas affected by conflict and insecurity. During the biennium, emphasis will be placed on: strengthening advocacy, political commitment and the engagement of communities, civil society and the non-state sector in the implementation of the Regulations; supporting countries to strengthen preparedness and other capacities, including in planning, health systems, surveillance, risk assessment and handling of public health problems of local, national and international importance; building research capacity to generate and disseminate the evidence and knowledge needed to strengthen disease control and prevention; and supporting Member States to resolve public health issues related to the sharing of viruses, as well as the integration of health services in underserved urban and rural communities, and the development of regional surveillance platforms covering epidemiology, alert and response, laboratory capacity, “events-based surveillance”, vaccine-preventable diseases and the evaluation of immunization programmes.

As a result of the reduced budget and adjusted financial outlook for 2012–2013, a number of actitivities either will be scaled down or will not be undertaken. For example, support will decline to the development of routine immunization programme strategies in those countries which are not eligible for support from the GAVI Alliance. This will affect lower-middle income countries and middle-income countries that are about to expand their immunization programmes from a programme for infants (under one-year-olds) to a broader programme encompassing child and adolescent health. Similarly, the introduction of new vaccines in these countries will lag behind those that receive full funding support for new vaccines from the GAVI Alliance.

The initial reduction, and now suspension, of funding for the strengthening of immunization services by the GAVI Alliance means that delivery of immunization through outreach services and periodic intensification of routine immunization activities (e.g. Child Health or Immunization Plus Days) may be reduced or cancelled.

The direct funding by the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases for drug discovery for tropical diseases will be wound down, and promising projects leads transitioned to other partners. Emphasis will be placed on utilizing the capacity and partnerships already established to assist in the establishment of regional networks of innovation, and to transition projects, where possible, to these networks. In addition, a number of diagnostics evaluation studies will no longer be undertaken.

Major WHO special programmes and collaborative arrangements contributing to the achievement of Organization-wide expected results, and included within the budgetary envelope

- Effective collaboration with the GAVI Alliance
- Global Poliomyelitis Eradication Initiative
- Partnership for the control of neglected tropical diseases
- UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases
- Vaccine research partnerships
- Tri-partite Agreement WHO-FAO-OIE on avian influenza management and other emerging diseases

Total budget by major office for the strategic objective for 2012–2013 (US$ million)

Budget (US$ million)							
Base programmes							
Africa	**The Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**
109.2	21.6	57.2	15.0	37.3	41.6	164.2	**446.1**
Special programmes and collaborative arrangements							**679.5**
Outbreak and crisis response							**152.6**
Grand total							**1 278.1**

Organization-wide expected results and indicators

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 2012	
	135	160
	Targets to be achieved by 2013	
	140	170

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 2012	
	90%	50%
	Targets to be achieved by 2013	
	100%	75%

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 disease-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 2012			
	190	95	8 500	20
	Targets to be achieved by 2013			
	193	145	7 500	25

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** Number of Member States for which WHO/UNICEF joint reporting forms on immunization surveillance and monitoring are received on time at global level in accordance with established timelines
	Baseline 2012	
	150	155
	Targets to be achieved by 2013	
	193	165

1.5 New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed and validated, with scientists from developing countries increasingly taking the lead in this research.	**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 2012	
	9	55%
	Targets to be achieved by 2013	
	12	60%

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 2012	
	120	130
	Targets to be achieved by 2013	
	193	180

1.7 Member States and the international community equipped to detect, assess, respond to and cope with major epidemic and pandemic-prone diseases (e.g. influenza, meningitis, yellow fever, haemorrhagic fevers, plague and smallpox) through the development and implementation of tools, methodologies, practices, networks and partnerships for prevention, detection, preparedness and intervention.	**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	**1.7.3** Number of severe emerging and re-emerging diseases for which prevention, surveillance and control strategies have been developed
	Baseline 2012		
	165	8	8
	Targets to be achieved by 2013		
	185	9	10

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
	Baseline 2012
	90
	Targets to be achieved by 2013
	120

1.9 Effective operations and response by Member States and the international community to declared emergency situations due to epidemic and pandemic-prone diseases.	**Indicators**
	1.9.1 Proportion of Member States' requests for assistance that have led to effective and timely interventions by WHO, delivered using a global team approach, in order to prevent, contain and control epidemics and other public health emergencies.
	Baseline 2012
	99%
	Targets to be achieved by 2013
	99%

STRATEGIC OBJECTIVE 2

To combat HIV/AIDS, tuberculosis and malaria

Scope

Work under this strategic objective will focus on: enabling countries to scale up and improve prevention, treatment, care and support interventions for HIV/AIDS, tuberculosis and malaria so as to achieve universal access, in particular for seriously affected populations and vulnerable groups; advancing related research; removing obstacles that block access to interventions and impediments to their use and quality; and contributing to the broader strengthening of health systems.

Critical links with other strategic objectives

Achievement of this strategic objective requires strong links and effective collaboration with almost all the other strategic objectives:

- Strategic objective 1: particularly work related to the delivery of interventions; strengthening research capacity and expanding access to new strategies and tools, such as vaccines; and strengthening systems for monitoring and surveillance of communicable diseases
- Strategic objective 3: particularly work relating to HIV and mental health
- Strategic objective 4: particularly efforts related to: supporting research and development of new tools and interventions; meeting specific needs of children, adolescents and women of child-bearing age; formulation and implementation of gender-sensitive interventions; and tackling sexually transmitted infections
- Strategic objective 6: specifically relating to prevention of tobacco use and its connection with tuberculosis, and prevention of unsafe sex
- Strategic objective 7: specifically work relating to approaches that enhance equity and are pro-poor, gender-responsive, ethical and human-rights based
- Strategic objective 8: particularly relating to environmental health and its connection with malaria
- Strategic objective 9: particularly work in the area of nutrition and its connection with HIV/AIDS
- Strategic objective 10: particularly efforts related to: the organization, management and delivery of health services; areas of human resources capacity strengthening, integrated training and widening of service provider networks; and work related to minimizing the potential of financial catastrophe and impoverishment due to out-of-pocket health expenses
- Strategic objective 11: specifically work related to essential medicines, medical products and technologies for the prevention and treatment of HIV/AIDS, tuberculosis and malaria
- Strategic objective 12: specifically work related to making health knowledge and advocacy material accessible to Member States.

Key achievements to date

Member States facing a high burden of HIV/AIDS, tuberculosis and/or malaria have made progress in tackling the diseases through well-planned and sustained efforts, focused on Millennium Development Goal targets. The response has included taking into account the specific needs of highly vulnerable populations, including women, children, the very poor and marginalized groups; innovative financing and technical assistance; and closer collaboration among global partners. Efforts have been stepped up to measure, and respond to, the emerging challenge of drug-resistant strains of tuberculosis, malaria and HIV.

Antiretroviral therapy has been made available to more than four million people worldwide, and health systems have been strengthened to deliver HIV programmes effectively by improving, inter alia, human resources capacity, information systems for managing procurement and supply of HIV-related medicines and diagnostics, laboratory diagnostic capacity for HIV and tuberculosis, and monitoring treatment and strategies to prevent mother-to-child transmission of HIV. Coverage of the latter in low- and middle-income countries has increased, and methods of preventing HIV infection for most-at-risk populations – inter alia, through expansion of male circumcision programmes – have been promoted in countries in sub-Saharan Africa with a high burden of HIV/AIDS. Most progress has been made in expanding the use of antiretroviral therapy in the prevention of mother-to-child transmission.

There has been a decline in tuberculosis incidence globally, so that the relevant target for 2015 has effectively been met for Millennium Development Goal 6 and progress is sustainable, although it needs to be accelerated. Tuberculosis mortality has declined by nearly 40% since 1990. As a result of increased domestic and international financing, more than 40 million people will have been successfully treated through DOTS programmes by the beginning of the biennium. Combined tuberculosis and HIV interventions, especially testing for HIV among tuberculosis patients, has been scaled up, and although integrated prevention and care policies have been widely adopted, their implementation needs to be accelerated. The challenge posed by multidrug-resistant tuberculosis is now widely recognized and there is a greater commitment to scaling up prevention and response activities. Over 80 countries have been taking steps to treat multidrug-resistant tuberculosis.

International commitment to funding malaria control has increased substantially. Member States have scaled up their response by distributing long-lasting insecticide-treated nets, and, to some extent, rapid diagnostics tests and artemisinin-based combination therapy. Implementation and its impact have been greatest in less populated countries with high per-capita investment in malaria elimination. Strong political support for elimination in countries with low endemicity has been emerging, triggered by evidence showing the link between malaria and slower development. Investment in improved and innovative technologies by key partners has focused attention on that area.

Coordinated technical support has been given to Member States, particularly for accessing and managing grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria. By engaging communities and civil society, partnerships have been expanded and donor financing secured for disease prevention, control, treatment and care.

National efforts to tackle the three pandemics have been more stringently monitored and evaluated, as reflected in comprehensive WHO annual reports that have been widely referenced and applied in planning global, regional, and local responses and in strengthening impact assessments. The results have also been used to improve the quality and scope of routine health information systems.

Key challenges

The first key challenge will be to maintain the level of financing needed to expand disease response efforts. Despite a substantial increase in overall financing, the flow of resources in many low- and lower-middle-income countries is unreliable. Therefore, providing support to sustain commitment and ensure the efficient use of resources is critical, given the pressing need of those who have not yet benefited from prevention and care activities, and the threat to health posed by emerging drug-resistant diseases.

The second challenge will be to build the capacities needed to undertake the more complex actions that will be required in the future. Implementing the recommended policies, strategies and global response plans for all three diseases will require increased technical and managerial capacity. For example, detecting and treating drug-resistant diseases increases the demands made on health workers, supporting programmes and affected communities, as well as responding to requests for technical assistance. Therefore, WHO will need to strengthen its role in providing and coordinating technical assistance.

The third challenge will be to improve the effectiveness of health systems through better integrated services. Policies on universal health-care coverage, drug quality regulation and human resources need to be revised in order to improve outcomes in relation to HIV/AIDS, tuberculosis and malaria. In order to be able to deliver effective integrated services for the care and prevention of diseases, maternal and child health, nutrition, sexual and reproductive health, and the needs of highly vulnerable populations and communities, guidance and innovation will also be required.

Priorities and emphasis for 2012–2013

Overall, priority will be given to maintaining the quality of the normative and strategic work as it is updated and revised to keep abreast of scientific and practical developments in disease prevention, treatment and care. The forthcoming WHO HIV/AIDS strategy for 2011–2015 contains details of the priority actions to be undertaken by the Organization. With regard to tuberculosis, WHO will focus on the priorities outlined in the Stop TB Strategy and the Global Plan to Stop TB, 2006–2015, paying particular attention to further accelerating efforts to prevent and treat multidrug-resistant tuberculosis. WHO will target work on the treatment and prevention of malaria to focus on applying policies to scale up the use of insecticide-treated nets, rapid diagnostic tests and artemisinin-

based combination therapies. In general, emphasis will be placed on the promotion of primary care and integrated services for all three diseases and on maternal and child care, including the prevention of mother-to-child transmission and sexual and reproductive services.

Increased demand for technical support will require further prioritization and coordination of efforts across WHO, hosted technical support mechanisms, WHO collaborating centres and with partners, as well as strengthened country office capacity, harmonization with existing WHO hosted partnerships covering HIV, tuberculosis and malaria, and strategic engagement in Global Fund activities. Partnerships should also be expanded by engaging communities, civil society and the non-state sector in disease prevention and care in order to provide a comprehensive health-system response. Drug resistance affecting all three diseases is causing growing concern and will require enhanced surveillance and containment capacity. Attention will therefore be paid to reinforcing human resources and management, routine programme and health service monitoring, evaluation and operational research, promoting health-care standards and guaranteeing the quality and timely supply of commodities. Collaboration with new funding mechanisms, such as the Millennium Foundation, patent pools and initiatives for universal health coverage, and the strengthening of existing ties with the Global Fund and the International Drug Purchase Facility (UNITAID), will also be undertaken.

Given restricted resources but increasing demand for WHO action and engagement, the top priority for strategic objective 2 will be to maintain WHO's core functions in development of policy and norms, in monitoring and evaluation, and in technical support including ensuring access to medicines and other technologies. Increased attention will be given to the strategic partnerships within and outside of WHO that further the fulfillment of WHO's core functions, achieve effective implementation of interventions by Member States, and increase efficiencies. There will also be a focus on technical support and capacity building in countries where major challenges have been identified in HIV/AIDS, tuberculosis or malaria prevention, care and treatment.

Major WHO special programmes and collaborative arrangements contributing to the achievement of Organization-wide expected results, and included within the budgetary envelope

- UNDP/UNFPA/WHO/World Bank Special Programme for Research, Development and Research Training in Human Reproduction
- Stop TB partnership
- Global Fund to Fight AIDS, Tuberculosis and Malaria and UNITAID
- UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases
- HIV Vaccine Initiative (including the African AIDS Vaccine Programme)

Total budget by major office for the strategic objective for 2012–2013 (US$ million)

Budget (US$ million)							
Base programmes							
Africa	**The Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**
146.3	20.1	73.3	21.0	39.1	46.4	100.3	**446.4**
Special programmes and collaborative arrangements							**93.9**
Outbreak and crisis response							**0.0**
Grand total							**540.3**

Organization-wide expected results and indicators

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 (a) antiretroviral therapy and (b) the prevention of mother-to-child transmission services	**2.1.2** Proportion of disease-endemic countries that have achieved their national intervention targets for preventing 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** Number of countries among the 27 priority ones with a high burden of multidrug-resistant tuberculosis that have detected and initiated treatment, under the WHO-recommended programmatic management approach, for at least 70% of estimated cases of multidrug-resistant tuberculosis	**2.1.5** Proportion of high-burden Member States that have achieved the target of 70% of persons with sexually transmitted infections diagnosed, treated and counselled at primary point-of-care sites
	Baseline 2012				
	(a) 15 (b) 20	60%	46	4	70%
	Targets to be achieved by 2013				
	(a) 35 (b) 45	60%	50	10	90%

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	**Indicators**		
	2.2.1 Number of targeted Member States with comprehensive WHO-recommended 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	**2.2.3** Number of countries among the 63 ones with a high burden of HIV/AIDS and tuberculosis that are implementing the WHO 12-point policy package for collaborative activities against HIV/AIDS and tuberculosis
	Baseline 2012		
	HIV/AIDS:115/131 Tuberculosis: 118/118 Malaria: 70/70	60%	30
	Targets to be achieved by 2013		
	HIV/AIDS: 131/131 Tuberculosis: 148 Malaria: 70/70	75%	45

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.					

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 new 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 2012				
	Medicines: 95	300	HIV/AIDS: 38 TB:107 Malaria:77	105	180
	Targets to be achieved by 2013				
	Medicines: 105	400	HIV/AIDS: 50 TB:107 Malaria:77	125	193

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 2012	
	HIV/AIDS: 120 Tuberculosis: 198 Malaria: 107	HIV/AIDS: 65 Tuberculosis: 125 Malaria: 107
	Targets to be achieved by 2013	
	HIV/AIDS: 130 Tuberculosis: 198 Malaria: 107	HIV/AIDS: 75 Tuberculosis: 130 Malaria: 107

2.5 Political commitment sustained and mobilization of resources ensured through advocacy and nurturing of partnerships on HIV/AIDS, tuberculosis and malaria at country, regional and global levels; support provided to countries as appropriate to develop or strengthen and implement mechanisms for resource mobilization and utilization and increase the absorption capacity of available resources; and engagement of communities and affected persons increased to maximize the reach and performance of HIV/AIDS, tuberculosis and malaria control programmes.	**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 2012	
	HIV/AIDS: 118 Tuberculosis: 110 Malaria: Not available	HIV/AIDS: 120 Tuberculosis: 87 Malaria: 70
	Targets to be achieved by 2013	
	HIV/AIDS: 131 Tuberculosis: 120 Malaria: Not available	HIV/AIDS: 131 Tuberculosis: 87 Malaria: 70

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 or implementation strategies for the prevention and control of HIV/AIDS, tuberculosis or malaria implemented by the public sector in at least one developing country	**2.6.2** Proportion of peer-reviewed publications arising from WHO-supported research on HIV/AIDS, tuberculosis or malaria and for which the main author's institution is based in a developing country
	Baseline 2012	
	6	55%
	Targets to be achieved by 2013	
	13	60%

STRATEGIC OBJECTIVE 3

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

Scope

The work under this strategic objective focuses on the following: policy development; programme implementation; monitoring and evaluation; strengthening of health and rehabilitation systems and services; and implementation of prevention programmes and capacity building in the areas of noncommunicable diseases, including genetic disorders, visual and hearing impairment, mental, behavioural and neurological disorders, including those related to psychoactive substance use, injuries due to road traffic crashes, drowning, burns, poisoning, falls, violence in the family and the community, and disabilities of all types.

Critical links with other strategic objectives

Achievement of this strategic objective requires strong links and effective collaboration with many other strategic objectives, in particular:

- Strategic objective 2: in connection with the development of synergies to accelerate progress in achieving Millennium Development Goals 5 and 6, and strengthen health care for chronic conditions
- Strategic objective 4: in connection with the development of synergies to accelerate achievement of Millennium Development Goal 4
- Strategic objective 5: in connection with strengthening emergency response for people with noncommunicable diseases and disabilities, upgrading emergency medical services and mass casualty management, and provision of psychosocial care during emergencies and chronic crises
- Strategic objective 6: in connection with health promotion, surveillance, prevention and reduction of risk factors for health, including population-wide approaches to combating tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity, and in relation to urban health development
- Strategic objective 7: in connection with integrating the social determinants of health into prevention initiatives, promoting health-in-all policies, enhancing human rights and health equity, and integrating pro-poor, gender-responsive approaches
- Strategic objective 8: in connection with promoting synergies in occupational health, health impact assessments, contributing to health-in-all policies, and assessing and addressing the health effects of climate change
- Strategic objective 9: in connection with improved nutrition throughout the life course
- Strategic objective 10: in connection with integrating the surveillance of noncommunicable conditions into the global health observatory and health information systems, as well as strengthening health services to respond more effectively to the health-care needs of those with noncommunicable conditions.

Key achievements to date

Member States have demonstrated their commitment to work in this area through the adoption of Health Assembly and United Nations General Assembly resolutions on prevention and control of noncommunicable diseases, violence prevention, road traffic injury prevention, emergency trauma care, disability and rehabilitation, and prevention of avoidable blindness and visual impairment, as well as numerous regional committee resolutions, including those on: road traffic injury prevention in the Eastern Mediterranean Region; a regional cancer control strategy in the African Region; a regional noncommunicable diseases prevention plan in the Western Pacific Region; and the Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment in the Region of the Americas. In addition, a resolution endorsing the Strategy and Plan of Action on Mental Health was adopted by PAHO's 49th Directing Council. A regional framework for injury prevention in the Western Pacific Region has been agreed and an assessment of the progress made in implementing a resolution on the prevention of injuries in the European Region has been completed.

Progress has been made in implementing the six objectives of the action plan for the global strategy for the prevention and control of noncommunicable diseases for the period 2008–2013. A progress report on actions taken during the first two years was discussed at the Sixty-third World Health Assembly.[1] Together, the action plan and evidence-based advocacy to raise the priority accorded to tackling noncommunicable diseases in development work at global and national levels have produced tangible results, for example, the Ministerial Declaration issued during the High-Level Segment of the United Nations Economic and Social Council (Geneva, 6–9 July 2009), and United Nations General Assembly resolution 64/265 on the prevention and control of noncommunicable diseases, in which, inter alia, it was decided to convene a high-level meeting of the General Assembly in September 2011, with the participation of Heads of State and Government, on the prevention and control of noncommunicable diseases.

Standards and core indicators for noncommunicable disease surveillance systems have been established and will be used for policy development and for monitoring global and national trends. A global survey on the capacity of Member States in devising and implementing comprehensive noncommunicable disease prevention programmes has been conducted and the same protocol will be used to monitor progress over a three-year period. The effectiveness of intersectoral action against noncommunicable diseases has been assessed on the basis of lessons learnt and the recommendations made. In collaboration with Member States and other stakeholders, resolutions on the marketing of food and non-alcoholic beverages to children[2] and on a global strategy to reduce the harmful use of alcohol were prepared and subsequently adopted by the Sixty-third World Health Assembly.[3]

The First Global Ministerial Conference on Road Safety, held in 2009, resulted in the adoption of the Moscow Declaration, which, in turn, led the United Nations General Assembly to proclaim the period 2011–2020 the Decade for Road Safety.

WHO's mental health Gap Action Programme has been launched to scale up health services for people suffering from mental, neurological and substance-use disorders. Technical support provided by WHO to Member States has covered the preparation and implementation of policies, strategies and legislation (i) on noncommunicable conditions, including violence and injury prevention and mental health, and (ii) to improve the lives of people with disabilities. Progress has been made in the implementation of cost-effective interventions and national policies and plans, and in developing a stronger evidence base for interventions. New key partnerships have been established and existing ones strengthened and the Global Noncommunicable Diseases Network (NCDnet) has been established.

Key challenges

The three major challenges faced by Member States concern the following: strengthening surveillance and monitoring of noncommunicable conditions and their determinants; promoting intersectoral action to enable health-in-all policies to be implemented; and improving access to essential health-care interventions for the management of common conditions. The availability of resources in several areas remains inadequate compared with the magnitude of the problems and the potential for action, thus limiting implementation of WHO's plans, recommendations and guidelines in many low- and middle-income countries. The Programme budget 2012–2013 will focus on responding to such challenges.

Priorities and emphasis for 2012–2013

The main priority for the biennium will be to capitalize on broad-based advocacy efforts that have served to increase awareness of, and commitment to, the prevention and control of noncommunicable conditions through the strengthening of national programmes and building of technical and managerial capacity with a focus on low- and middle-income countries. National programmes will be supported to adapt, implement and evaluate primary prevention measures, and the prevention of noncommunicable conditions will be integrated into national development agendas. Implementation of existing resolutions, frameworks, action plans and normative guidance will be strengthened and the prevention and management of noncommunicable conditions, including mental and

[1] Document A63/12.

[2] Resolution WHA63.14.

[3] Resolution WHA63.13.

neurological disorders, injuries and disabilities, will be integrated into initiatives for strengthening health-systems.

Emphasis will also be placed on generating evidence-based recommendations in order to refine and strengthen existing interventions while continuing to integrate the prevention of noncommunicable conditions into the global development agenda. In scaling up the development and strengthening of national programmes, the challenges previously mentioned will need to be taken into account. Special emphasis will be placed on strengthening noncommunicable disease surveillance initiatives and integrating them into national health information systems. Other priorities will include: promoting mechanisms for encouraging intersectoral action and health-in-all policies based on good practice and lessons learnt; preparing affordable evidence-based packages of interventions; further developing, strengthening and utilizing multisectoral partnerships, including approaching additional government and civil society stakeholders; and enhancing the private sector's contribution to the implementation of existing policies and plans while avoiding conflicts of interest. The contribution of the Global Noncommunicable Diseases Network will be increased in the areas of advocacy, innovative resourcing and scaling up implementation of the Action plan for the global strategy for the prevention and control of noncommunicable diseases.

The reduction in the Proposed programme budget and the adjusted financial outlook for 2012–2013 will have implications for this strategic objective that need careful review. Noncommunicable diseases, mental disorders, violence, injuries and visual impairment are neglected areas in public health and the strategic approaches to address these remain valid and require continued emphasis. In the area of noncommunicable diseases, the focus will be on the priorities included in the Action plan for the global strategy for the prevention and control of noncommunicable diseases and less emphasis given to other activities.

Total budget by major office for the strategic objective for 2012–2013 (US$ million)

Budget (US$ million)							
Base programmes							
Africa	**The Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**
18.9	9.8	11.5	16.5	7.8	12.4	36.8	**113.8**
Special programmes and collaborative arrangements							**0.0**
Outbreak and crisis response							**0.0**
Grand total							**113.8**

Organization-wide expected results and indicators

3.1 Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities together with visual impairment, including blindness.	**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 diseases
	Baseline 2012			
	162		100	122
	Targets to be achieved by 2013			
	170		110	152

3.2 Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.	**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 diseases	**3.2.4** Number of Member States that are implementing comprehensive national plans for the prevention of hearing or visual impairment
	Baseline 2012			
	88	56	90	100
	Targets to be achieved by 2013			
	94	64	105	130

3.3 Improvements made in Member States' capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.	**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 diseases	**3.3.5** Number of Member States documenting, according to population-based surveys, the burden of hearing or visual impairment
	Baseline 2012				
	175	163	110	136	38
	Targets to be achieved by 2013				
	180	168	120	155	42

3.4 Improved evidence compiled by WHO on the cost–effectiveness of interventions to tackle chronic noncommunicable diseases, mental and neurological and substance-use disorders, violence, injuries and disabilities together with visual impairment, including blindness.	**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 diseases
	Baseline 2012	
	Published and disseminated for 12 interventions	Published and disseminated for 5 interventions
	Targets to be achieved by 2013	
	Published and disseminated for 14 interventions	Published and disseminated for 8 interventions

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 2012		
	14	21	100
	Targets to be achieved by 2013		
	18	23	130

3.6 Guidance and support provided to Member States to improve the ability of their health and social systems to prevent and manage chronic noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities together with visual impairment, including blindness.	**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 of cardiovascular risk and integrated management of noncommunicable diseases using WHO guidelines	**3.6.5** Number of Member States with tobacco cessation support incorporated into primary health care
	Baseline 2012				
	27	35		26	40
	Targets to be achieved by 2013				
	32	41		55	45

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

Scope

The work under this strategic objective seeks to improve and expand access to, and use of, effective public health interventions that will reduce morbidity and mortality related to pregnancy and childbirth and improve child survival and child and adolescent health and development. It also focuses on actions that will ensure universal access to sexual and reproductive health services, with a particular emphasis on reducing barriers to use of services and reaching marginalized populations. To be successful, the work must be carried out in concert with strengthening health systems and ensuring integrated care, especially for children, adolescents and women of reproductive age. The work emphasizes the linkages between different points throughout the life course and includes healthy and active ageing.

As the HIV pandemic continues, it is especially important that programmes and services intended to reach adolescents and women of reproductive age, including antenatal care, family planning services, and treatment of sexually transmitted infections, systematically include programmes and services for the prevention and treatment of HIV infection, including prevention of mother-to-child transmission.

It is recognized that the underlying gender inequities must be addressed to achieve the Millennium Development Goals health targets, including those covered under this strategic objective. In this context, violence against women is increasingly recognized as a major public health problem, including being linked to HIV infection, and requires greater attention from the public health community.

Critical links with other strategic objectives

Achievement of this strategic objective requires strong links and effective collaboration with other strategic objectives, in particular:

- Strategic objectives 1 and 2: in connection with ensuring the effective delivery, in an integrated manner, of immunization and other interventions for the control of major infectious diseases through services for maternal, newborn and child and adolescent health, and sexual and reproductive health
- Strategic objective 5: in connection with the response to the health needs of vulnerable populations, especially mothers and children in emergency situations
- Strategic objectives 6 to 9, especially 6, 7 and 9: sufficient attention needs to be given to (a) social and economic determinants of ill-health that limit progress towards this strategic objective, (b) major risk factors, such as poor nutrition, and (c) human rights-based and gender-responsive approaches to ensure equitable access to key services at various stages of life
- Strategic objectives 10 and 11: particularly the specific actions required to strengthen health systems so they can rapidly expand access to effective interventions for maternal, newborn, child, adolescent and sexual and reproductive health, while ensuring a continuum of care throughout the life-course and across different levels of the health system, including the community.

Key achievements to date

There were indications of greater political commitment by the international community to attaining Millennium Development Goals 4 and 5, increasing the likelihood of more funding. The four key agencies with responsibility for those Goals – namely, WHO, UNICEF, UNFPA and the World Bank – have intensified and coordinated their efforts to improve maternal and newborn health in the neediest countries. WHO has developed new tools and guidelines in connection with sexual and reproductive health, maternal, newborn and child health, and adolescent health, and has supported their use. Globally, child mortality has continued to decline. Work under the strategic objective has focused on supporting countries to scale up implementation of the Integrated Management of Childhood Illness strategy, and on training more community health workers in order to bring services closer to children, including through the introduction of the community health workers programme. The

Sixty-third World Health Assembly adopted a resolution on the prevention and treatment of pneumonia, a major cause of child mortality.[1] Programmatic guidance to improve the quality of, and access to, youth-friendly services and school-health services has been developed in order to promote adolescent health.

The availability of services for the prevention of mother-to-child transmission of HIV has increased dramatically. In the publication, *PMTCT strategic vision 2010–2015*,[2] WHO affirms its commitment to providing global and country support in order to scale up access to services and to integrating them in maternal, newborn and child health programmes. The strengthening of systems for the monitoring and surveillance of maternal mortality has contributed to improved data reporting by countries, although significant gaps remain. Globally, the proportion of births attended by skilled health personnel has increased as a result of WHO's continued support for the training of health-care workers, and wider access to emergency obstetric care and family planning services. Contraceptive prevalence in developing countries continued to rise, although unmet needs for family planning remain. WHO's report entitled *Women and health*[3] describes the health issues that particularly affect girls and women throughout their life course. It also identifies areas where new data, analysis, and research are needed, and is intended to stimulate a policy dialogue at country, regional and global levels to inform actions and draw attention to innovative strategies that will lead to real improvements in the health and lives of girls and women worldwide. WHO and UNAIDS have begun working on the links between violence against women and HIV infection.

Key challenges

Reducing child mortality increasingly depends on tackling neonatal mortality: globally, about 40% of deaths among children under five are estimated to occur in the first month of life, most in the first week. The coverage of crucial interventions such as oral rehydration therapy for diarrhoea and case management with antibiotics for acute respiratory infections remains inadequate. Undernutrition continues to play an unacceptably large role in child morbidity and mortality.

Reducing maternal mortality remains a major challenge, especially in parts of the world where vital registration systems are weak or nonexistent; antenatal, childbirth and postpartum services therefore need to be made available to all women, especially the poorest and those living in rural or remote areas. Particular emphasis should be placed on improving access to, and the quality of, services in facilities that provide emergency obstetric care. More effective ways of measuring progress than those offered by current surveillance and monitoring systems are needed, as well as more reliable health information systems in countries.

Slow and uneven progress towards achieving universal access to sexual and reproductive health services in countries is jeopardizing achievement of the Millennium Development Goals, particularly Goal 5. The role of HIV infection in maternal mortality is becoming increasingly clear and calls for intensified efforts to prevent infection among young people, including integration of HIV prevention and treatment services in family planning and antenatal care services. Violence against women, especially intimate partner violence, is recognized as a serious problem about which more information is needed in order to be able to identify effective interventions.

As the proportion of older people increases globally, the importance of encouraging active ageing has been recognized by regional offices and countries. Although disease-specific interventions are covered under other strategic objectives, ageing as part of the life-course and the need for a holistic approach to healthy ageing are included under this strategic objective.

[1] Resolution WHA63.24.

[2] *PMTCT strategic vision 2010–2015: preventing mother-to-child transmission of HIV to reach the UNGASS and Millennium Development Goals: moving towards the elimination of paediatric HIV, December 2009.* Geneva, World Health Organization, 2010.

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

Priorities and emphasis for 2012–2013

In response to the numerous challenges, the main focus of attention in future will be on supporting countries to strengthen health systems in order to enable them to deliver integrated services covering: sexual and reproductive health, including for adolescents; antenatal care; combined mother and newborn care during childbirth and the postpartum/neonatal period; and prevention and treatment of, and testing and counselling for, HIV and other sexually transmitted infections. Greater emphasis will also be placed on working in partnership with other United Nations agencies, key donors and stakeholders in order to provide coherent support to countries in that regard.

The provision of support to countries in scaling up child and newborn health interventions, particularly at community level, will be given higher priority, as will promoting recognition of the importance of childhood development for later life. Improving the indicators for maternal health and methods for measuring progress in reducing maternal mortality will also be prioritized and partners active in the area will be involved in efforts to strengthen health information systems in countries. Member States will receive extra support in order to: set national targets and indicators for achieving universal access to sexual and reproductive health; establish systems for monitoring progress, including in the availability of national data on health outcomes and determinants that are disaggregated by sex and age; and monitor and evaluate interventions for maternal, newborn, child and adolescent health. Priority will also be given to reducing maternal mortality and morbidity by continuing to support countries in increasing the number of skilled birth attendants and enhancing their skills, and in improving the quality of, and access to, facilities that provide emergency obstetric care. More attention will be given to reaching young adolescents in the context of school health in order to influence behaviour patterns, and to tackling violence against women.

A global action plan for ageing and health is planned, as well as guidelines and training programmes for responding to the needs of older people, including in emergency situations.

Research in many of the above areas will continue to be a priority with particular emphasis on implementing the findings, particularly when integrating key evidence-based interventions across health systems with the aim of providing universal access to reproductive, maternal, newborn and child health services.

Within the scenario of a reduced programme budget and related financing, the focus will be to maintain WHO's core functions in policy and norms development, in monitoring and evaluation, and in technical support to countries. However, it is likely that support to Member States will be reduced, some research activities curtailed and a number of planned systematic reviews not accomplished. Greater attention will be paid to the strategic partnerships within and outside of WHO that further the fulfillment of WHO's priorities in this area, achieve effective implementation of interventions by Member States and increase efficiencies.

Major WHO special programmes and collaborative arrangements contributing to the achievement of Organization-wide expected results, and included within the budgetary envelope

- UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction

Total budget by major office for the strategic objective for 2012–2013 (US$ million)

Budget (US$ million)							
Base programmes							
Africa	**The Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**
77.1	13.3	13.6	10.9	8.4	10.6	52.5	**186.3**
Special programmes and collaborative arrangements							**32.0**
Outbreak and crisis response							**0.0**
Grand total							**218.3**

Organization-wide expected results and indicators

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 2012	
	40	40
	Targets to be achieved by 2013	
	60	50

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 2012		
	8	28	40
	Targets to be achieved by 2013		
	10	34	50

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 2012
	50
	Targets to be achieved by 2013
	70

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 2012
	50
	Targets to be achieved by 2013
	57

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 2012	
	50	45
	Targets to be achieved by 2013	
	60	50

4.6 Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, and for the scaling up of a package of prevention, treatment and care interventions in accordance with established standards.	**Indicators**
	4.6.1 Number of Member States with a functioning adolescent health and development programme
	Baseline 2012
	50
	Targets to be achieved by 2013
	55

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 WHO reproductive health strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health agreed at the 1994 International Conference on Population and Development (ICPD), its five-year review (ICPD+5), the Millennium Summit and the United Nations General Assembly in 2007	**4.7.2** Number of targeted Member States having reviewed their existing national laws, regulations or policies relating to sexual and reproductive health
	Baseline 2012	
	40	12
	Targets to be achieved by 2013	
	50	15

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.	**Indicators**
	4.8.1 Number of Member States with a functioning active healthy ageing programme consistent with resolution WHA58.16 on strengthening active and healthy ageing
	Baseline 2012
	20
	Targets to be achieved by 2013
	30

STRATEGIC OBJECTIVE 5

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

Scope

The joint efforts of the Member States and the Secretariat under this strategic objective involve the following: health-sector emergency preparedness; intersectoral action for reducing risk and vulnerability within the framework of the United Nations International Strategy for Disaster Reduction; responding to health needs during emergencies and crises (including nutrition-related, water and sanitation needs); assessing needs of affected populations; health actions during the transition and recovery phases following conflicts and disasters; health of migrants; gender in humanitarian action fulfilling WHO's mandate within the framework of the reform process to enhance the United Nations humanitarian response; the global alert and response system for environmental and food-safety public health emergencies within the framework of the International Health Regulations (2005); risk reduction in respect of specific threats; and preparedness and response programmes for environmental and food-safety public health emergencies. In this way, WHO is contributing to health security, which also has critical implications for efforts to promote peace, and responding to the mandates of Member States contained in three Health Assembly resolutions, namely, resolutions WHA58.1, WHA59.22 and WHA61.17.

Critical links with other strategic objectives

Achievement of this strategic objective requires strong links and effective collaboration with other strategic objectives, in particular:

- Strategic objective 1: in connection with the International Health Regulations (2005) and responding to public health emergencies involving epidemics
- Strategic objective 3: in connection with gender inequalities and gender-based violence, responding to psychosocial needs of most affected populations; responding to the health needs of the disabled; mass-casualty management; and health care for those suffering from chronic diseases
- Strategic objective 4: in connection with the response to the health needs of vulnerable populations, especially women and children in emergency situations
- Strategic objective 8: in connection with intersectoral action for emergency preparedness and risk reduction, and for dealing with environmental, chemical and radiological emergencies
- Strategic objective 9: in connection with nutrition in emergency situations
- Strategic objective 10: in connection with health of migrants, safe hospitals and health-sector risk reduction measures.

Key achievements to date

An increasing number of Member States now have national emergency preparedness plans and programmes for disaster risk reduction, including for making health facilities safer. Institutional capacity has been developed through regular training courses, such as those targeted at WHO Representatives and coordinators of the Inter-Agency Standing Committee Global Health Cluster. Staff members at global, regional and country levels have received training in WHO emergency standard operating procedures. A central logistics platform, with decentralized stocks in five regional warehouses, has been established to respond to humanitarian, as well as public health, emergencies. WHO-led health clusters are supporting the efforts of most Member States facing protracted emergency situations in order to fill critical gaps in service provision and satisfy priority health needs. Communicable disease control interventions have been systematically implemented during all acute natural disasters and conflict situations, and national communicable disease risk profiles have been prepared to guide the response effort. Progress has been made in preparing guidelines and forming networks for food safety and environmental health emergencies, as well as for gender mainstreaming as part of the humanitarian response to crises and disasters.

WHO has played an influential role in humanitarian policy setting through its involvement in numerous interagency bodies.

Key challenges

Member States and donors have shown increasing confidence in WHO's leadership by making financial contributions to specific protracted and sudden-onset crises. However, such funding cannot be spent on core activities and staff. A lack of predictable, secure and flexible funding affects all three levels of the Organization, compromising its ability to fulfil commitments to Member States and their affected populations, as well as those to humanitarian partners, donors and fellow members of the Inter-Agency Standing Committee. Having access to secure, flexible funding would ensure that enough trained, qualified and dedicated staff were permanently available in order to: help Member States to introduce the policies, programmes, structures and systems needed for emergency preparedness and risk reduction, as well as monitor service delivery and gather and analyse health data; lead the Health Cluster in support of national priorities and efforts, and provide technical expertise to Member States and partners in protracted and sudden-onset crises; and ensure that interagency humanitarian policies, guidance, tools and approaches are commonly implemented in order to increase the number of humanitarian health actors ready to provide coherent and coordinated support. In addition, a basic level of core funding from the Organization is needed to ensure that contributions to country Consolidated Appeals Processes (CAP) and Flash Appeals are effectively implemented.

Priorities and emphasis for 2012–2013

During the biennium, priority will be given to two areas. The first, emergency preparedness and disaster risk reduction, encompasses: developing programmes to ensure that the health sector is fully integrated into community-based emergency risk management in most-at-risk countries; establishing health emergency preparedness and risk reduction as key elements in primary health care; ensuring that national all-hazards health emergency management programmes are an integral function of national health systems, health plans and strategies; making provision for environmental and food safety emergencies; using reliable global surveys of health emergency preparedness to advocate for and build health emergency capacities; reducing the vulnerability of health facilities in natural disasters; and securing acceptance of the Vulnerability and Risk Assessment and Mapping methodology as the standard baseline data collection tool for vulnerability and risk analysis.

The second priority area covers the development of response and recovery capacities and involves: ensuring that all Consolidated and Flash Appeals include a health component and that WHO's activities in that context are effectively implemented in at least 30 countries each year and operate from a common WHO platform; expanding the range of emergency stocks available in regional depots; familiarizing all WHO departments with standard operating procedures; developing and implementing health recovery strategies; organizing regular global and regional training programmes on public health in humanitarian settings within overall staff development and institutional readiness programmes; and introducing communicable-disease control interventions, early-warning systems and disease surveillance systems for use in emergencies.

Emphasis will continue to be placed on enhancing WHO's leadership of the Health Cluster by gaining acceptance of the health-cluster approach and ensuring that the relevant guidance and tools are fully institutionalized and implemented in accordance with the policy of the Inter-Agency Standing Committee. WHO Representatives and staff in country offices and Health Cluster coordinators will receive training in health-cluster procedures and in using the relevant guidance and tools. Emphasis will also be placed on working with countries with a presence in the area of emergency preparedness and humanitarian action in order to generate health information and intelligence for publication in the *Health Cluster Bulletin*, and on analysing the recovery capacity of health systems in at least eight countries.

Within the scenario of the reduced Proposed programme budget and related financing, the focus for strategic objective 5 will be to maintain WHO's core functions in policy and norms development, in monitoring and evaluation, and in technical support to countries. However, the number and scope of activities in support of the expected results will be reduced. Increased attention will be given to strategic partnerships within and outside of WHO that help to further the fulfilment of WHO's priorities in this area, achieve effective implementation interventions by Member States and increase efficiencies.

Major WHO special programmes and collaborative arrangements contributing to the achievement of Organization-wide expected results, and included within the budgetary envelope

- Health and Nutrition Tracking Service

Total budget by major office for the strategic objective for 2012–2013 (US$ million)

Budget (US$ million)							
Base programmes							
Africa	**The Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**
14.5	5.9	7.7	4.0	7.6	3.0	21.9	**64.6**
Special programmes and collaborative arrangements							**1.3**
Outbreak and crisis response							**316.1**
Grand total							**382.0**

Organization-wide expected results and indicators

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 2012	
	65%	50
	Targets to be achieved by 2013	
	70%	55

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 2012	
	100%	35
	Targets to be achieved by 2013	
	100%	43

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 2012	
	In all countries with humanitarian coordinators	18
	Targets to be achieved by 2013	
	In all countries with humanitarian coordinators	20

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 diseases-surveillance for emergencies
	Baseline 2012
	100%
	Targets to be achieved by 2013
	100%

5.5 Support provided to Member States for strengthening national preparedness and for establishing alert and response mechanisms for food-safety and environmental health emergencies.	**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 2012	
	65%	In all Member States
	Targets to be achieved by 2013	
	65%	In all Member States

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	**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 2012	
	80%	75%
	Targets to be achieved by 2013	
	100%	75%

5.7 Acute, ongoing and recovery operations implemented in a timely and effective manner.	**Indicators**	
	5.7.1 Proportion of acute-onset emergencies for which WHO mobilizes coordinated national and international action	**5.7.2** Proportion of interventions for chronic emergencies implemented in accordance with humanitarian action plans' health components
	Baseline 2012	
	90%	80%
	Targets to be achieved by 2013	
	100%	85%

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

Scope

The work under this strategic objective focuses on integrated, comprehensive, multisectoral and multidisciplinary health promotion and disease prevention strategies, approaches, tools and processes across all relevant WHO programmes; and on the prevention or reduction of the occurrence of six major risk factors: use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diet, physical inactivity and unsafe sex.

The main activities involve the development of ethical and evidence-based policies, strategies, standards, guidelines and interventions for health promotion, disease prevention and reduction of the occurrence of the major risk factors. Special emphasis is given to surveillance of risk factors, and capacity building for health promotion across all relevant programmes.

Critical links with other strategic objectives

Achievement of this strategic objective requires strong links and effective collaboration with other strategic objectives, in particular:

Strategic objectives 2, 3, 4, 7, 8 and 9: although these seek to deal with the determinants of poor health and strengthen service provision, the aim of this strategic objective is to create healthy environments to allow individuals to make healthy choices. The deliverables of strategic objective 6 complement those of strategic objective 3, which focuses on surveillance, prevention and health care to control noncommunicable diseases, mental disorders, violence, injuries and visual impairment.

Key achievements to date

The action plan for the global strategy for the prevention and control of noncommunicable diseases for the period 2008–2013 provides the overarching framework for tackling the modifiable risk factors shared by the major noncommunicable diseases, namely: cardiovascular diseases, cancer, diabetes and chronic respiratory diseases.

By late 2009, 167 Member States had become Parties to the WHO Framework Convention on Tobacco Control. The global strategy to reduce the harmful use of alcohol was developed, in collaboration with Member States, and adopted by the Sixty-third World Health Assembly,[1] and regional information systems on alcohol and health have been introduced. Global surveys have been conducted on alcohol and health and on the assessment of countries' capacity to tackle the risk factors for noncommunicable diseases. Evidence-based policies and interventions have assisted countries in preventing or reducing public health problems caused by alcohol and drug use.

In all regions, strategies to promote healthy diets and physical activity have been adapted to suit national requirements on the basis of the WHO Global Strategy on Diet, Physical Activity and Health and 66 countries have adopted related multisectoral strategies. The number of countries using innovative and sustainable sources of financing for health promotion, such as earmarked taxation on tobacco and alcohol, has increased. However, there is a growing awareness of the "implementation gaps" that exist between the evidence for health promotion and its translation into action. By late 2009, key provisions of the WHO Framework Convention on Tobacco Control were increasingly being implemented. However, despite its widespread ratification, only 20 countries had approved comprehensive smoke-free legislation and 26 have a comprehensive ban on tobacco advertising, promotion and sponsorship. Over 25% of Member States (49 countries) had seen a relative reduction in the prevalence of tobacco use of at least 10%. As a result of intersectoral collaboration, tobacco tax assessment missions have completed their work in Egypt, Indonesia, Maldives, Pakistan and Ukraine.

[1] Resolution WHA63.13.

Standards have been developed for the surveillance of risk factors for noncommunicable diseases together with core indicators for monitoring trends at global and national levels. The core indicators are being integrated into the global health observatory. Both the WHO STEPwise approach to surveillance of noncommunicable disease risk factors and the Global School-based Student Health Survey are being more widely used. Currently, 123 countries have received training in the STEPS approach; 80 countries have completed their data collection, including 19 that have conducted more than one survey. A total of 103 countries have received training in conducting the Global School-based Student Health Survey; 54 countries have completed their data collection, including eight that have carried out repeat surveys.

Evidence generated on the determinants and consequences of unsafe sex has been included in the WHO report entitled, *Women and health*,[1] and both interventions to reduce risks and tools for surveillance have been developed. A systematic review has been conducted, and an expert consultation held, on effective interventions to address violence against women and HIV/AIDS. The findings have been used as the basis for programme and policy guidance. WHO has also contributed towards UNESCO's guidance document on sexuality.[2]

Key challenges

Past advocacy efforts have been successful in raising the profile of noncommunicable diseases and their common risk factors; however, resources, particularly in low- and middle-income countries, are insufficient in relation to the magnitude of the problem and the action needed. Intersectoral action also needs strengthening, particularly in addressing tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol. Sectors, such as finance, transport, urban design, education, agriculture, and the food industry that either contribute to risk, or that could play a significant role in its reduction, have few incentives to work together in the interests of better health.

Developing new strategies and introducing a wider range of actors into risk reduction, while avoiding conflicts of interest, call for the careful design of measurement strategies and organizational incentives, including dialogue highlighting the co-benefits of action and/or regulations. The relevant strategies and incentives must also be made available in an appropriate range. Improving techniques for the measurement and surveillance of key risk factors and integrating them into national health information systems constitute a major challenge. Rules for involvement with the private sector need to be more precisely elaborated and intersectoral actions implemented through health-in-all policies and approaches.

Health promotion actions should be integrated into the mainstream of work on priority public health conditions. Resolution WHA60.24 on health promotion in a globalized world urges Member States, inter alia, to frame sound policies for health promotion as an essential component of equitable social and economic development. The challenge will be to scale up the integration of evidence-based cost-effective health promotion interventions into health systems.

Dealing with unsafe sex and risks related to sexuality remains a particularly sensitive topic; strong political will and close interagency collaboration are essential for success in this area.

Priorities and emphasis for 2012–2013

High priority will be given to advocacy and awareness-raising and to ensuring due follow-up of the outcomes of the high-level meeting on noncommunicable diseases, to be convened by the United Nations General Assembly in September 2011. This event will serve to raise awareness of the way in which risk factors for noncommunicable diseases – especially tobacco use, harmful use of alcohol, unhealthy diet, and physical inactivity – are hindering progress towards attainment of the Millennium Development Goals. Other elements in this area include exploring and responding to the unmet needs of vulnerable groups, mainstreaming health promotion and disease prevention activities, and reducing health and social inequities through the work being undertaken on social determinants of health and the revival of primary health care.

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

[2] *International technical guidance on sexuality education.* United Nations Educational, Scientific and Cultural Organization, Paris, 2009.

Emphasis will be placed on integrating health promotion into the mainstream of the various health programmes through the development and implementation of an affordable and evidence-based package of health promotion interventions. National strategies and plans will also be scaled up, primarily through the following: country-level actions, such as the global strategy to reduce the harmful use of alcohol; an Internet-based package of actions for preventing or reducing major health risk factors for use in the delivery of country support; operational models and good practices for incorporation in policies and programmes to improve diet; technical support, capacity building and the creation of intersectoral partnerships in low- and middle-income Parties to the WHO Framework Convention on Tobacco Control; and addressing risk factors, such as unsafe sex.

As a result of the reduced budget and the adjustments in the financing scenario, the focus for this strategic objective will be to maintain WHO's core functions in policy and norms development, in monitoring and evaluation, and in technical support to countries. In addition, the work on health promotion will be mainstreamed within the Organization during the biennium 2012–2013. The Secretariat is currently developing the managerial options to ensure that all relevant WHO programmes will be attentive to taking such cross-cutting issues into account in their work; that staff are empowered and trained to do so and that indicators are developed so that progress on the mainstreaming of health promotion can be evaluated and monitored. The work to build capacity at country level to implement the WHO Framework Convention on Tobacco Control may be affected if financing at country level is not forthcoming. Similarly, the Secretariat may not be able to implement the global strategy to reduce the harmful use of alcohol fully, and may not therefore meet the increased expectations of Member States in this area. Increased attention will be given to the strategic partnerships within and outside of WHO that further the fulfillment of WHO's priorities in this area, achieve effective implementation of interventions by Member States, and increase efficiencies.

Major WHO special programmes and collaborative arrangements contributing to the achievement of Organization-wide expected results, and included within the budgetary envelope

- WHO Centre for Health Development (Kobe)
- UNDP/UNFPA/WHO/World Bank Special Programme for Research, Development and Research Training in Human Reproduction

Total budget by major office for the strategic objective for 2012–2013 (US$ million)

Budget (US$ million)							
Base programmes							
Africa	**The Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**
20.3	9.1	13.0	14.5	10.6	12.8	30.8	**111.1**
Special programmes and collaborative arrangements							**11.1**
Outbreak and crisis response							**0.0**
Grand total							**122.3**

Organization-wide expected results and indicators

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 2012	
	~~40~~	22
	Targets to be achieved by 2013	
	~~50~~	40

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 2012	
	85	58
	Targets to be achieved by 2013	
	88	73

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 comprehensive bans on smoking in indoor public places and workplaces	**6.3.3** Number of Member States with bans on tobacco advertising, promotion and sponsorship
	Baseline 2012		
	82	29	20
	Targets to be achieved by 2013		
	92	33	21

6.4 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease or death associated with alcohol, drugs and other psychoactive substance use, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.	**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 2012	
	50	14
	Targets to be achieved by 2013	
	55	17

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 2012	
	65	20
	Targets to be achieved by 2013	
	68	24

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.	**Indicators**	
	6.6.1 Number of Member States generating evidence on the determinants and/or consequences of unsafe sex	**6.6.2** Number of Member States generating comparable data on unsafe sex indicators using WHO STEPS surveillance tools
	Baseline 2012	
	10	5
	Targets to be achieved by 2013	
	12	7

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

Scope

The work under this strategic objective focuses on leadership in intersectoral action on the broad social and economic determinants of health; the improvement of population health and health equity by better meeting the health needs of poor, vulnerable and excluded social groups; the connections between health, poverty and various social and economic factors (labour, housing and educational circumstances; trade and macroeconomic factors; and the social status of various groups such as women, children, elderly people, ethnic minorities and indigenous populations); the formulation of policies and programmes that are ethically sound, responsive to gender inequalities, sustainable, effective in meeting the needs of poor people and other vulnerable groups, and consistent with human-rights law.

Critical links with other strategic objectives

Achievement of this strategic objective requires strong links and effective collaboration with other strategic objectives, in particular:

- Strategic objectives 1 to 5: notwithstanding the technical complexities, it is firmly established that health outcomes are powerfully influenced by social and economic determinants, as well as by the availability, quality and ethics of clinical services
- Strategic objectives 6, 8 and 9: strategic objective 7 is primarily concerned with the underlying determinants and structural factors (such as labour markets, education system, and gender inequality) defining people's different positions in social hierarchies, which affect intermediate determinants such as the environment, including food (strategic objectives 8 and 9) and individual factors such as behaviours (strategic objective 6). An ethical approach is required in particular in dealing with individual behaviours and responsibilities, professional duties, and health and research priorities
- Strategic objectives 10 and 11: health policies and systems need to include intersectoral action on health determinants and ethical analysis. Coherent action on health inequities also depends on the availability of appropriately disaggregated health data and the capacity to analyse and use such data to develop policies and services that respond to the needs of different social groups and address structural factors.

Key achievements to date

It is recognized that health equity can best be achieved through policies and programmes that address the social determinants of health. A total of 18 country case studies on factors that encourage or hinder intersectoral action for health equity have been analysed, and tools and resources developed to facilitate country work. The Secretariat and Member States have also enhanced their capacity to conduct disaggregated analysis of health equity by sex and ethnicity.

It is now better understood by the Organization that applying a human-rights based approach to health in a manner consistent with international and regional human rights treaties benefits both social and economic development. Human rights, ethical and gender considerations are being integrated into numerous WHO public health programmes at all levels; key cross-cutting normative work is continuing; capacity at regional and country levels is increasing; and a policy dialogue on women's health has been initiated. Normative documents addressing the ethics of public health and the ethics of research have been disseminated; several hundred health professionals have been trained in all WHO regions; research ethics committees and national ethics committees have been strengthened to tackle emerging ethical issues at country level; and the Sixty-third World Health Assembly endorsed the WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation.[1]

[1] Resolution WHA63.22.

Furthermore, a close working relationship has now been established with the Office of the United Nations High Commissioner for Human Rights. Efforts to support the integration of a human rights-based approach to health have been undertaken jointly at country, regional and headquarters levels.

Key challenges

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

Meeting the expectations raised by several reports and guidance issued on human rights, gender and ethics will require the appropriate follow-up activities. Technical cooperation is needed, particularly at country level for which it continues to be difficult to attract sufficient resources to permit effective implementation. In order to improve efficiency in the future, innovative solutions should be explored, including examining ways to use existing resources more effectively, developing fundable country cooperation programmes and working with partners to achieve the objectives.

There is very strong support for ethical decision-making processes both within WHO and beyond. To ensure the transparency and fairness of these processes, an ethical framework is needed.

Priorities and emphasis for 2012–2013

As the need to tackle the social determinants of health is broadly recognized, work on this public health priority will now focus less on the "what" and more on the "how". Accordingly, sufficient tools and fundable programmes will be developed for the effective implementation of the recommendations of the Commission on Social Determinants of Health, both within and outside the Organization.

Implementation will focus on two key areas of activity. The first will involve the fostering of a whole-of-Government approach to health through intersectoral action, in which other sectors will be engaged to integrate health-related issues and policies into their sectoral programmes. At a global level it will be important to increase partnerships with stakeholders, United Nations agencies and donors to tackle and monitor inequities in health.

The second key area will concern the strengthening of Member States' capacities to integrate gender-, human rights- and ethics-based approaches into the mainstream of the health sector and beyond – including in the areas of trade and global health diplomacy – while taking into consideration, and dealing with, issues relating to the social determinants of health. It is also important to increase responsibility and action on the part of the health sector in tackling violence against women, especially at the primary health care level.

Other priorities include the dissemination and implementation of human rights and ethical guidance for public health programmes, in particular those involving communicable diseases, organ transplantation, research and new technologies. The Secretariat plans to undertake assessments on ethical aspects of WHO's programmes. Global consultations will be held in order to identify priority ethical issues for the Organization to tackle. A review will be conducted to identify strengths and gaps in the implementation of the strategy for integrating gender analysis and actions into the work of WHO. Efforts to advance women's health based on the findings of the WHO's report on women and health[1] will focus on: (i) providing policy, advocacy and programming directions to guide the response of Member States, partners and the various stakeholders in the report; (ii) equity analysis and monitoring; and (iii) evaluation of the effectiveness of policies to deal with the social determinants of health issues in countries and share learning. The Secretariat's work to strengthen national capacity for disaggregated data has obtained a good response; further efforts will therefore concentrate more narrowly on the small number of countries requiring further support.

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

The work on health and human rights will focus on advancing health as a human right in international law and integrating a human rights-based approach into WHO policies and programmes and building the capacity of the Secretariat and Member States in this field.

Within the scenario of a reduced Proposed programme budget and financing, the focus will be to maintain WHO's core functions in policy and norms development, in monitoring and evaluation, and in technical support to countries. In addition, the work on Social Determinants of Health, Human Rights and Gender will be mainstreamed within the Organization during the biennium 2012–2013. The Secretariat is currently developing the managerial options to ensure that all relevant WHO programmes will pay serious attention to such cross-cutting issues in their work; that staff are empowered and trained to do so, and that indicators are developed so that progress on the mainstreaming can be evaluated and monitored. Work on trade and health will be covered under the activities related to the Global Strategy on Public Health, Innovation and Intellectual Property. Increased attention will be given to the strategic partnerships within and outside of WHO that further the fulfilment of WHO's priorities in this area, achieve effective implementation of interventions by Member States and increase efficiencies.

Total budget by major office for the strategic objective for 2012–2013 (US$ million)

Budget (US$ million)							
Base programmes							
Africa	**The Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**
10.7	3.2	2.5	5.9	5.2	0.9	13.9	**42.3**
Special programmes and collaborative arrangements							**0.5**
Outbreak and crisis response							**0.0**
Grand total							**42.8**

Organization-wide expected results and indicators

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 2012
	6
	Targets to be achieved by 2013
	6

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 2012	
	14	~~9~~
	Targets to be achieved by 2013	
	38	~~10~~

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 2012
	40
	Targets to be achieved by 2013
	50

7.4 Ethics- and human 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 use of 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 2012	
	37	16
	Targets to be achieved by 2013	
	45	19

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 tools or documents developed or updated, or joint activities by WHO technical units undertaken, in order to promote gender-responsive actions in the work of WHO	**7.5.2** Number of gender mainstreaming activities conducted in Member States and supported by WHO
	Baseline 2012	
	85	170
	Targets to be achieved by 2013	
	90	190

STRATEGIC OBJECTIVE 8

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

Scope

This strategic objective is to reduce a broad range of traditional, modern and emerging hazards to health and the environment. The work will encourage strong health-sector leadership for primary prevention of disease through environmental management and impart strategic direction and give guidance to partners in non-health sectors on ensuring that their policies and investments also benefit health.

Work will focus on the assessment and management of environmental and occupational health hazards such as unsafe water and inadequate sanitation, indoor air pollution and solid fuel use, and vector transmission of diseases. Its scope also covers: health risks related to change in the global environment (e.g. climate change and biodiversity loss); development of new products and technologies (e.g. nanotechnology); consumption and production of energy from new sources and the increasing number and use of chemicals; and health risks related to changes in lifestyle, urbanization, and working conditions (e.g. deregulation of labour, an expanding informal sector and export of hazardous working practices to poor countries).

Critical links with other strategic objectives

Achievement of this strategic objective requires strong links and effective collaboration with other strategic objectives, in particular:

- Strategic objective 1: strengthening health systems capacities to adapt to the health impacts of climate change, through enhanced early warning and strengthened communicable disease response capacities, will contribute to reducing vulnerability to public health security threats and will help reduce the potential health, social and economic impacts of climate change on communicable diseases
- Strategic objectives 2 to 4: given that eliminating environmental hazards to health can prevent up to a quarter of the global burden of disease, work will contribute especially to the reduction in disease burden among children (strategic objective 4), from vector-borne diseases (strategic objective 2) and from noncommunicable diseases (strategic objective 3)
- Strategic objective 5: preparedness and response to environmental health emergencies, crucial to achieving strategic objective 8, are linked with other aspects of emergency response
- Strategic objective 10: occupational and environmental health services are a key part of the preventive function of health services
- Strategic objectives 5, 6, 7, 9 and 12: influencing sectors of the economy to reduce risks and promote health through their investments and policy decisions is essential in terms of work on determinants of health (strategic objectives 5, 6, 7 and 9) and for establishing partnerships to advance the global health agenda (strategic objective 12).

Key achievements to date

The biennium 2010–2011 saw a multipronged effort to tackle the 25% of the total burden of disease that is attributable to environmental risk factors. The work involved major policy initiatives, capacity-building activities in regions and countries, the publication of new normative standards, guidance and toolkits, and the performance of advocacy. Key highlights include: the organization of the First Inter-Ministerial Conference on Health and Environment in Africa, convened jointly by UNEP and WHO, and the resulting Libreville Declaration; the launching of renewed interagency collaboration to reduce reliance on DDT for vector control; the initiation of a "mercury-free health care" global initiative; the approval during the Second Session of the International Conference on Chemicals Management (Geneva, 11–15 May 2009) of a resolution on the health aspects of the sound management of chemicals; the strengthening of interagency collaboration on the elimination of asbestos-related diseases in the context of implementation of resolution WHA60.26; and the endorsement by the Executive Board at its 124th session of a workplan developed in the context of resolution WHA61.19 on climate

change and health.[1] The theme of World Health Day 2008, "Protecting health from climate change", was the subject of advocacy activities across the regions, as well as of WHO's contributions to the Fifteenth Conference of the Parties to the United Nations Framework Convention on Climate Change.

Key challenges

The key challenges are: (i) to provide support to Member States in addressing the environmental determinants of health and ill-health (primary prevention) through cross-sectoral actions in different settings of daily life (e.g. communities, public transport, schools and workplaces), including strengthening the evidence base for cross-sectoral policy development by elaborating integrated health and environment systems for assessing risk and impact; and (ii) to support Member States and regional working groups in implementing commitments made by health and environment ministers (in the Declarations of Libreville, Parma, Jeju and elsewhere) and global environmental agreements where protection and/or promotion of public health is stated as a primary objective.

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

Priorities and emphasis for 2012–2013

Building on the increased awareness of health and environmental issues and of the relevant normative standards, guidance and toolkits that have been developed, the priority for this biennium will be to strengthen the capacity of national health sectors to respond to climate change and improve public health through adaptation and mitigation policies (health "co-benefits") in sectors such as agriculture, energy, environment, transport and water and to provide support to countries to strengthen environmental health governance mechanisms. It will also be important to increase normative capacities; to foster the development of (i) national water policies and institutional frameworks to protect drinking-water quality and (ii) developing-country occupational health services; to develop capacities to support international environmental agreements to which WHO is party and capacities for environmental health risk assessment and communication; and to support the development or consolidation of national and regional health and environment strategic alliances.

Work will continue on responding to ongoing public health concerns related to chemicals (especially asbestos, lead and mercury), indoor and outdoor air pollution, water safety and availability, electronic waste, and non-ionizing radiation. This will involve more effective and systematic intersectoral collaboration at country level, particularly between the health and environmental sectors.

In parallel with efforts to support country implementation, work will continue on developing links between the areas of health and sustainable development and "green growth" economy. This will include the further qualification and quantification of the health benefits associated with environmental policies, involving the systematic collection, collation and analysis of interlinked health and environment information in order to support the development of evidence-based public health and environment policy options and monitor the effectiveness of their implementation against measured baselines. Among other things, this will assist the implementation of the Libreville and Parma Declarations. More emphasis will also be given to the assessment of risks from hazards in combination, as opposed to the assessment of individual risks. Greater importance will be given to activities such as decreasing reliance on solid fuel use for heating and cooking, strengthening the evidence base for the effectiveness of primary health and environment interventions in urban settings, and coordinating support for occupational health.

Finally, there is a need to reinvigorate United Nations and regional partnerships on environment and health, using improvement of human health as leverage to gain intersectoral commitment and to further position health benefits as a key component of efforts to mitigate the effects of climate change.

Within the scenario of a reduced Proposed programme budget and financing, the focus will be to maintain WHO's core functions in policy and norms development, in monitoring and evaluation, and in technical support

[1] Resolution EB124.R5.

to countries. However, a number of programmatic activities are likely to be affected including some pertaining to water resources and health (health impact assessment and environmental management). Support to the work on emergencies and humanitarian crises as it relates to water and sanitation may be phased out unless additional financing is forthcoming. Similarly the work of the Cholera Task Force would not be able to be carried out, and without substantial additional financial and human resources, the work on chemicals emergency response and preparedness activities (including those in support of the implementation of the International Health Regulations (2005) would also need to be phased out . Implementation of some of the 18 climate change and health activities listed in the workplan endorsed by the Executive Board in 2009[1] (e.g. 3.6 indicator development, 3.7 economic assessment, 4.5 early warning system evaluation, 4.6 emergency management evaluation) may be jeopardized. Increased attention will be given to the strategic partnerships within and outside of WHO that further the fulfillment of WHO's priorities in this area, achieve effective implementation of interventions by Member States and increase efficiencies.

[1] Resolution EB124.R5.

Total budget by major office for the strategic objective for 2012–2013 (US$ million)

Budget (US$ million)							
Base programmes							
Africa	**The Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**
12.7	8.7	9.4	15.5	6.3	7.5	26.8	**86.8**
Special programmes and collaborative arrangements							**0.0**
Outbreak and crisis response							**0.0**
Grand total							**86.8**

Organization-wide expected results and indicators

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~~ with proven capacity to conduct assessments of specific environmental threats to health, in order to quantify, with WHO technical support, the environmental burden of disease, so as to add sustainability to MDG 4, 5 and 6 achievements.	**8.1.2** Number of new or updated WHO norms, standards or guidelines on occupational or environmental health issues published during the biennium
	Baseline 2012	
	44	20
	Targets to be achieved by 2013	
	58	24

8.2 Technical support and guidance provided to Member States for the implementation of primary prevention interventions that reduce environmental hazards to health, enhance safety and promote public health, including in specific settings (e.g. workplaces, homes or urban settings) and among vulnerable population groups (e.g. children).	**Indicators**
	8.2.1 Number of Member States implementing ~~primary prevention interventions in order to reduce environmental risks to health~~, with WHO technical support, primary prevention interventions to reduce pneumonia in children, diarrhoeal and noncommunicable diseases in at least one of the following settings: homes, workplaces, or urban settings
	Baseline 2012
	52
	Targets to be achieved by 2013
	66

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, with secretariat support, national action plans or policies for the management of occupational health risks, such as in relation to WHO's global plan of action on workers' health 2008–2017.
	Baseline 2012
	72
	Targets to be achieved by 2013
	87

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 are~~ implementing WHO-supported initiatives to ~~identify and respond to the health impacts of activities in one or more of the following sectors:~~ reduce noncommunicable and communicable diseases through healthy agriculture, energy, and transportation policies.
	Baseline 2012
	72
	Targets to be achieved by 2013
	86

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, including 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 2012		
	17	10	10
	Targets to be achieved by 2013		
	21	12	8

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 adverse effects on health of climate change
	Baseline 2012	
	30	30
	Targets to be achieved by 2013	
	35	50

STRATEGIC OBJECTIVE 9

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

Scope

Work under this strategic objective focuses on nutritional quality and safety of foods; promotion of healthy dietary practices throughout the life-course, starting with pregnant women, breastfeeding and adequate complementary feeding, and considering diet-related chronic diseases; prevention and control of nutritional disorders, including micronutrient deficiencies, especially among biologically and socially vulnerable groups, with emphasis on emergencies, and in the context of HIV/AIDS epidemics; prevention and control of zoonotic and non-zoonotic foodborne diseases; stimulation of intersectoral actions promoting the production and consumption of, and access to, food of adequate quality and safety; and promotion of higher levels of investment in nutrition, food safety and food security at global, regional and national levels.

Critical links with other strategic objectives

Achievement of this strategic objective requires strong links and effective collaboration with many other strategic objectives, in particular:

- Strategic objective 1: in relation to prevention of zoonoses and foodborne diseases, and the interrelationship between vaccines and nutritional status
- Strategic objective 2: in relation to expanding and improving interventions related to prevention, treatment, care and support in respect of HIV/AIDS and tuberculosis
- Strategic objective 3: in relation to the surveillance and prevention of diet-related noncommunicable diseases and the prevention of birth defects and genetic and congenital disorders
- Strategic objective 4: in relation to public-health interventions for maternal, newborn, child and adolescent health
- Strategic objective 5: in relation to emergency preparedness, minimizing the impact of emergency situations on the nutritional status of populations and recovery from crises
- Strategic objective 6: in relation to promotion of healthy diet throughout the life-course
- Strategic objective 7: in relation to addressing social determinants of differences in access to food and care and in nutritional status
- Strategic objective 8: in relation to environmental health risks
- Strategic objective 10: in relation to the integration of nutrition surveillance into health information systems, assessing costs and cost–effectiveness of nutrition interventions and the provision of nutritional care through health services
- Strategic objective 12: in relation to strengthening governance, partnerships and collaboration with United Nations agencies, the World Bank and other stakeholders.

Key achievements to date

The commitment of Member States was demonstrated by the adoption of a resolution on advancing food safety initiatives at the Sixty-third World Health Assembly.[1]

Greater attention is being paid to this critical area and WHO has therefore promoted increased coherence and effectiveness in the support being provided to Member States, in collaboration with United Nations partners, the World Bank and nongovernmental organizations. Continued collaborative efforts with international partners, including FAO and OIE, have allowed information on food events to be shared through the International Food Safety Authorities Network (INFOSAN) and regional networks.

In addition, WHO has strengthened its system to provide scientific advice on nutrition and updated guidelines on the following: micronutrient fortification and supplementation; malnutrition; and sugar and fat intake. Within the framework of the FAO/WHO Codex Alimentarius Commission, new standards were developed, including those

[1] Resolution WHA63.3.

for the assessment of genetically modified food and the prevention of antimicrobial resistance. The training programme on Five Keys to Safer Food is being initiated in more than 70 countries, involving all WHO regions.

Growth standards have been adopted in 109 countries, with adoption being considered in 69 additional countries. The WHO Global Database on Child Growth and Malnutrition contains nearly 3000 surveys from 145 countries, with results presented in a standardized format that allows international comparisons. The Nutrition Landscape Information System has been established, allowing country-level nutrition profiles to be developed; 36 countries with the highest burden of chronic malnutrition have completed the analysis of country commitment and readiness to act in nutrition; and 115 countries have conducted a review of food and nutrition policies.

A key initiative to estimate the global burden of foodborne diseases was launched and in addition, 173 Member States joined the WHO Global Foodborne Infections Network.

Key challenges

The achievement of Millennium Development Goals 1, 4 and 5 in high-burden countries will require nutrition interventions to be scaled up, and this is intimately linked to the need to strengthen national capacities and increase financial resources for implementation in these countries.

Further work is needed to integrate effective surveillance activities within national health information systems; additional resources also need to be mobilized to enable WHO to further strengthen its normative functions and its provision of scientific and technical advice to Member States.

Priorities and emphasis for 2012–2013

The principal activities for the biennium include the following: scaling up nutrition interventions both those for children during the first two years of age and those for mothers; complementing the continuing revision of the Essential Nutrition Actions Package with the inclusion of maternal nutrition interventions within the integrated management of pregnancy and childbirth; strengthening the existing international WHO networks – such as the WHO Global Foodborne Infections Network, the Global Environment Monitoring System/Food Contamination Monitoring and Assessment Programme (GEMS/Food) and INFOSAN – to build national capacity for laboratory testing, integrated surveillance, and global data-sharing; and enhancing the application of risk-benefit assessment methodologies to inform the development of guidelines that include both food safety and nutrition considerations.

A stronger emphasis will also be placed on the following: the development and updating of policies that address the double burden of malnutrition; the evidence-based review of essential nutrition interventions; nutrition surveillance, including nutritional status and dietary patterns; and the provision of guidance on effective nutrition interventions and the monitoring of their impact.

Additional activities will involve responding to needs outlined in country cooperation strategies to support countries to strengthen relevant national activities; undertaking country studies to estimate the foodborne disease burden; strengthening the links between INFOSAN and the International Health Regulations (2005) in support of the investigation of and response to food safety-related disease outbreaks. Concerted efforts in advocacy and resource mobilization are also envisaged.

In view of the reduction in budget and the adjusted financing scenario, the focus for 2012–2013 will be to maintain WHO's core functions in policy and norms development, in monitoring and evaluation, and in technical support to countries. However, some activities will be affected, including the development of a comprehensive implementation plan on infant and young child nutrition and its contribution to the implementation of the United Nations Secretary-General's Global Strategy for Women's and Children's Health. Work related to the development of food safety standards, and the support to monitoring, surveillance and management of foodborne and zoonotic diseases, as well as the development of guidance on public health aspects of zoonotic diseases originating at the human–animal interface would have to be reduced.

Major WHO special programmes and collaborative arrangements contributing to the achievement of Organization-wide expected results, and included within the budgetary envelope

- Codex Alimentarius Commission

Total budget by major office for the strategic objective for 2012–2013 (US$ million)

Budget (US$ million)							
Base programmes							
Africa	**The Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**
10.6	4.5	4.1	6.0	2.6	5.4	17.8	**51.1**
Special programmes and collaborative arrangements							**3.8**
Outbreak and crisis response							**0.0**
Grand total							**54.9**

Organization-wide expected results and indicators

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 2012	
	125	35
	Targets to be achieved by 2013	
	100	35

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 2012	
	0	0
	Targets to be achieved by 2013	
	5	30

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 2012	
	85	152
	Targets to be achieved by 2013	
	90	130

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 provided with support to optimize nutrition in emergencies (covering the preparedness planning, emergency response and recovery phases)
	Baseline 2012				
	97	77	80	59	47
	Targets to be achieved by 2013				
	105	80	80	65	50

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 2012	
	75	80
	Targets to be achieved by 2013	
	80	80

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 2012	
	85	70
	Targets to be achieved by 2013	
	70	80

STRATEGIC OBJECTIVE 10

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

Scope

The work under this objective aims to improve health service delivery in support of better health outcomes. It is guided by the principles of primary health care, and involves the scaling up of service coverage as well as the improvement of equity in access and outcomes. It focuses on five of the six supply-side components, or building blocks, of health system: leadership and governance, health financing, the health workforce, health information systems, and the organization and management of service delivery.[1] Work on these building blocks is complemented by efforts to increase the community's participation in health system development. Each area is underpinned by research, documentation and comparative analysis.

In addition to specific technical work on health systems, activities under this objective will include the coordination of efforts across WHO to provide support to Member States in developing and implementing national policies, strategies and plans. A robust national health policy and strategy will ensure complementarity between all the elements needed to improve health outcomes. In countries that receive significant levels of external aid, national strategies provide the best means of ensuring alignment between external inputs and national priorities.

Critical links with other strategic objectives

Achievement of this strategic objective requires strong links and effective collaboration with other strategic objectives, in particular:

- All strategic objectives concerned with the achievement of specific health outcomes, primarily strategic objectives 1 to 4
- All health- and disease-related strategic objectives: the work provides a platform for close collaboration with the evidence component
- Strategic objective 5: complementing the specific circumstances of service delivery in fragile states
- Strategic objective 7: particularly in relation to health equity, pro-poor health policies and the progressive realization of the right to health – the work translates achievements in those areas into service delivery
- Strategic objective 12: particularly work on providing leadership, strengthening governance, knowledge generation, access to knowledge and encouraging partnerships and collaboration in engagement with countries.

Key achievements to date

In partnership with others, WHO has developed a normative and conceptual framework – based on the idea of the six building blocks – which is widely used to guide work on health system strengthening. In the area of financing, *The world health report 2010* sets out a guide to decision-making for countries aiming to extend financing for universal coverage. *The world health report 2012* will focus on research for better health. In the area of information systems, WHO has developed a common monitoring framework for use at country level, which has been agreed by all partners in the Health 8 group. The Sixty-third World Health Assembly adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel.[2] Rapid progress has been made on establishing and strengthening systems to enhance patient safety by raising awareness, building evidence and developing tools for improvement. In line with the expanded scope of this objective, WHO has also developed a framework for national health policies, strategies and plans for review by Member States in the biennium 2010–2011.

[1] Medical products, vaccines and technologies – the remaining building block – falls under strategic objective 11.

[2] Resolution WHA63.16.

Sustained advocacy on the part of WHO and its partners has meant that the vital role played by health system in delivering better outcomes is now widely acknowledged. Health system strengthening features strongly in the Ministerial Declaration at the high-level segment of the United Nations Economic and Social Council, held in Geneva, 6–9 July 2009, and at the G8 summits in 2008 and 2009. A strong health system is now seen as essential for improving maternal health and accelerating progress on Millennium Development Goal 5 (Improve maternal health). The growing political prominence accorded to health systems and the recognition of the damaging impact of continuing underinvestment, have resulted in increased levels of funding for health system strengthening. Both the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria have increased their financial support for systems strengthening, as has the World Bank.

Several regions have established health system observatories, modelled in part on the European Observatory on Health Systems and Policies. This network will continue to provide a steady stream of comparative analysis to be used in national policy dialogue. Work has begun on a country health intelligence platform to provide Member States with regularly updated situation analyses of their health systems. Following WHO's inputs to the third High-Level Forum on Aid Effectiveness (Accra, 2–4 September 2008) the OECD/Development Assistance Committee-hosted Working Party on Aid Effectiveness has established the Task Team on Health as a Tracer Sector to examine and promote strategies for increasing the effectiveness of external technical and financial support in the health sector.

The International Health Partnership Plus (IHP+), coordinated by WHO and the World Bank – which has 47 partners, including 22 developing countries – provides a working model for scaling up the development of national policies, strategies and plans. The Joint Assessment of National Strategies, a process that is being developed with a wide range of partners, is also available to be used as an instrument for assessing conformity to standards of good practice.

Key challenges

The principal challenge for the Organization is to ensure an effective response to the growing demand from countries for high-quality technical support. In the biennium 2010–2011, more than 30 countries received support to identify the number of people at risk of financial catastrophe linked to out-of-pocket payments and estimate the financial implications and costs of health insurance. Following the publication of *The world health report 2010* the demand for such support will increase. Similarly, demands for support will be further increased by the following: countries' proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance; countries wanting to strengthen their information systems and develop plans to train and retain health personnel; and health ministries and hospitals wishing to increase patient safety. In addition, if the framework for national health policies, strategies and plans is adopted by the Sixty-fourth World Health Assembly in 2011 further demands will be placed on the Organization by countries wanting to use the framework.

WHO can draw on a growing body of knowledge and experience in health system strengthening when providing advice to countries. At the same time, strategic decisions in sensitive areas such as health financing and human resources need to take full account of the political context in which they are to be implemented. The challenge for WHO is to ensure consistency in approach, given the Organization's role as the key supporter of health ministries, and the potential for conflicting advice coming from other partners. Furthermore, WHO has a finite capacity and needs to concentrate on areas where the Organization has a clear comparative advantage.

Priorities and emphasis for 2012–2013

In the light of the above analysis it is intended to change the emphasis on action in certain areas. The principal change for the biennium will be to concentrate on ensuring that countries can access the technical support they require for all of the health system building blocks, including follow-up to *The world health report 2010*. This may come through harnessing resources from all levels of the Organization, and increasing efforts to build the requisite capacity in country offices. At the same time, however, the Secretariat will work to establish technical support networks that will both increase access to high-quality support as well as help to build institutional capacity in countries.

Greater emphasis will also be placed on improving links between work on health system strengthening and other strategic objectives. This will be most evident in the revitalized work on national policies, strategies and plans,

where strengthening health systems and increasing aid effectiveness are only part of the picture. Equally, as health system strengthening is a means of achieving health outcomes, rather than an end in itself, there will be more emphasis on consistent work with programmes delivering technical interventions.

Additional attention will also be focused on WHO's role as a partner. The Organization's work to meet the health system strengthening objectives in this budget will be enhanced if it performs as a reliable and consistent member of the United Nations country team, and if it benefits from support to implement the requirements of the Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (notably in strengthening country systems for financial management, financial information and procurements so that partners can use them with confidence).

The rapid development of information systems and statistical capacity in countries will be a particular priority for WHO. The objective is to support the strengthening of standard-based country health-information platforms that provide and use high-quality and timely information for country health planning and for monitoring progress towards national and major international goals. In the area of human resources, the main priority is to elaborate global guidelines for educating health professionals, particularly doctors and nurses, so that they are fully responsive to their local situations. In addition, guidance will be developed to enable countries to strengthen their information strategy for human resources for health. In relation to service delivery the key concern will remain reorganization, in line with the four policy areas: dealing with health inequalities by moving towards universal coverage; putting people at the centre of service delivery; integrating health into public policies across sectors; and providing inclusive leadership for health governance.

Work on health system strengthening will continue to be backed by a strong research, monitoring and normative base. This will include work on classification and terminology and the eleventh revision of the International Classification of Diseases. The monitoring of the global health situation and trends will continue, including the following activities: burden of disease and risk factor analyses, estimates for key health indicators, evaluation of scaling up, and addressing information gaps such as maternal mortality.

Although the main shift in emphasis will be from the global to the country level – putting evidence into action – there remains a need to improve quality in the area of health system strengthening. Support to national systems and capacity for better knowledge and evidence for health decision-making will be aimed at improving access to – and consolidation and publication of – existing evidence, facilitating knowledge generation in priority areas, and enhancing global leadership in health research policy and coordination, including with regard to ethical conduct.

The budget contains no completely new areas of work. Nevertheless, the impact of a wide range of new developments on the cost and effectiveness of health systems needs to be assessed. Some new technologies, if left uncontrolled, could rapidly provoke an escalation of costs and an increase in inequity. Others could have the opposite effect, dramatically cutting costs and increasing efficiency. One key area to be explored is eHealth. Of 115 countries surveyed in 2009 by the WHO Global Observatory for eHealth, 53 had policies in place. The impact of these policies will require urgent exploration.

Within the scenario of a reduced budget and adjusted financing, the focus for strategic objective 10 will be to maintain WHO's core functions in policy and norms development, in monitoring and evaluation, and in technical support to countries. However, a number of programmatic activities are likely to be affected including the monitoring of health situation and trends, as part of global (and regional) health observatory work, the work on standards such as classifications and data collection tools, and technical assistance to countries for the strengthening of health information systems. Ongoing restructuring in 2010–2011 will result in integration of the functions of one department into other departments, thus leading to further efficiency savings in 2012–2013. Work will continue to promote global guidelines on developing national plans and strategies, the WHO Code of Practice on International Recruitment of Health Personnel and *The world health report 2010*. However, depending on resources available, technical assistance to countries in these areas may be reduced accordingly. Increased attention will be given to the strategic partnerships within and outside of WHO that further the fulfilment of WHO's priorities in this area, achieve effective implementation of interventions by Member States, and increase efficiencies.

Major WHO special programmes and collaborative arrangements contributing to the achievement of Organization-wide expected results, and included within the budgetary envelope

- World Alliance for Patient Safety
- European Observatory on Health Systems and Policies
- UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training

Total budget by major office for the strategic objective for 2012–2013 (US$ million)

Budget (US$ million)							
Base programmes							
Africa	**The Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**
71.8	29.7	36.4	25.5	38.8	35.9	84.2	**322.3**
Special programmes and collaborative arrangements							**25.8**
Outbreak and crisis response							**0.0**
Grand total							**348.1**

Organization-wide expected results and indicators

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.	**Indicators**
	10.1.1 Number of Member States that have regularly updated databases on numbers and distribution of health facilities and health interventions offered
	Baseline 2012
	35
	Targets to be achieved by 2013
	40

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.	**Indicators**	
	10.2.1 Number of Member States that have in the last five years developed comprehensive national health planning processes in consultation with stakeholders	**10.2.2** Number of Member States that conduct a regular or periodic evaluation of progress, including implementation of their national health plan, based on a commonly agreed performance assessment of their health system
	Baseline 2012	
	107	65
	Targets to be achieved by 2013	
	115	75

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 2012
	30
	Targets to be achieved by 2013
	35

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 2012		
	45%		
	Targets to be achieved by 2013		
	60%		

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 2012		
	90%	35	Mechanisms operating at global and all regional levels
	Targets to be achieved by 2013		
	90%	45	Mechanisms operating at global and all regional levels

10.6 National health research for development of health system strengthened in the context of regional and international research and engagement of civil society.	**Indicators**	
	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 2012	
	15%	
	Targets to be achieved by 2013	
	20%	

10.7 Knowledge management and eHealth policies and strategies developed and implemented in order to strengthen health systems.	**Indicators**		
	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 2012		
	100	170	75
	Targets to be achieved by 2013		
	110	180	90

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 a national policy and planning unit for human resources for health
	Baseline 2012	
	96	50
	Targets to be achieved by 2013	
	100	55

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 plan for human resources in health	**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 2012	
	30%	25%
	Targets to be achieved by 2013	
	30%	25%

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 develop health financing systems to attain or maintain universal coverage	**10.10.2** Number of key policy briefs prepared, disseminated and their use supported, which document best practices on revenue-raising, pooling and purchasing, including contracting, provision of interventions and services, and handling of fragmentation in systems associated with vertical programmes and inflow of international funds
	Baseline 2012	
	45	17 technical briefs
	Targets to be achieved by 2013	
	20 during the biennium	15 technical briefs

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 health financing policy development and implementation for universal coverage developed, disseminated and their use supported.	**10.11.2** Number of Member States provided with technical support for using WHO tools relating to health financing for universal coverage.
	Baseline 2012	
	Tools and frameworks modified, updated and disseminated as necessary	50
	Targets to be achieved by 2013	
	Tools and frameworks modified, updated and disseminated as necessary	20 during the biennium

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.	**Indicators**	
	10.12.1 WHO presence and leadership in international, regional and national partnerships	**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
	Baseline 2012	
	WHO participation in 4 partnerships	Annual updates of health expenditures for Member States, together with capacity building exercises in 60 countries
	Targets to be achieved by 2013	
	WHO participation in 4 partnerships	Annual updates of health expenditures for all Member States and capacity building in financial policy and analysis in 20 countries

10.13 Evidence-based norms, standards and measurement tools developed to support Member States to quantify and decrease the level of unsafe health care provided.	**Indicators**	
	10.13.1 Key tools, norms and standards to guide policy development, measurement and implementation disseminated and their use supported	**10.13.2** Number of Member States participating in global patient safety challenges and other global safety initiatives, including research and measurement
	Baseline 2012	
	2 global safety standards and 20 major supporting tools	45
	Targets to be achieved by 2013	
	4 global safety standards and 40 major supporting tools	90

STRATEGIC OBJECTIVE 11

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

Scope

Medical products include chemical and biological medicines; vaccines; blood and blood products; cells and tissues mostly of human origin; biotechnology products; traditional medicines and medical devices. Technologies include, among others, those for diagnostic testing, imaging and laboratory testing. The work undertaken under this strategic objective will focus on making access more equitable (as measured by availability, price and affordability) to essential medical products and technologies of assured quality, safety, efficacy and cost–effectiveness, and on their sound and cost-effective use. For the sound use of products and technologies, work will focus on: building appropriate regulatory systems; evidence-based selection; information for prescribers and patients; appropriate diagnostic, clinical and surgical procedures; vaccination policies; supply systems, dispensing and injection safety; and blood transfusion. Information includes clinical guidelines, independent product information and ethical promotion. The work outlined above will contribute to the implementation of WHO-led specific actions as set out in the global strategy and plan of action on public health, innovation and intellectual property. In addition, in collaboration with other relevant international intergovernmental organizations, including WIPO, WTO and UNCTAD, specific actions will be undertaken in relation to the application and management of intellectual property in support of health-related innovation, and the promotion of public health.

Critical links with other strategic objectives

Achievement of this strategic objective requires strong links and effective collaboration with other strategic objectives, in particular:

- Strategic objectives 1 and 2: in connection with the global strategy and plan of action on public health, innovation and intellectual property.
- Strategic objectives 1 to 5 (health outcomes): none of these objectives can be achieved without essential medical products, medicines and health technologies. With regard to access, work under this strategic objective will focus on “horizontal” issues such as comprehensive supply systems, pricing surveys and national pricing policies. All WHO’s work on quality assurance and regulatory support is covered by this strategic objective. Work on rational use will focus on general aspects such as evidence-based selection of essential medical products and technologies, development of clinical guidelines, pharmacovigilance and patient safety, compliance with long-term treatment regimens and containing antimicrobial resistance
- Strategic objective 7: in relation to good governance
- Strategic objective 10: work also contributes to health service delivery; sustainable financing of products and technologies, on which access also depends. An integrated approach to health systems in support of primary health care will be promoted
- Strategic objective 12: in connection with global public policy

Key achievements to date

WHO has developed, updated and promoted global nomenclature systems, and quality norms and standards for vaccines, medicines and medical technologies, and, through the WHO/UN Programme on Prequalification of Medicines, the Organization has prequalified a range of medicines, including paediatric formulations, as well as vaccines. The seventeenth edition of the WHO Model List of Essential Medicines and second edition of the WHO Model List for Children have been published. A draft list of essential medical devices for 100 clinical practice protocols and five types of health facility has been prepared. National programmes to promote access to, and the quality and rational use of, medicines have been supported, and training and advocacy meetings have been held in policy-related areas and were well attended. A total of 10 countries have developed national transplantation policies. The WHO African and Western Pacific regions have updated regional medicines policy guidelines and strategies, and several countries in those regions have developed national policies for traditional medicine. Technical support has been provided to priority countries for strengthening their blood transfusion services and improving injection safety. A total of 15 countries have developed safe blood policies.

Global indicators for monitoring access to essential medicines have been refined and used in two United Nations reports on progress towards achieving target 8E for Millennium Development Goal 8. A monitoring and implementation framework for the global strategy and plan of action on public health, innovation and intellectual property has been developed. By late 2009, 46 national medicine regulatory agencies and 114 vaccine regulatory agencies had been formally assessed and many laboratories in developing countries were participating in WHO's external quality assurance system. Several regional economic blocks in Africa are working towards regional regulatory harmonization. Most countries now use national lists of essential medicines as the basis for medicines procurement and use in the public sector. Regional training courses have been held, and several countries have received specific support in connection with clinical guidelines, medicines pricing and reimbursement for essential medicines.

Key challenges

Many developing countries still lack adequate regulatory systems for medicines, vaccines, blood products, diagnostics and other health technologies. Despite the potential of comprehensive supply strategies and the rational use of medical products to reduce medical and economic waste, progress in promoting them is being hampered by a lack of political will at country level and of resources in WHO.

Priorities and emphasis for 2012–2013

During the biennium, priority will be given to continuing and expanding the work on policy development and widening access to medical products and technologies. Emphasis will be placed on cross-cutting health system approaches, such as including medicines benefits in health insurance, human resources for medicines supply, providing comprehensive support to district hospitals, as well as programmes to promote transparency, good governance and prevention of corruption. In addition to essential medicines for priority diseases, greater attention will also be paid to providing access to specific categories of medical products, such as essential medicines for children, controlled medicines for pain, terminal palliative care and drug abuse, and antirabies and antisnake serums. Work will continue on developing innovative public health concepts, such as promoting patent pools and medicine pricing policies.

Priority will also be given to the continuing provision of support to countries for normative work to improve the quality of medical products and technologies. Emphasis will be placed on global regulatory harmonization and regional collaboration for promoting the efficacy, quality and safety of vaccines, medicines and technologies, as well as on combating substandard and falsified medicines. WHO will continue to carry out its normative functions in relation to the following: the International Nonproprietary Names nomenclature programme; quality specifications for medicines and biologicals; good manufacturing standards; *The international pharmacopoeia;* the WHO Model List of Essential Medicines, including prequalification of new vaccines and medicines for neglected diseases; and the United Nations prequalification programme. The third priority area covers the continuing development of innovative public health concepts, such as those outlined in the global strategy and plan of action on public health, innovation and intellectual property, as well as medicine pricing policies.

The focus for strategic objective 11, in the context of the reduced Programme budget, will be to maintain WHO's core functions in policy and norms development, in monitoring and evaluation, and in technical support to countries. In headquarters, unless additional resources are forthcoming, a number of programmatic activities will be affected including WHO's scientific work in support of the International Narcotics Control Board, the medicine safety and pharmacovigilance programme, WHO's anti-counterfeit medicine programme and WHO's work on the quality norms of blood and blood products. In countries, work on supply issues, regulatory support and promoting rational use of medicines will especially be affected. Under these circumstances, increased attention will be given to the strategic partnerships within and outside of WHO that further the fulfilment of WHO's priorities in this area and support their effective implementation by Member States.

Total budget by major office for the strategic objective for 2012–2013 (US$ million)

Budget (US$ million)							
Base programmes							
Africa	**The Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**
25.8	7.3	6.2	3.0	8.7	10.8	59.8	**121.6**
Special programmes and collaborative arrangements							**15.7**
Outbreak and crisis response							**0.0**
Grand total							**137.3**

Organization-wide expected results and indicators

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 2012			
	90	40	25	Report published
	Targets to be achieved by 2013			
	100	32	20	1 report published (2013)

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 2012			
	15 additional	8500	300	75
	Targets to be achieved by 2013			
	12 additional	8750	350	86

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.	**Indicators**	
	11.3.1 Number of national or regional programmes receiving support for promoting sound and cost-effective use of medical products or technologies	**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
	Baseline 2012	
	40	135
	Targets to be achieved by 2013	
	32	120

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

Scope

The purpose of strategic objective 12 is to facilitate the work being carried out by WHO to achieve the other strategic objectives. Responding to the priorities set out in the Eleventh General Programme of Work, it recognizes that the nature of international health and the environment in which it operates has changed significantly. Strategic objective 12 is concerned with the coordination of a process of reform that will ensure WHO is more fit for purpose in the future. The Objective encompasses three complementary areas: (a) ensuring the necessary organizational coherence to provide leadership in global health governance; (b) WHO's support for, presence in, and engagement with individual Member States, including support for government leadership, and coordination and effective management of health actors, partnerships and resources; and (c) the Organization's role in bringing the collective energy and experience of Member States and other actors to bear on health issues of global and regional importance.

This objective also seeks to harness WHO's country experience in order to influence global and regional debates, and thereby support national policy-makers, and contribute to the attainment of the health-related Millennium Development Goals and other internationally agreed health-related goals.

Links with other strategic objectives

The purpose of this strategic objective is to facilitate the achievement of the other 12 strategic objectives, to which it is intrinsically linked, by providing direction and guidance for the Organization's work. The link with strategic objective 10 is particularly strong because of the close relationship between supporting national leadership, coordination and management of the health sector, and work to develop, finance and evaluate national health policies and strategic plans. It is also closely related and complementary to strategic objective 13: while the latter is geared towards managerial and administrative issues within the Organization, strategic objective 12 focuses on leadership and governance, work in and with Member States, and collaboration with partners, including the United Nations system, at global, regional and country levels. The reform agenda will now require even closer alignment between strategic objectives 12 and 13 so that managerial aspects of the reform – particularly in the area of human resources policy and practice – match the evolving role of WHO.

Key achievements to date

Coherence and synergy in the work of the different parts of the Organization have improved as a result of the Director-General's leadership, facilitated by good working relations with Regional Directors and Assistant Directors-General. Progress has been made towards the closer alignment of WHO country cooperation strategies with national priorities, and their harmonization with those of the United Nations and other development partners. Country cooperation strategies underpin the development of WHO's biennial workplans, the alignment of the core capacity of country offices with countries' needs, and the strengthening of the health component of the United Nations Development Assistance Framework. At global, regional and country levels, WHO has reinforced its collaboration with the United Nations Development Group, the Group's Regional Directors' Teams and the United Nations Country Teams. WHO's leadership – in partnership with the United Nations agencies, the World Bank, global health partners and key bilateral organizations – has contributed to the establishment of more effective platforms for action, coordination and coherence at country level. At a global level WHO has been successful in shaping health priorities in major global forums, for example at the high-level plenary meeting of the sixty-fifth session of the United Nations General Assembly on the review of the Millennium Development Goals (New York, 20–22 September 2010), and at successive G8 Summits in relation to the health of women and children. Equally, WHO has been able to secure growing political support for new health priorities, as evidenced by the high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases (due to be held on 19 and 20 September 2011).

Key challenges

In recent years, the global health architecture has become increasingly complex, in part due to the growing diversity of health challenges the world faces, and in part due to the growing number of those who are concerned with global health. In parallel, there has been an evolution in what Member States and other partners expect from the Organization, and an increase in the range of demands being made. WHO therefore faces two closely-related challenges. The first requires the Organization to adjust and realign to a new and more stringent financial reality. The second requires embarkation on a programme of reform that will ensure WHO's future strength and relevance in a changing global environment. Success will require WHO to (a) capitalize more effectively on its leadership position in global health; (b) retain the flexibility to adapt to a changing environment and have the capacity to address new challenges; and (c) reduce the diversity of its current activities, and be more selective in setting priorities.

In a global environment still preoccupied by financial and economic instability there is a need to promote health not just as a vital component of the Millennium Development Goals, but as an equally important aspect of inclusive economic growth.

Priorities and emphasis for 2012–2013

Overall, there will be a sharper focus on WHO's core business and priorities, namely, delivering results in those areas where it has a clear competitive advantage while leaving other tasks to those best placed to perform them. At a global level WHO will work to reduce fragmentation and increase coherence between the many stakeholders in global health. This will be reflected at country level where the priority will be to assist Member States as they seek to achieve better alignment between national health policies, strategies and priorities and the work of multiple development partners. Better communication and increased access to information will improve the quality of WHO's work. In providing support to countries, WHO will ensure a closer match between the level and nature of the support provided and national needs, including in those countries where the Organization has no physical presence.

The budget for strategic objective 12 is based on 2008–2009 expenditures. Given that most of this expenditure was on staff salaries and that staff costs have risen sharply, it is inevitable that capacity will have to be reduced. Thus, while WHO will continue to explore ways to improve the effectiveness and inclusiveness of global health governance, the current budget does not allow for the rise in number of intergovernmental working groups and similar meetings that took place in 2010–2011. It will be necessary to streamline and rationalize the time and resources needed for the sessions of the WHO governing bodies, as well as organizing preparatory meetings, partnership boards, working groups, and international task forces. Collaboration with the United Nations and broader engagement in the reform process will be more strategic, focusing particularly at country level, and reducing engagement in working groups and task forces. Strategies for involvement with the commercial private sector will be improved, interaction with the nongovernmental sector expanded and an operational framework for partnerships developed. Increased emphasis will be placed on improving organizational performance through the continuous monitoring and evaluation of key indicators, the provision of strategic guidance to enhance institutional mechanisms for integrity and accountability, and the development of a sound financial framework.

Total budget by major office for the strategic objective for 2012–2013 (US$ million)

Budget (US$ million)							
Africa	**The Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**
46.0	10.9	13.0	27.5	25.0	15.4	119.8	**257.6**

Organization-wide expected results and indicators

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 Percentage 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 2012	
	95%	~~91% of stakeholders familiar/very familiar with WHO roles and priorities~~
	Targets to be achieved by 2013	
	80%	~~96% of stakeholders familiar/very familiar with WHO roles and priorities~~

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** Percentage of WHO country offices which have reviewed and adjusted their core capacity in accordance with their country cooperation strategy
	Baseline 2012	
	33 of the 145 country cooperation strategies updated/revised	70%
	Targets to be achieved by 2013	
	38 of the 145 country cooperation strategies updated/revised	80%

[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.

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** Percentage of health partnerships managed by WHO that comply with WHO partnership policy guidance	**12.3.3** Percentage 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 2012		
	30	100%	80%
	Targets to be achieved by 2013		
	40	100%	90%

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 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 2012	
	6.7 million	80 000
	Targets to be achieved by 2013	
	7 million	70 000

STRATEGIC OBJECTIVE 13

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

Scope

The scope of this strategic objective covers the functions that support the work of the Secretariat in country and regional offices and in headquarters. Those functions are organized within a comprehensive results-based management framework that includes the following processes: strategic and operational planning and budgeting; performance monitoring and evaluation; the management of financial resources through monitoring, mobilization and Organization-wide coordination in order to ensure an efficient flow of available resources across the Organization; and the management of human resources, including planning, recruitment, staff development and learning, health and safety, performance management, conditions of service and entitlements in a manner that reflect best practice in the United Nations common system. The work focuses on the following activities: delivering expected results; maintaining excellence in performance and increasing employee engagement; providing an enabling working environment, including the management of infrastructure and logistics, the security of staff and premises, and the provision of medical services and information technology; and ensuring appropriate accountability and governance mechanisms across all areas.

Critical links with other strategic objectives

Achievement of this strategic objective requires strong links and effective collaboration with other strategic objectives, in particular:

Strategic objective 13 should not be considered in isolation from the other strategic objectives as its scope reflects, and is responsive to, the needs of the Organization as a whole. In particular, it should be read in conjunction with strategic objective 12. Strategic objective 13 is geared towards managerial and administrative issues, whereas strategic objective 12 focuses on WHO leadership and governance and collaboration with Member States and partners at global, regional and country levels. Strategic objective 13 also covers broad institutional reform that will ensure that the above functions are continually strengthened and provide more efficient and cost-effective support to the Organization; it is therefore closely linked to broader reforms within the United Nations system at both country and global levels.

Key achievements to date

WHO's results-based management framework has been reinforced through the stricter use of performance indicators and closer alignment with the priorities defined in country cooperation strategies. The Global Management System has been introduced in five major offices, with introduction in the African Region fully implemented as from 4 January 2011. Preparations are progressing to allow full introduction of the International Public Sector Accounting Standards as part of the United Nations harmonization process as from January 2012. The Global Service Centre is now fully operational.

The first global human resources plan has been drawn up, and a revised selection process for heads of WHO country offices, using a global roster, has been introduced. The resolution adopted by the Executive Board at its 125th session,[1] in which the Board decided to establish an Independent Expert Oversight Advisory Committee will have a positive impact on risk management and control systems. A WHO working group on cost recovery has been established and has recommended, inter alia, the implementation of a new headcount-based cost recovery system to ensure the sustainable financing of strategic objectives 12 and 13. WHO is the first United Nations agency to have a global occupational health and safety policy. The remit of the strategic objective also covers meeting the purchasing requirements of other strategic objectives, and the sourcing and delivery of essential pharmaceuticals and other health-related products required by Member States.

[1] Resolution EB125.R1.

Key challenges

A continuing key challenge is to ensure that the Organization gains maximum benefit from the Global Management System. The Global Management System is the main platform for consistent, real-time and integrated information management. However, management and administrative support services must be strictly controlled and their quality assured through an adequate control framework in all locations in order to maintain confidence in WHO's processes for managing income, assets and expenditure. Given the need to strengthen controls while striving for efficiencies, the delivery of services across the Organization will be re-assessed in order to make fuller use of existing specialist administrative networks. The process will involve further improving the operational capacity of the Global Service Centre, as well as simplifying the Global Management System. In parallel, the network will be continuously assessed to identify where efficiencies can be achieved in the delivery of core services, which could lead to some functions being transferred to low-cost locations in order to meet cost-saving objectives. Such developments must be carried out in a way that does not compromise internal controls or the quality and provision of core services.

Priorities and emphasis for 2012–2013

The Global Management System is due to be upgraded in 2013. A detailed analysis will be carried out before any decision is taken on the appropriate information and communications technology strategy to be used, in order to ensure that the new system delivers maximum benefits and causes minimum disruption to users.

In the area of planning and resource mobilization, countries' priorities will be systematically integrated into overall planning, and budgeting processes and engagement with donors will be strengthened in order to ensure predictable and flexible funding and the closer alignment of resource management with programme implementation.

Emphasis will be placed on fully implementing the International Public Sector Accounting Standards, although this will depend on the status of fixed assets, inventory data and accounting preparation. Incremental changes have been made to back-charging and cost-recovery mechanisms. Attention now will turn to ensuring a consistent and coherent approach that also supports adequate cost control and optimal resource allocation between offices. The Organization's health insurance scheme, which is managed by the Department of Finance and provides health coverage for current and retired staff and their dependants, will be subject to a major review that will focus on governance and design so that the scheme will continue to be "fit for purpose".

Key objectives in the area of human resources management are to introduce a systematic mobility scheme, to enhance staff performance management, to provide wider access to staff health promotion opportunities, and to improve occupational safety. Compliance with Minimum Operating Safety Standards has long been an objective, but so far progress has been hampered by resource constraints. Provided that additional resources are forthcoming, greater emphasis will be placed on meeting minimum security requirements in all locations. Greater attention will also be paid to addressing risk management in a more systematic and effective way because of the potential of this cross-cutting issue to affect the achievement of the various goals included under strategic objective 13.

Within the scenario of a reduced Proposed programme budget and financing, the focus will be on cost reductions and efficiency savings. Efforts will be made to achieve a 15% real-term reduction in the cost of delivering services and results in the biennium 2012–2013. A number of administrative functions will be transferred to the Global Service Centre and other low-cost locations to reduce operating costs.

Total budget by major office for the strategic objective for 2012–2013 (US$ million)

Budget (US$ million)							
Africa	**The Americas**	**South-East Asia**	**Europe**	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**
76.2	17.2	30.7	26.5	35.0	19.8	171.3	**376.7**

Organization-wide expected results and indicators

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 Percentage 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** Percentage of Office Specific Expected Results ~~(OSERs)~~ for which progress status has been updated within the established time frames for periodic reporting
	Baseline 2012	
	95%	85%
	Targets to be achieved by 2013	
	100%	90%

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** Amount of voluntary contributions that are classified as fully and highly flexible
	Baseline 2012	
	Systems and opening accounts fully compliant	US$ 300 million
	Targets to be achieved by 2013	
	First fully compliant IPSAS annual financial statements presented to the Sixty-sixth World Health Assembly in May 2013	US$ 400 million

13.3 Human resource policies and practices in place to attract and retain top talent, promote learning and professional development, manage performance, and foster ethical behaviour.	**Indicators**		
	13.3.1 ~~Percentage of offices with approved human resources plans for a biennium~~ New human resources policies implemented in line with the United Nations General Assembly and World Health Assembly resolutions.	**13.3.2** Number of staff assuming a new position or moving to a new location during a biennium ~~(delayed until biennium 2010–2011)~~	**13.3.3** Percentage of staff in compliance with the cycle of the Performance Management Development System
	Baseline 2012		
	~~100%~~ 5	200	80%
	Targets to be achieved by 2013		
	~~100%~~ 7	400	85%

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 implemented Organization-wide according to industry-best-practices benchmarks	**13.4.2** Proportion of offices using consistent real-time management information
	Baseline 2012	
	5	Headquarters, 5 regional offices and associated country offices
	Targets to be achieved by 2013	
	7	All relevant WHO locations, including sub-country and field offices, where appropriate

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.	**Indicators**	
	13.5.1 Proportion of services delivered by the global service centre according to criteria in service-level agreements	**13.5.2** Transaction processing errors to be reduced by 15%
	Baseline 2012	
	90%	To be defined
	Targets to be achieved by 2013	
	100%	baseline minus 15%

13.6 Working environment conducive to the well-being and safety of staff in all locations.	**Indicators**	
	13.6.1 The percentage of offices which are Moss compliant.	**13.6.2** Level of funding and execution of the biennial Capital Master Plan
	Baseline 2012	
	70%	70%
	Targets to be achieved by 2013	
	95%	95%

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

ANNEX 1

Programme support for activities related to strategic objective 13 – recurrent costs

The directly funded strategic objectives 12 and 13, together with the technical strategic objectives 1 to 11, comprise the total Proposed programme budget 2012–2013. Strategic objectives 12 and 13 are financed to a very great extent from assessed contributions and programme support cost charges, as well as from limited voluntary contributions.

In addition, strategic objective 13 is also financed through a separate mechanism, the post occupancy charge, to cover global common services. Charges made in respect of these services (e.g. those applied to salary costs throughout the budget) are not added to the total Proposed programme budget in order to avoid double-counting.

Organization-wide expected result	Proposed programme budget 2012–2013	Strategic objective 13	Strategic objective 13*bis* – funded through		Total
			Post occupancy costs	Capital Master Plan fund	
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.	43	0.0	-	43
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.	55	0.0	-	55
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.	24	14	-	37
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.	56	58	-	114
13.5	Managerial and administrative support services necessary for the efficient functioning of the Organization provided in accordance with service-level agreements that emphasize quality and responsiveness.	146	14	-	160
13.6	Working environment conducive to the well-being and safety of staff in all locations.	53	52	48	153
Total costs		**377**	**138**	**48**	**563**

ANNEX 2

Proposed programme budget 2012–2013

US$ million

	Base		
Strategic objective	**Africa**	**The Americas**	**South-East Asia**
1. To reduce the health, social and economic burden of communicable diseases	109.2	21.6	57.2
2. To combat HIV/AIDS, malaria and tuberculosis	146.3	20.1	73.3
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment	18.9	9.8	11.5
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	77.1	13.3	13.6
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	14.5	5.9	7.7
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	20.3	9.1	13.0
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	10.7	3.2	2.5
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	12.7	8.7	9.4
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development	10.6	4.5	4.1
10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research	71.8	29.7	36.4
11. To ensure improved access, quality and use of medical products and technologies	25.8	7.3	6.2
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	46.0	10.9	13.0
13. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	76.2	17.2	30.7
TOTAL	**640.3**	**161.5**	**278.6**

by strategic objective, major office and segment

(before currency adjustment)

programmes by major office					Special programmes and collaborative arrangements	Outbreak and crisis response	Total
Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total			
15.0	37.3	41.6	164.2	**446.1**	679.5	152.6	**1 278.1**
21.0	39.1	46.4	100.3	**446.4**	93.9	-	**540.3**
16.5	7.8	12.4	36.8	**113.8**	-	-	**113.8**
10.9	8.4	10.6	52.5	**186.3**	32.0	-	**218.3**
4.0	7.6	3.0	21.9	**64.6**	1.3	316.1	**382.0**
14.5	10.6	12.8	30.8	**111.1**	11.1	-	**122.3**
5.9	5.2	0.9	13.9	**42.3**	0.5	-	**42.8**
15.5	6.3	7.5	26.8	**86.8**	-	-	**86.8**
6.0	2.6	5.4	17.8	**51.1**	3.8	-	**54.9**
25.5	38.8	35.9	84.2	**322.3**	25.8	-	**348.1**
3.0	8.7	10.8	59.8	**121.6**	15.7	-	**137.3**
27.5	25.0	15.4	119.8	**257.6**	-	-	**257.6**
26.5	35.0	19.8	171.3	**376.7**	-	-	**376.7**
191.8	**232.5**	**222.2**	**900.0**	**2 626.8**	**863.5**	**468.7**	**3 959.0**

ANNEX 3

Special programmes and collaborative arrangements

(US$ million, before currency adjustments)

Strategic objectives/special programmes and collaborative arrangements	Total US$ million
Strategic objective 1	
Collaboration with partners in the GAVI Alliance	95.1
Global Poliomyelitis Eradication Initiative	441.0
Partnership for the control of neglected tropical diseases	53.3
UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases	71.0
Vaccine research partnerships	3.0
WHO/FAO/OIE agreement on the management of avian influenza and other emerging diseases	16.0
Total	**679.5**
Strategic objective 2	
Stop TB Partnership	28.8
UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction	0.9
UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases	32.2
Collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria	25.2
Green Light Committee/Global Laboratory Initiative	6.7
Total	**93.9**
Strategic objective 4	
UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction	32.0
Total	**32.0**
Strategic objective 5	
Health and Nutrition Tracking Service	1.3
Total	**1.3**
Strategic objective 6	
WHO Centre for Health Development (Kobe)	11.1
Total	**11.1**
Strategic objective 7	
UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction	0.5
Total	**0.5**
Strategic objective 9	
Codex Alimentarius Commission	3.8
Total	**3.8**

Strategic objective 10	
UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction	0.5
European Observatory on Health Systems and Policies	5.0
World Alliance for Patient Safety	20.3
Total	**25.8**
Strategic objective 11	
WHO/UN Programme on Prequalification of Medicines	15.7
Total	**15.7**
Grand total	**863.5**
The following partnerships were within the Programme budget 2008–2009 or 2010–2011, but moved out for 2012–2013	
Health Metrics Network	
Roll Back Malaria Partnership	
Water Supply and Sanitation Collaborative Council	
Partnership for Maternal, Newborn and Child Health	
United Nations Standing Committee on Nutrition	
Global Health Workforce Alliance	
Alliance for Health Policy and Systems Research	
Intergovernmental Forum on Chemical Safety (no longer operational)	
HIV Vaccine Initiative (including AAVP) (no longer operational)	

= = =