STRATEGIC OBJECTIVE 1

STRATEGIC OBJECTIVES

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

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

Lessons learnt

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

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

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

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

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

STRATEGIC APPROACHES

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

Lessons learnt

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

The Secretariat will focus on:

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

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

The Secretariat will focus on:

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

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

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

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

ORGANIZATION-WIDE EXPECTED RESULTS

1.1 Policy and technical support provided to Member States in order to maximize equitable access of all people to vaccines of assured quality, including new immunization products and technologies, and to integrate other essential child-health interventions with immunization.

INDICATORS	
1.1.1 Number of Member States with at least 90% national vaccination coverage (DTP3)	**1.1.2** Number of Member States that have introduced *Haemophilus influenzae* type b vaccine in their national immunization schedule
BASELINE 2008	
114	104
TARGETS TO BE ACHIEVED BY 2009	
130	135
TARGETS TO BE ACHIEVED BY 2011	
140	150
TARGETS TO BE ACHIEVED BY 2013	
150	160

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
153 584	159 846	181 000

JUSTIFICATION

In resolution WHA58.15 the Health Assembly welcomed the Global Immunization Vision and Strategy, with its approaches to protecting more people by making immunization available to all eligible people, introducing new vaccines and technologies, and linking immunization to the delivery of other health interventions and overall development of the health sector. It also requested policy and technical support to Member States in implementing the strategy. More than 75% of the resources are for activities at regional and country levels. Global health partnerships, such as the Global Alliance for Vaccines and Immunization, and increasing availability of resources to Member States for implementing immunization programmes through initiatives such as the International Financing Facility for Immunization raise the pressure on the Secretariat to provide policy and technical support to Member States in implementing evidence-based health-system approaches so as to ensure that the resources are used in a financially sustainable way in the long term.

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

INDICATORS	
1.2.1 Percentage of final country reports demonstrating interruption of wild poliovirus transmission and containment of wild poliovirus stocks accepted by the relevant regional commission for the certification of poliomyelitis eradication	**1.2.2** Percentage of Member States using trivalent oral poliovirus vaccine that have a timeline and strategy for eventually stopping its use in routine immunization programmes
BASELINE 2008	
63%	0%
TARGETS TO BE ACHIEVED BY 2009	
75%	0%
TARGETS TO BE ACHIEVED BY 2011	
95%	50%
TARGETS TO BE ACHIEVED BY 2013	
100%	100%

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
262 615	466 318	240 000

JUSTIFICATION

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

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

INDICATORS			
1.3.1 Number of Member States certified for eradication of dracunculiasis	**1.3.2** Number of Member States that have eliminated leprosy at subnational levels	**1.3.3** Number of reported cases of human African trypanosomiasis for all endemic countries	**1.3.4** Number of Member States having achieved the recommended target coverage of population at risk of lymphatic filariasis, schistosomiasis and soil-transmitted helminthiases through regular anthelminthic preventive chemotherapy
BASELINE 2008			
176	6	11 500	11
TARGETS TO BE ACHIEVED BY 2009			
186	10	10 000	15
TARGETS TO BE ACHIEVED BY 2011			
190	13	8 500	20
TARGETS TO BE ACHIEVED BY 2013			
193	18	7 500	25

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
131 669	152 149	185 000

JUSTIFICATION

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

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

INDICATORS

1.4.1 Number of Member States with surveillance systems and training for all communicable diseases of public health importance for the country	**1.4.2** 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 time-lines
BASELINE 2008	
60	115
TARGETS TO BE ACHIEVED BY 2009	
80	135
TARGETS TO BE ACHIEVED BY 2011	
150	150
TARGETS TO BE ACHIEVED BY 2013	
193	165

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
79 668	89 561	87 000

JUSTIFICATION

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

1.5 New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed and validated, with scientists from developing countries 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 2008	
None	30%
TARGETS TO BE ACHIEVED BY 2009	
4	50%
TARGETS TO BE ACHIEVED BY 2011	
9	55%
TARGETS TO BE ACHIEVED BY 2013	
14	60%

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
72 334	109 552	42 000

JUSTIFICATION

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

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

INDICATORS

1.6.1 Number of Member States that have completed the assessment and developed a national action plan to achieve core capacities for surveillance and response in line with their obligations under the International Health Regulations (2005)	**1.6.2** Number of Member States whose national laboratory system is engaged in at least one external quality-control programme for epidemic-prone communicable diseases
BASELINE 2008	
50	90
TARGETS TO BE ACHIEVED BY 2009	
95	100
TARGETS TO BE ACHIEVED BY 2011	
160	150
TARGETS TO BE ACHIEVED BY 2013	
193	193

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
76 485	54 840	120 000

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

1.7 Member States and the international community equipped to detect, assess, respond to and cope with major epidemic and pandemic-prone 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 or re-emerging diseases for which prevention, surveillance and control strategies have been developed
	BASELINE 2008		
	90	4	2
	TARGETS TO BE ACHIEVED BY 2009		
	135	7	6
	TARGETS TO BE ACHIEVED BY 2011		
	165	8	8
	TARGETS TO BE ACHIEVED BY 2013		
	193	9	10
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	61 516	83 467	76 000
	JUSTIFICATION		
	Strong programmes and projects on diseases or specific themes are vital for WHO to ensure that serious threats are dealt with systematically and that WHO maintains its much-needed global expertise in vital areas (e.g. influenza, smallpox, biosafety, epidemics caused by deliberate release of pathogens, and yellow fever). The avian influenza crisis has highlighted the need for the Secretariat to accelerate work with Member States in order to ensure that their ability to detect, assess, respond to and cope with the threat of known epidemic-prone and emerging infectious diseases. The development of standard operating procedures and stockpiling of necessary medicines and vaccines are crucial for mitigating the potential impact of these diseases. Maintaining and expanding existing networks and partnerships providing support to Member States in the different aspects of preparedness and response to specific epidemic risks, and developing new ones where required, are essential elements of WHO's strategy. By the end of 2007, all Member States will have national preparedness plans devised, implemented and tested, thus providing the backbone to the response to a potential pandemic.		

1.8 Regional and global capacity coordinated and made rapidly available to Member States for detection, verification, risk assessment and response to	**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 2008
	7
	TARGETS TO BE ACHIEVED BY 2009
	60

epidemics and other public health emergencies of international concern.	**TARGETS TO BE ACHIEVED BY 2011**
	90
	TARGETS TO BE ACHIEVED BY 2013
	120

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
56 172	52 620	71 000

JUSTIFICATION

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

1.9 Effective operations and response by Member States and the international community to declared emergencies situations due to epidemic and pandemic prone diseases.	**INDICATORS**
	1.9.1 Proportion of Member States' requests for assistance that have lead to effective and timely interventions by WHO, delivered using a global team approach, in order to prevent, contain and control epidemic and other public health emergencies.
	BASELINE 2008
	90%
	TARGETS TO BE ACHIEVED BY 2009
	95%
	TARGETS TO BE ACHIEVED BY 2011
	99%
	TARGETS TO BE ACHIEVED BY 2013
	99%

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	100 000	

JUSTIFICATION

STRATEGIC OBJECTIVE 2

To combat HIV/AIDS, tuberculosis and malaria

Indicators and targets

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

ISSUES AND CHALLENGES

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

STRATEGIC APPROACHES

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

Lessons learnt

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

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

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

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

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

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

Lessons learnt

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

The Secretariat will focus on:

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

ASSUMPTIONS, RISKS AND OPTIONS

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

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

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

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

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

The Secretariat will focus on:

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

ORGANIZATION-WIDE EXPECTED RESULTS

2.1 Guidelines, policy, strategy and other tools developed for prevention of, and treatment and care for patients with, HIV/AIDS, tuberculosis and malaria, including innovative approaches for increasing coverage of the interventions among poor people, and hard-to-reach and vulnerable populations.

INDICATORS

2.1.1 Number of low and middle income countries that have achieved 80% coverage for antiretroviral therapy and the prevention of mother-to-child transmission services	**2.1.2** Proportion of endemic countries that have achieved their national intervention targets for malaria	**2.1.3** Number of Member States that have achieved the targets of at least 70% case detection and 85% treatment success rate for tuberculosis	**2.1.4** 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 2008				
34	5%	54	2	28%
TARGETS TO BE ACHIEVED BY 2009				
60	50%	100	3	52%
TARGETS TO BE ACHIEVED BY 2011				
80	60%	140	15	70%
TARGETS TO BE ACHIEVED BY 2013				
131	100%	193	27	90%

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
146 534	118 579	150 000

JUSTIFICATION

WHO is firmly committed to maximizing access to interventions against HIV/AIDS, tuberculosis and malaria, pursuant to various Health Assembly resolutions, the global health-sector strategy for HIV/AIDS, the Stop TB strategy, the Global Plan to Stop TB 2006-2015, the Global Strategic Plan 2005–2015 to Roll Back Malaria; the Global Strategy for the Prevention and Control of Sexually Transmitted Infections, and the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health; articulation of its contribution to scaling up towards universal access to HIV/AIDS prevention, care and treatment (and the need to advance work done under the "3 by 5" Initiative); and to achieving the Millennium Development Goals and other internationally agreed goals. Most of the resources are for country and regional level activities.

2.2 Policy and technical support provided to countries towards expanded gender-sensitive delivery of prevention, treatment and care interventions for HIV/AIDS, tuberculosis and malaria, including integrated training

INDICATORS

2.2.1 Number of targeted Member States with comprehensive policies and medium-term plans in response to HIV, tuberculosis and malaria	**2.2.2** Proportion of high-burden countries monitoring provider initiated HIV testing and counselling in sexually transmitted infection and family planning services	**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 2008		
HIV/AIDS:80/131 Tuberculosis:50/87	0%	5

and service delivery; wider service-provider networks; and strengthened laboratory capacities and better linkages with other health services, such as those for sexual and reproductive health, maternal, newborn and child health, sexually transmitted infections, nutrition, drug-dependence treatment services, respiratory care, neglected diseases and environmental health.	**TARGETS TO BE ACHIEVED BY 2009**		
	HIV/AIDS: 131/131 Tuberculosis: 87/87 Malaria: 70/70	25%	15
	TARGETS TO BE ACHIEVED BY 2011		
	HIV/AIDS: 131/131 Tuberculosis: 118/118 Malaria: 70/70	50%	30
	TARGETS TO BE ACHIEVED BY 2013		
	HIV/AIDS: all countries Tuberculosis: 148 Malaria: 70/70	75%	45
	RESOURCES (US$ THOUSAND)		
	Budget 2008–2009 258 132	Proposed budget 2010–2011 199 417	Estimates 2012–2013 300 000
	JUSTIFICATION		
	WHO plays a critical role in supporting countries to scale up effective and gender-sensitive interventions to all those who need them; to remove the human resources obstacles to progress; to create or maximize synergies among existing programmes and service-delivery modes and to ensure that vulnerable and high-risk populations benefit from the interventions.		

2.3 Global guidance and technical support provided on policies and programmes in order to promote equitable access to essential medicines, diagnostic tools and health technologies of assured quality for the prevention and treatment of HIV/AIDS, tuberculosis and malaria, and their rational use by prescribers and consumers, and, in order to ensure uninterrupted supplies of diagnostics, safe blood and blood products, injections and other essential health technologies and commodities.	**INDICATORS**				
	2.3.1 Number of new or updated global norms and quality standards for medicines and diagnostic tools for HIV/AIDS, tuberculosis and malaria	**2.3.2** Number of priority medicines and diagnostic tools for HIV/AIDS, tuberculosis and malaria that have been assessed and pre-qualified for United Nations procurement	**2.3.3** Number of targeted countries receiving support to increase access to affordable essential medicines for HIV/AIDS, tuberculosis and malaria whose supply is integrated into national pharmaceutical systems (the number of targeted countries is determined for the six-year period)	**2.3.4** Number of Member States implementing quality-assured HIV/AIDS screening of all donated blood	**2.3.5** Number of Member States administering all medical injections using sterile single use syringes
	BASELINE 2008				
	5	150	10	77	115
	TARGETS TO BE ACHIEVED BY 2009				
	10	225	20	134	154
	TARGETS TO BE ACHIEVED BY 2011				
	15	300	75% of targeted countries	161	170

TARGETS TO BE ACHIEVED BY 2013

20	400	All targeted countries	193	193

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
58 284	81 775	29 000

JUSTIFICATION

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

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

INDICATORS

2.4.1 Number of Member States providing WHO with annual data on surveillance, monitoring or financial allocation data for inclusion in the annual global reports on control of HIV/AIDS, tuberculosis or malaria and the achievement of targets	**2.4.2** Number of Member States reporting drug resistance surveillance data to WHO for HIV/AIDS, tuberculosis or malaria
BASELINE 2008	
HIV/AIDS: 48 Tuberculosis:185 countries and territories Malaria: 107	HIV/AIDS: 13 Tuberculosis: 120 Malaria: 107
TARGETS TO BE ACHIEVED BY 2009	
HIV/AIDS: 65 Tuberculosis: 192 Malaria: 107	HIV/AIDS: 40 Tuberculosis: 135 Malaria: 107
TARGETS TO BE ACHIEVED BY 2011	
HIV/AIDS: 75 Tuberculosis: 192 Malaria: 107	HIV /AIDS: 45 Tuberculosis: 145 Malaria: 107
TARGETS TO BE ACHIEVED BY 2013	
HIV/AIDS:85 Tuberculosis:193 Malaria: 107	HIV/AIDS:50 Tuberculosis:155 Malaria: 107

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
104 598	80 627	150 000

JUSTIFICATION

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

2.5 Political commitment sustained and mobilization of resources ensured through advocacy and nurturing of partnerships on HIV/AIDS, tuberculosis and malaria at country, regional and global levels; support provided to countries as appropriate to develop or strengthen and implement mechanisms for resource mobilization and utilization and 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 2008	
	HIV/AIDS: 80 Tuberculosis: 45 Malaria: 28	HIV/AIDS: 131 Tuberculosis: 65 Malaria: 28
	TARGETS TO BE ACHIEVED BY 2009	
	HIV/AIDS: 131 Tuberculosis: 87 Malaria: 50	HIV/AIDS: 131 Tuberculosis: 87 Malaria: 50
	TARGETS TO BE ACHIEVED BY 2011	
	HIV/AIDS: 131 Tuberculosis: 87 Malaria: 70	HIV/AIDS: 131 Tuberculosis: 87 Malaria: 70
	TARGETS TO BE ACHIEVED BY 2013	
	HIV/AIDS: 131 Tuberculosis: 87 Malaria: 70	HIV/AIDS: 131 Tuberculosis: 87 Malaria: 70

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
35 930	51 042	30 000

JUSTIFICATION

Resources are required to ensure engagement and coordination with various partners for rapid scaling up of interventions for HIV/AIDS, tuberculosis and malaria, including advocacy, coordination, and collaboration with key partners, networks and stakeholders such as UNAIDS, the Stop TB Partnership including the Global Drug Facility and Roll Back Malaria Partnership, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States' President's Emergency Plan for AIDS Relief, the Malaria Medicines and Supply Service, and AIDS Medicines and Diagnostics Service. They are also needed for promoting funding of work on aspects of HIV/AIDS, tuberculosis and malaria that remain severely underfunded, such as laboratory capacity and human resources. The work cuts across all three levels of the Organization.

2.6 New knowledge, intervention tools and strategies developed and validated to meet priority needs for the prevention and control of HIV/AIDS, tuberculosis and malaria, with scientists from developing countries increasingly taking the lead in this research.

INDICATORS	
2.6.1 Number of new and improved tools 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 2008	
0	48%
TARGETS TO BE ACHIEVED BY 2009	
2	50%
TARGETS TO BE ACHIEVED BY 2011	
6	55%
TARGETS TO BE ACHIEVED BY 2013	
13	60%

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
103 454	102 440	81 000

JUSTIFICATION

Appropriately directed research can have a significant impact on the control of HIV/AIDS, tuberculosis and malaria through the improvement, development and evaluation of new tools, interventions and strategies. WHO's facilitative role is crucial to finding the most effective measures for combating the three diseases and building a sustainable base in order to enable developing countries to undertake research of national and local relevance.

STRATEGIC OBJECTIVE 3

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

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

Lessons learnt

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

STRATEGIC APPROACHES

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

The Secretariat will focus on:

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

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

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

ORGANIZATION-WIDE EXPECTED RESULTS

3.1 Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable 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 2008			
80	No report	140	67
TARGETS TO BE ACHIEVED BY 2009			
110	Draft prepared	150	90
TARGETS TO BE ACHIEVED BY 2011			
140	Published in 6 languages	150	122
TARGETS TO BE ACHIEVED BY 2013			
170	Report launched and implementation started in 40 countries	160	152

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
25 837	28 267	20 000

JUSTIFICATION

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

3.2 Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable 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 2008			
30	39	53	67
TARGETS TO BE ACHIEVED BY 2009			
75	48	75	75
TARGETS TO BE ACHIEVED BY 2011			
78	50	90	100

	TARGETS TO BE ACHIEVED BY 2013

80	54	105	130

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
30 440	30 302	33 000

JUSTIFICATION

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

3.3 Improvements made in Member States' capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable 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 2008				
0	60	80	100	32
TARGETS TO BE ACHIEVED BY 2009				
130	90	100	120	38
TARGETS TO BE ACHIEVED BY 2011				
150	115	110	136	43
TARGETS TO BE ACHIEVED BY 2013				
180	140	120	155	45

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
23 987	18 544	35 000

JUSTIFICATION

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

3.4 Improved evidence compiled by WHO on the cost-effectiveness of interventions to tackle chronic noncommunicable

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

diseases, mental and neurological and substance-use disorders, violence, injuries and disabilities together with visual impairment, including blindness.

BASELINE 2008

None published and disseminated	Published and disseminated for 2 interventions

TARGETS TO BE ACHIEVED BY 2009

Published and disseminated for 4 interventions	Published and disseminated for 4 interventions

TARGETS TO BE ACHIEVED BY 2011

Published and disseminated for 8 interventions	Published and disseminated for 5 interventions

TARGETS TO BE ACHIEVED BY 2013

Published and disseminated for 12 interventions	Published and disseminated for 8 interventions

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
23 700	18 575	30 000

JUSTIFICATION

Resources will be used to support further research in low- and middle-income countries on the cost-effectiveness of interventions. This will include training and workshops to refine methodology, studies, and compilation of results at national, regional and global levels, including through documents on best practices and focused dissemination strategies. Resources will also be used to provide policy-makers at country level with information and support their use of such information for priority-setting.

3.5 Guidance and support provided to Member States for the preparation and implementation of multisectoral, population-wide programmes to promote mental health, and to prevent mental and behavioural disorders, violence and injuries, together with hearing and visual impairment, including blindness.

INDICATORS

3.5.1 Number of guidelines published and widely disseminated on multisectoral interventions to prevent violence and unintentional injuries	**3.5.2** Number of Member States that have initiated community-based projects during the biennium to reduce suicides	**3.5.3** Number of Member States implementing strategies recommended by WHO for the prevention of hearing or visual impairment

BASELINE 2008

4	0	67

TARGETS TO BE ACHIEVED BY 2009

10	17	75

TARGETS TO BE ACHIEVED BY 2011

14	22	100

TARGETS TO BE ACHIEVED BY 2013

18	27	130

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
21 476	20 630	69 000

JUSTIFICATION

Resources will be used to support the implementation of prevention programmes at local, national and regional levels, including provision of the necessary training and workshops. Resources will also be used for global and regional guidelines and documents on best practices, and for global coordination and monitoring of country experiences and lessons learnt.

3.6 Guidance and support provided to Member States to improve the ability of their health and social systems to prevent and manage chronic noncommunicable 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 noncommunic-able diseases using WHO guidelines	**3.6.5** Number of Member States with tobacco cessation support incorporated into primary health care
BASELINE 2008				
3	0	48	Precise data on current baseline unavailable	35
TARGETS TO BE ACHIEVED BY 2009				
8	10	72	12	37
TARGETS TO BE ACHIEVED BY 2011				
14	25	80	26	40
TARGETS TO BE ACHIEVED BY 2013				
20	40	90	55	45

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
32 664	29 631	43 000

JUSTIFICATION

Resources will be used for the provision of documents, training, workshops and direct support for the strengthening of health and rehabilitation services in low- and middle-income countries, diseases, mental and behavioural disorders, violence, injuries and disabilities.

STRATEGIC OBJECTIVE 4

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

Indicators and targets

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

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

ISSUES AND CHALLENGES

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

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

Lessons learnt

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

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

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

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

Lessons learnt

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

The Secretariat will focus on:

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

STRATEGIC APPROACHES

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

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

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

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

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

The Secretariat will focus on:

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie attainment of this strategic objective:

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

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

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

ORGANIZATION-WIDE EXPECTED RESULTS

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

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

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
36 032	37 920	75 000

JUSTIFICATION

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

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

INDICATORS		
4.2.1 Number of research centres that have received an initial grant for comprehensive institutional development and support	**4.2.2** Number of completed studies on priority issues that have been supported by WHO	**4.2.3** Number of new or updated systematic reviews on best practices, policies and standards of care for improving maternal, newborn, child and adolescent health, promoting active and healthy ageing or improving sexual and reproductive health
BASELINE 2008		
None	None	None
TARGETS TO BE ACHIEVED BY 2009		
8	16	20
TARGETS TO BE ACHIEVED BY 2011		
8	28	40

	TARGETS TO BE ACHIEVED BY 2013

12	40	60

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
72 497	68 297	80 000

JUSTIFICATION

Country-led identification of research priorities and opportunities for strengthening national research capacity will have to be given greater attention, and the setting of those research priorities, done in close consultation with national research partners and other stakeholders, will have to be improved. Support will be needed for use of research findings in informing policies and programmes.

4.3 Guidelines, approaches and tools for improving maternal care applied at the country level, including technical support provided to Member States for intensified action to ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods, particularly for poor and disadvantaged populations, with progress monitored.

INDICATORS

4.3.1 Number of Member States implementing strategies for increasing coverage with skilled care for childbirth

BASELINE 2008

10

TARGETS TO BE ACHIEVED BY 2009

25

TARGETS TO BE ACHIEVED BY 2011

50

TARGETS TO BE ACHIEVED BY 2013

75

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
65 389	66 460	130 000

JUSTIFICATION

Attention needs to be paid to strengthening human resources capacity, providing a supportive environment to ensure skilled care for every birth, and ensuring a continuum of care between communities and facilities, with referral care at all times in particular for marginalized populations and communities in order to enhance their participation in designing approaches that improve access to essential health services and referral care. Further, attainment of these results will need monitoring and auditing systems that identify maternal deaths and detect failures of the system to meet needs, especially those of marginalized and underserved populations.

4.4 Guidelines, approaches and tools for improving neonatal survival and health applied at country level, with technical support provided to Member States for intensified action towards universal coverage, effective interventions and monitoring of progress.

INDICATORS

4.4.1 Number of Member States implementing strategies for increasing coverage with interventions for neonatal survival and health

BASELINE 2008

20

TARGETS TO BE ACHIEVED BY 2009

40

TARGETS TO BE ACHIEVED BY 2011

50

	TARGETS TO BE ACHIEVED BY 2013
	60

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
50 790	30 147	115 000

JUSTIFICATION

Achievement of this expected result will require a continuum of care between maternal, newborn and child health services and strengthened links between these and other programmes such as immunization, family planning, nutrition, HIV/AIDS, syphilis elimination and malaria control. Furthermore, it will need community involvement and promotion of contact between mothers, their families and health workers, a continuum of care between communities and health facilities, provision of suitable facilities for maternal and newborn care at community and primary-care levels, especially for low birth-weight infants and systems for monitoring trends in neonatal survival, disaggregated by sex, that allow the detection of subpopulations at high risk.

4.5 Guidelines, approaches and tools for improving child health and development applied at the country level, with technical support provided to Member States for intensified action towards universal coverage of the population with effective interventions and for monitoring progress, taking into consideration international and human-rights norms and standards, notably those stipulated in the Convention on the Rights of the Child.

INDICATORS	
4.5.1 Number of Member States implementing strategies for increasing coverage with child health and development interventions	**4.5.2** Number of Member States that have expanded coverage of the integrated management of childhood illness to more than 75% of target districts
BASELINE 2008	
20	10
TARGETS TO BE ACHIEVED BY 2009	
40	30
TARGETS TO BE ACHIEVED BY 2011	
40	45
TARGETS TO BE ACHIEVED BY 2013	
75	60

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
41 776	52 916	93 000

JUSTIFICATION

Achievement of this expected result will depend on the following: a continuum of care from mothers and newborns to children, and between different levels of the health system; capacity building at all levels; links with work on addressing the underlying social, environmental and behavioural determinants of ill-health and poor nutrition; promotion of child development and healthy lifestyles; enhanced building of community capacity and involvement in support of the integrated management of childhood illness; and systems for monitoring trends in child survival, disaggregated by age and sex, that allow the detection of subpopulations at high risk.

4.6 Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, and for the scaling up of a package of

INDICATORS
4.6.1 Number of Member States with a functioning adolescent health and development programme
BASELINE 2008
30
TARGETS TO BE ACHIEVED BY 2009
40
TARGETS TO BE ACHIEVED BY 2011
50

prevention, treatment and care interventions in accordance with established standards.	**TARGETS TO BE ACHIEVED BY 2013** 60

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
34 632	29 733	74 000

JUSTIFICATION

Achievement of this expected result will depend on capacity being built at the country level for collecting and disseminating the data necessary for programme implementation and for health services, with the participation of young people, the engagement of community structures and a focus on particularly vulnerable groups and settings, in order to respond to the priority health needs of adolescents and to increase their access to services. Moreover, the policy environment will need to be supportive in order to ensure that the health sector provides evidence on effective interventions and examples of good practice. Systems will be needed to monitor trends in adolescent health and development, with data disaggregated by age and sex, and to allow the detection of subpopulations at high risk.

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 2008	
20	3
TARGETS TO BE ACHIEVED BY 2009	
30	8
TARGETS TO BE ACHIEVED BY 2011	
40	12
TARGETS TO BE ACHIEVED BY 2013	
50	15

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
48 064	40 436	113 000

JUSTIFICATION

Achievement of this result will depend on capacity being built at the country level for collecting, analysing and disseminating the data necessary for programme implementation; stronger links between sexual and reproductive health services and other health programmes, such as those on HIV/AIDS and nutrition; and monitoring and evaluation of sexual and reproductive health programmes within and outside the health system, along with the establishment of accountability mechanisms.

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 WHA58.16 "Strengthening active and healthy ageing" **BASELINE 2008** None **TARGETS TO BE ACHIEVED BY 2009** 15 **TARGETS TO BE ACHIEVED BY 2011** 20 **TARGETS TO BE ACHIEVED BY 2013** 25

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
10 653	6 789	22 000

JUSTIFICATION

Achievement of this expected result will depend on building the capacity of health services to support active and healthy ageing; support for the establishment of age-friendly primary health-care centres; ensuring the participation of older persons in the national policy development and programme planning process, with an emphasis on their contribution to society; and support for multisectoral initiatives that promote active ageing, such as "age-friendly cities".

STRATEGIC OBJECTIVE 5

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

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

STRATEGIC APPROACHES

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

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

Lessons learnt

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

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

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

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

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

The Secretariat will focus on:

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

ORGANIZATION-WIDE EXPECTED RESULTS

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

INDICATORS	
5.1.1 Proportion of Member States with national emergency preparedness plans that cover multiple hazards	**5.1.2** Number of Member States implementing programmes for reducing the vulnerability of health facilities to the effects of natural disasters
BASELINE 2008	
25%	20
TARGETS TO BE ACHIEVED BY 2009	
60%	40
TARGETS TO BE ACHIEVED BY 2011	
65%	50
TARGETS TO BE ACHIEVED BY 2013	
70%	60

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
45 614	31 541	51 000

JUSTIFICATION

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

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

INDICATORS	
5.2.1 Operational platforms for surge capacity in place in regions and headquarters ready to be activated in acute-onset emergencies	**5.2.2** Number of global and regional training programmes on public health operations in emergency response
BASELINE 2008	
50%	5
TARGETS TO BE ACHIEVED BY 2009	
100%	16
TARGETS TO BE ACHIEVED BY 2011	
100%	18
TARGETS TO BE ACHIEVED BY 2013	
100%	20

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
67 796	24 517	74 000

JUSTIFICATION

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

5.3 Norms and standards developed and capacity built to enable Member States to assess needs and for planning interventions during the transition and recovery phases of conflicts and disasters.

INDICATORS

5.3.1 Number of humanitarian action plans with a health component formulated for ongoing emergencies	**5.3.2** Number of countries in transition that have formulated a recovery strategy for health
BASELINE 2008	
6	8
TARGETS TO BE ACHIEVED BY 2009	
12	15
TARGETS TO BE ACHIEVED BY 2011	
15	18
TARGETS TO BE ACHIEVED BY 2013	
18	20

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
46 465	23 976	65 000

JUSTIFICATION

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

5.4 Coordinated technical support provided to Member States for communicable disease control in natural disaster and conflict situations.

INDICATORS

5.4.1 Proportion of acute natural disasters or conflicts where communicable disease-control interventions have been implemented, including activation of early-warning systems and disease-surveillance for emergencies

BASELINE 2008

60%

TARGETS TO BE ACHIEVED BY 2009

100%

TARGETS TO BE ACHIEVED BY 2011

100%

TARGETS TO BE ACHIEVED BY 2013

100%

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
22 948	5 560	53 000

JUSTIFICATION

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

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

INDICATORS

5.5.1 Proportion of Member States with national plans for preparedness, and alert and response activities in respect of chemical, radiological and environmental health emergencies	**5.5.2** Number of Member States with focal points for the International Food Safety Authorities Network and for the environmental health emergencies network
BASELINE 2008	
30%	50
TARGETS TO BE ACHIEVED BY 2009	
60%	75
TARGETS TO BE ACHIEVED BY 2011	
65%	85
TARGETS TO BE ACHIEVED BY 2013	
70%	100

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
19 190	6 700	18 000

JUSTIFICATION

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

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

INDICATORS

5.6.1 Proportion of Member States affected by acute-onset emergencies and those with ongoing emergencies and a humanitarian coordinator in which the Inter-Agency Standing Committee Humanitarian Health Cluster is operational in line with IASC cluster standards	**5.6.2** Proportion of Member States with ongoing emergencies and a humanitarian coordinator having a sustainable WHO technical presence covering emergency preparedness, response and recovery
BASELINE 2008	
30%	30%
TARGETS TO BE ACHIEVED BY 2009	
60%	60%
TARGETS TO BE ACHIEVED BY 2011	
80%	75%
TARGETS TO BE ACHIEVED BY 2013	
100%	90%

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
16 400	20 629	17 000

JUSTIFICATION

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

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 2008	
	60%	
	TARGETS TO BE ACHIEVED BY 2009	
	80%	100%
	TARGETS TO BE ACHIEVED BY 2011	
	90%	100%
	TARGETS TO BE ACHIEVED BY 2013	
	100%	100%

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	251 100	

JUSTIFICATION

STRATEGIC OBJECTIVE 6

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

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

Lessons learnt

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

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

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

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

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

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

Lessons learnt

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

The Secretariat will focus on:

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

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

technological change is greatest, new public health issues and problems are emerging.

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

STRATEGIC APPROACHES

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

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

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

In order to ensure lasting success there is a need for comprehensive approaches that use a combination of

The Secretariat will focus on:

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

strategies to resolve policy issues and build capacities at individual, family and community levels.

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

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

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

ORGANIZATION-WIDE EXPECTED RESULTS

6.1 Advice and support provided to Member States to build their capacity for health promotion across all relevant programmes, and to establish effective multisectoral and multidisciplinary collaborations for promoting health and preventing or reducing major risk factors.

INDICATORS	
6.1.1 Number of Member States that have evaluated and reported on at least one of the action areas and commitments of the Global Conferences on Health Promotion.	**6.1.2** Number of cities that have implemented healthy urbanization programmes aimed at reducing health inequities
BASELINE 2008	
24	6
TARGETS TO BE ACHIEVED BY 2009	
30	12
TARGETS TO BE ACHIEVED BY 2011	
40	22
TARGETS TO BE ACHIEVED BY 2013	
50	46

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
38 879	51 925	66 000

JUSTIFICATION

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

6.2 Guidance and support provided in order to strengthen national systems for surveillance of major risk factors through development and validation of frameworks, tools and operating procedures and their dissemination to Member States where a high or increasing burden of death and disability is attributable to these risk factors.

INDICATORS	
6.2.1 Number of Member States with a functioning national surveillance system for monitoring major risk factors to health among adults based on the WHO STEPwise approach to surveillance	**6.2.2** Number of Member States with a functioning national surveillance system for monitoring major risk factors to health among youth based on the Global school-based student health survey methodology
BASELINE 2008	
25	25
TARGETS TO BE ACHIEVED BY 2009	
50	50
TARGETS TO BE ACHIEVED BY 2011	
58	58
TARGETS TO BE ACHIEVED BY 2013	
73	73

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
23 807	14 940	31 000

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

6.3 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease and death associated with tobacco use, enabling them to strengthen institutions in order to tackle or prevent the public health problems concerned; support also provided to the Conference of the Parties to the WHO Framework Convention on Tobacco Control for implementation of the provisions of the Convention and development and implementation of protocols and guidelines.	**INDICATORS**		
	6.3.1 Number of Member States having comparable adult tobacco prevalence data available from recent national representative surveys, such as the Global Adult Tobacco Survey (GATS) or STEPS	**6.3.2** Number of Member States with 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 2008		
	44	16	20
	TARGETS TO BE ACHIEVED BY 2009		
	50	18	23
	TARGETS TO BE ACHIEVED BY 2011		
	65	22	26
	TARGETS TO BE ACHIEVED BY 2013		
	75	26	29

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
38 466	49 459	72 000

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

6.4 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease or death associated with alcohol, drugs and other psychoactive substance use, enabling them to strengthen institutions in order to combat or	**INDICATORS**	
	6.4.1 Number of Member States that have developed, with WHO support, strategies, plans and programmes for combating or preventing public health problems caused by alcohol, drugs and other psychoactive substance use	**6.4.2** Number of WHO strategies, guidelines, standards and technical tools developed in order to provide support to Member States in preventing and reducing public health problems caused by alcohol, drugs and other psychoactive substance use
	BASELINE 2008	
	25	5
	TARGETS TO BE ACHIEVED BY 2009	
	35	8
	TARGETS TO BE ACHIEVED BY 2011	
	50	10
	TARGETS TO BE ACHIEVED BY 2013	
	60	15

prevent the public health problems concerned.

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
20 978	18 736	33 000

JUSTIFICATION

In order to be credible, the Organization's response to public health problems attributable to use of alcohol, drugs and other psychoactive substances must be commensurate with the burden of disease and death with which such behaviours are associated. Significant additional investment is urgently needed, therefore, for work that includes capacity building and institutional strengthening at all levels of the Secretariat, including WHO collaborating centres, with particular emphasis on regional and country offices for effective responses to Member States' needs, and support for the implementation of relevant resolutions of the Health Assembly. A comprehensive and integrated approach to prevention and reduction efforts in respect of this group of risk factors will be encouraged, but provision of a substantial increase in resources remains a necessity.

6.5 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed and technical support provided to Member States with a high or increasing burden of disease or death associated with unhealthy diets and physical inactivity, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.

INDICATORS

6.5.1 Number of Member States that have adopted multisectoral strategies and plans for healthy diets or physical activity, based on the WHO Global Strategy on Diet, Physical Activity and Health	**6.5.2** Number of WHO technical tools that provide support to Member States in promoting healthy diets or physical activity
BASELINE 2008	
29	9
TARGETS TO BE ACHIEVED BY 2009	
50	14
TARGETS TO BE ACHIEVED BY 2011	
62	16
TARGETS TO BE ACHIEVED BY 2013	
72	18

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
20 347	14 400	31 000

JUSTIFICATION

WHO's guidelines on interactions with external stakeholders will be revised and updated to provide a better reflection of the current environment, especially in relation to the food and the alcoholic and non-alcoholic beverage industries, thus ensuring that public health objectives are highlighted. WHO needs to strengthen its normative work on physical activity, and most of the work related to the revision of guidelines will involve consultations with Member States. Interactions also need to include international and national nongovernmental organizations and community groups.

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 2008	
	4	0
	TARGETS TO BE ACHIEVED BY 2009	
	8	2
	TARGETS TO BE ACHIEVED BY 2011	
	10	5
	TARGETS TO BE ACHIEVED BY 2013	
	12	8

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
18 580	12 220	30 000

JUSTIFICATION

Significant additional resources are required to continue and expand urgently needed interventions to tackle unsafe sex, whose consequences constitute the second most common cause of death and disability in high-mortality countries. The actions required range from generating relevant evidence to providing countries with support to implement policies, strategies and interventions. Investments to achieve this expected result, will also help efforts to reach the goals for other risky behaviours. More resources will be made available for generating and building an evidence base and strengthening WHO's normative role.

STRATEGIC OBJECTIVE 7

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

Lessons learnt

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

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

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

Lessons learnt

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

STRATEGIC APPROACHES

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

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

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

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

The Secretariat will focus on:

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

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

The Secretariat will focus on:

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

ASSUMPTIONS, RISKS AND OPTIONS

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

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

The main risks that prevent achieving this strategic objective are:

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

ORGANIZATION-WIDE EXPECTED RESULTS

7.1 Significance of social and economic determinants of health recognized throughout the Organization and incorporated into normative work and technical collaboration with Member States and other partners.	**INDICATORS**
	7.1.1 Number of WHO regions with a regional strategy for addressing social and economic determinants of health as identified in the Report of the Commission on the Social Determinants of Health endorsed by the Director-General
	BASELINE 2008
	2
	TARGETS TO BE ACHIEVED BY 2009
	4
	TARGETS TO BE ACHIEVED BY 2011
	5
	TARGETS TO BE ACHIEVED BY 2013
	6

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
17 814	16 668	23 100

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

7.2 Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels to address social and economic determinants of health, including understanding and acting upon the public health implications of trade and trade agreements, and to encourage poverty-reduction and sustainable development.	**INDICATORS**	
	7.2.1 Number of published country experiences on tackling social determinants for health equity	**7.2.2** Number of tools to support countries in analysing the implications of trade and trade agreements for health
	BASELINE 2008	
	2	7
	TARGETS TO BE ACHIEVED BY 2009	
	10	7
	TARGETS TO BE ACHIEVED BY 2011	
	14	9
	TARGETS TO BE ACHIEVED BY 2013	
	38	10

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
16 499	19 192	21 400

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

7.3 Social and economic data relevant to health collected, collated and analysed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).	**INDICATORS**
	7.3.1 Number of country reports published during the biennium incorporating disaggregated data and analysis of health equity
	BASELINE 2008
	25
	TARGETS TO BE ACHIEVED BY 2009
	35
	TARGETS TO BE ACHIEVED BY 2011
	40
	TARGETS TO BE ACHIEVED BY 2013
	60

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
13 410	10 027	17 500

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

7.4 Ethics- and 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 using a human rights-based approach to advance health	**7.4.2** Number of tools produced for Member States or the Secretariat giving guidance on use of ethical analysis to improve health policies
BASELINE 2008	
20	8
TARGETS TO BE ACHIEVED BY 2009	
28	12
TARGETS TO BE ACHIEVED BY 2011	
37	16
TARGETS TO BE ACHIEVED BY 2013	
45	20

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
7 423	6 517	9 700

JUSTIFICATION

In addition to normative work on ethics and human rights carried out by core teams, more work will be carried out by staff with relevant background at all levels of the Organization; they will also translate global documents into actions at country level. This growth in expertise and activity across the Organization accounts for the modest biennium-to-biennium budget increase.

7.5 Gender analysis and responsive actions incorporated into WHO's normative work and support provided to Member States for formulation of gender-responsive policies and programmes.

INDICATORS

7.5.1 Number of WHO tools, 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 2008	
38	83
TARGETS TO BE ACHIEVED BY 2009	
54	107
TARGETS TO BE ACHIEVED BY 2011	
70	155
TARGETS TO BE ACHIEVED BY 2013	
86	203

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
10 759	10 243	13 900

JUSTIFICATION

The increased support for gender-related activities across WHO in 2008–2009 reflects commitment to the goal of incorporating this area into the mainstream of work throughout the Organization. In subsequent bienniums, growth is accounted for by increased staff and activities at regional and country levels.

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

Lessons learnt

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

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

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

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

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

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

Lessons learnt

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

The Secretariat will focus on:

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

STRATEGIC APPROACHES

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

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

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

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

The Secretariat will focus on:

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie the achievement of this strategic objective:

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

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

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

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

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

ORGANIZATION-WIDE EXPECTED RESULTS

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

INDICATORS	
8.1.1 Number of Member States that have conducted assessments of specific environmental threats to health or have quantified the environmental burden of disease with WHO technical support during the biennium	**8.1.2** Number of new or updated WHO norms, standards or guidelines on occupational or environmental health issues published during the biennium
BASELINE 2008	
3	5
TARGETS TO BE ACHIEVED BY 2009	
10	10
TARGETS TO BE ACHIEVED BY 2011	
12	12
TARGETS TO BE ACHIEVED BY 2013	
15	15

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
32 960	29 679	35 000

JUSTIFICATION

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

8.2 Technical support and guidance provided to Member States for the implementation of primary prevention interventions that reduce environmental hazards to health, enhance safety and promote public health, including in specific settings (e.g. workplaces, homes or urban settings) and among

INDICATORS
8.2.1 Number of Member States implementing primary prevention interventions for reducing environmental risks to health, with WHO technical support, in at least one of the following settings: workplaces, homes or urban settings
BASELINE 2008
2
TARGETS TO BE ACHIEVED BY 2009
8
TARGETS TO BE ACHIEVED BY 2011
12
TARGETS TO BE ACHIEVED BY 2013
15

vulnerable population groups (e.g. children)

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
35 208	23 922	29 000

JUSTIFICATION

Following successes in tackling occupational environmental health hazards in specific settings in close connection with local partners, there is a strong demand for the Secretariat to revitalize and extend its support to developing and implementing primary prevention interventions in specific settings and to reducing the major risks. New global initiatives have been planned to support interventions for reducing risks and promoting health in the workplace, school, municipality, home and health-care settings, and to document and inform about costs and benefits of different interventions.

8.3 Technical assistance and support provided to Member States for strengthening national occupational and environmental health risk management systems, functions and services

INDICATORS

8.3.1 Number of Member States that have implemented national action plans/policies for the management of occupational health risks, such as in relation to the Global Plan of Action on Workers' Health (2008–2017), with support from WHO

BASELINE 2008

0

TARGETS TO BE ACHIEVED BY 2009

5

TARGETS TO BE ACHIEVED BY 2011

10

TARGETS TO BE ACHIEVED BY 2013

15

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
21 224	16 400	33 000

JUSTIFICATION

The ability of health systems to deal with occupational and environmental health risks is limited and not commensurate with the great potential for primary prevention of disease through better working and living environments. The planned work will strengthen the health sector's ability to plan and deliver good-quality occupational and environmental health services and expand interventions and surveillance through a better evidence base, logistical and technical support, the engagement of a range of organizations in executing initiatives to reduce risks and promote health, for instance among workers in the informal economy.

8.4 Guidance, tools and initiatives created in order to support the health sector in influencing policies in other sectors to allow policies that improve health, the environment and safety to be identified and adopted

INDICATORS

8.4.1 Number of Member States that are implementing WHO-supported initiatives to identify and respond to the health impacts of activities in one or more of the following sectors: agriculture, energy and transportation

BASELINE 2008

0

TARGETS TO BE ACHIEVED BY 2009

3

TARGETS TO BE ACHIEVED BY 2011

5

	TARGETS TO BE ACHIEVED BY 2013
	8

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
21 000	12 349	32 000

JUSTIFICATION

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

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

INDICATORS		
8.5.1 Number of studies or reports on new and re-emerging occupational and environmental health issues published or co-published by WHO	**8.5.2** Number of reports published or jointly published by WHO on progress made in achieving water and sanitation objectives of major international development frameworks, such as the Millennium Development Goals	**8.5.3** Number of high-level regional forums on environment and health issues organized or technically supported by WHO biennially
BASELINE 2008		
3	4	3
TARGETS TO BE ACHIEVED BY 2009		
5	6	4
TARGETS TO BE ACHIEVED BY 2011		
7	8	5
TARGETS TO BE ACHIEVED BY 2013		
9	10	6

RESOURCES (US$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
20 064	15 896	23 000

JUSTIFICATION

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

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

8.6 Evidence-based policies, strategies and recommendations developed, and technical support provided to Member States for identifying, preventing and tackling public health problems resulting from climate change

INDICATORS

8.6.1 Number of studies or reports on the public health effects of climate change published or co-published by WHO	**8.6.2** Number of countries that have implemented plans to enable the health sector to adapt to the health effects of climate change
BASELINE 2008	
Not available	Not available
TARGETS TO BE ACHIEVED BY 2009	
25	10
TARGETS TO BE ACHIEVED BY 2011	
30	30
TARGETS TO BE ACHIEVED BY 2013	
35	50

RESOURCES (US$ THOUSAND)

Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	16 118	

JUSTIFICATION

Climate change affects the fundamental environmental determinants of health, and poses a risk to achievement of the health-related Millennium Development Goals. WHO has previously led international work to describe and assess the health implications of climate change, raise awareness and implement pilot projects. Activities under this Organization-wide expected result will build on this progress, responding to the requests of Member States for supporting evidence, and strengthening health systems to cope with the challenges of climate change. The indicators will be used to measure progress made in, respectively, further strengthening the existing evidence base, and applying this in the implementation of national adaptation plans that protect the health of vulnerable populations from the impact of climate change.