STRATEGIC OBJECTIVE 9

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

**Indicators and targets**

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

### ISSUES AND CHALLENGES

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

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

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

**Lessons learnt**

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

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

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

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

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

### STRATEGIC APPROACHES

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

**The Secretariat will focus on:**

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

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

### ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

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

## ORGANIZATION-WIDE EXPECTED RESULTS

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

| INDICATORS | |
|---|---|
| **9.1.1** Number of Member States that have functional institutionalized coordination mechanisms to promote intersectoral approaches and actions in the area of food safety, food security or nutrition | **9.1.2** Number of Member States that have included nutrition, food-safety and food-security activities and a mechanism for their financing in their sector-wide approaches or Poverty Reduction Strategy Papers |
| **BASELINE 2008** | |
| 30 | 44 |
| **TARGETS TO BE ACHIEVED BY 2009** | |
| 55 | 55 |
| **TARGETS TO BE ACHIEVED BY 2011** | |
| 70 | 70 |
| **TARGETS TO BE ACHIEVED BY 2013** | |
| 80 | 80 |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 16 975 | 18 481 | 10 000 |

**JUSTIFICATION**

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

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

| INDICATORS | |
|---|---|
| **9.2.1** Number of new nutrition and food-safety standards, guidelines or training manuals produced and disseminated to Member States and the international community | **9.2.2** Number of new norms, standards, guidelines, tools and training materials for prevention and management of zoonotic and non-zoonotic foodborne diseases |
| **BASELINE 2008** | |
| 4 (+106 Codex standards) | 2 |
| **TARGETS TO BE ACHIEVED BY 2009** | |
| 15 (+105 Codex standards) | 3 |
| **TARGETS TO BE ACHIEVED BY 2011** | |
| 20 (+200 Codex standards) | 5 |
| **TARGETS TO BE ACHIEVED BY 2013** | |
| 20 (+200 Codex standards) | 5 |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 30 031 | 30 496 | 30 000 |

**JUSTIFICATION**

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

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

**INDICATORS**

| **9.3.1** Number of Member States that have adopted and implemented the WHO Child Growth Standards | **9.3.2** Number of Member States that have nationally representative surveillance data on major forms of malnutrition |
|---|---|
| **BASELINE 2008** | |
| 20 | 90 |
| **TARGETS TO BE ACHIEVED BY 2009** | |
| 50 | 100 |
| **TARGETS TO BE ACHIEVED BY 2011** | |
| 70 | 120 |
| **TARGETS TO BE ACHIEVED BY 2013** | |
| 100 | 150 |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 18 509 | 17 709 | 15 000 |

**JUSTIFICATION**

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

**9.4** Capacity built and support provided to target Member States for the development, strengthening and implementation of nutrition plans, policies and programmes aimed at improving nutrition throughout the life-course, in stable and emergency situations.

**INDICATORS**

| **9.4.1** Number of Member States that have implemented at least three high-priority actions recommended in the Global Strategy for Infant and Young Child Feeding | **9.4.2** Number of Member States that have implemented strategies to prevent and control micronutrient malnutrition | **9.4.3** Number of Member States that have implemented strategies to promote healthy dietary practices for preventing diet-related chronic diseases | **9.4.4** Number of Member States that have included nutrition in their responses to HIV/AIDS | **9.4.5** Number of Member States that have national preparedness and response plans for nutritional emergencies |
|---|---|---|---|---|
| **BASELINE 2008** | | | | |
| 60 | 40 | 40 | 65 | 30 |
| **TARGETS TO BE ACHIEVED BY 2009** | | | | |
| 90 | 70 | 70 | 65 | 45 |
| **TARGETS TO BE ACHIEVED BY 2011** | | | | |
| 105 | 75 | 75 | 70 | 50 |
| **TARGETS TO BE ACHIEVED BY 2013** | | | | |
| 120 | 80 | 80 | 80 | 70 |

**RESOURCES** (US$ THOUSAND)

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 24 314 | 21 261 | 40 000 |

**JUSTIFICATION**

*Most resources will be used at regional and country levels. WHO's presence in nutrition and food safety at these levels will also be substantially enhanced. In 2008–2009 resources will be used adequately to staff regional, subregional and country offices and to support the effective implementation of nutrition interventions according to countries' needs and demands. During the bienniums 2010–2011 and 2012–2013, the amount of resources required is expected to fall slightly. Enhancement of countries' programmes could lead to a reduction in the demand for direct technical support.*

**9.5** Systems for surveillance, prevention and control of zoonotic and non-zoonotic foodborne diseases strengthened; food-hazard monitoring and evaluation programmes established and integrated into existing national surveillance systems, and results disseminated to all key players.

**INDICATORS**

| **9.5.1** Number of Member States that have established or strengthened intersectoral collaboration for the prevention, control and surveillance of foodborne zoonotic diseases | **9.5.2** Number of Member States that have initiated a plan for the reduction in the incidence of at least one major foodborne zoonotic disease |
|---|---|
| **BASELINE 2008** | |
| 20 | 50 |
| **TARGETS TO BE ACHIEVED BY 2009** | |
| 30 | 60 |
| **TARGETS TO BE ACHIEVED BY 2011** | |
| 45 | 80 |
| **TARGETS TO BE ACHIEVED BY 2013** | |
| 60 | 90 |

**RESOURCES** (US$ THOUSAND)

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 17 032 | 16 714 | 30 000 |

**JUSTIFICATION**

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

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

**INDICATORS**

| **9.6.1** Number of selected Member States receiving support to participate in international standard-setting activities related to food, such as those of the Codex Alimentarius Commission | **9.6.2** Number of selected Member States that have built national systems for food safety with international links to emergency systems |
|---|---|
| **BASELINE 2008** | |
| 90 | 30 |
| **TARGETS TO BE ACHIEVED BY 2009** | |
| 90 | 40 |
| **TARGETS TO BE ACHIEVED BY 2011** | |
| 90 | 60 |
| **TARGETS TO BE ACHIEVED BY 2013** | |
| 110 | 80 |

**RESOURCES** (US$ THOUSAND)

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 20 073 | 15 724 | 30 000 |

**JUSTIFICATION**

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

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

**Indicators and targets**

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

## ISSUES AND CHALLENGES

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

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

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

**Lessons learnt**

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

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

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

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

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

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

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

**Lessons learnt**

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

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

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

**Lessons learnt**

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

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

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

## STRATEGIC APPROACHES

WHO's approach to country support will be tailored to the political, cultural and social context of which the health system is part. It will centre on the renewal of primary health care by moving towards universal coverage; putting people at the centre of service delivery; integrating health into public policies across sectors; and investing in inclusive leadership for better health governance. It will be guided by the values and principles of Health For All and relevant Health Assembly resolutions.

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

**The Secretariat will focus on:**

- working with countries to renew and reinvigorate health systems based on primary health care, to promote more equitable health systems;
- four broad policy directions for reducing health inequalities and improving health for all: organizing health-care delivery around people-centred primary care; ensuring universal access with social protection; promoting health in all policies; and building national capacities for inclusive and accountable health leadership;
- diagnosing health-system constraints through use of consistent approaches that incorporate a system-wide perspective, yet are sufficiently flexible to be used by programme and systems groups with different entry points;
- producing and communicating norms, standards and guidelines on health and health systems; developing standardized methods, such as for national health accounting in low- and middle-income countries, and cost-effectiveness tools; and defining a set of measurements that capture the status and performance of a health system;

research; and provide support for countries' monitoring of trends in health systems and their performance.

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

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

WHO will use its convening power and authority to shape the environment of international health aid for the health sector in line with the Paris Declaration on Aid Effectiveness.

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

### ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

**The Secretariat will focus on:**

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

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

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

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

**The Secretariat will focus on:**

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

## ORGANIZATION-WIDE EXPECTED RESULTS

**10.1** Management and organization of integrated, population-based health-service delivery through public and nonpublic providers and networks improved, reflecting the primary health care strategy, scaling up coverage, equity, quality and safety of personal and population-based health services, and enhancing health outcomes.

**INDICATORS**

| | | |
|---|---|---|
| **10.1.1** Number of Member States that have regularly updated databases on numbers and distribution of health facilities and health interventions offered | | |
| **BASELINE 2008** | | |
| 15 | | |
| **TARGETS TO BE ACHIEVED BY 2009** | | |
| 20 | | |
| **TARGETS TO BE ACHIEVED BY 2011** | | |
| 30 | | |
| **TARGETS TO BE ACHIEVED BY 2013** | | |
| 49 | | |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 73 379 | 109 865 | 96 000 |

**JUSTIFICATION**

*The management and organization of service delivery presents challenges for many countries, particularly where management of health systems is fragmented, and for WHO, which will need to adjust its way of operating. Progress towards this objective will be measured in terms of results and improvement in institutional arrangements, specifically the integration of programme and system development. The former will use composite indicators that are being operationalized. The latter will assess evolution over time against country or region-specific benchmarks that take regional context into account. As WHO's way of working evolves and its capacity for support expands, demand for support is expected to grow, which will require increased funding.*

**10.2** National capacities for governance and leadership improved through evidence-based policy dialogue, institutional capacity-building for policy analysis and development, strategy-based health system performance assessment, greater transparency and accountability for performance, and more effective intersectoral collaboration.

**INDICATORS**

| | |
|---|---|
| **10.2.1** Number of Member States that have in the last five years developed a comprehensive national health planning processes in consultation with stakeholders | **10.2.2**Number of Member States that conduct a regular or periodic evaluation of progress, including implementation of their national health plan, based on a commonly agreed performance assessment of their health system |
| **BASELINE 2008** | |
| 69 | 27 |
| **TARGETS TO BE ACHIEVED BY 2009** | |
| 88 | 45 |
| **TARGETS TO BE ACHIEVED BY 2011** | |
| 103 | 56 |
| **TARGETS TO BE ACHIEVED BY 2013** | |
| 117 | 67 |

| RESOURCES (US$ THOUSAND) | | |
|---|---|---|
| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
| 87 484 | 48 058 | 108 000 |

**JUSTIFICATION**

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

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

**10.3** Coordination of the various mechanisms (including donor assistance) that provide support to Member States in their efforts to achieve national targets for health-system development and global health goals improved.

**INDICATORS**

**10.3.1** Number of Member States where the inputs of major stakeholders are harmonized with national policies, measured in line with the Paris Declaration on Aid Effectiveness

**BASELINE 2008**

5

**TARGETS TO BE ACHIEVED BY 2009**

16

**TARGETS TO BE ACHIEVED BY 2011**

23

**TARGETS TO BE ACHIEVED BY 2013**

29

| RESOURCES (US$ THOUSAND) | | |
|---|---|---|
| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
| 15 801 | 17 295 | 17 000 |

JUSTIFICATION

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

| | |
|---|---|
| **10.4** Country health-information systems that provide and use high-quality and timely information for health planning and for monitoring progress towards national and major international goals strengthened. | **INDICATORS** |
| | **10.4.1** Proportion of low- and middle-income countries with adequate health statistics and monitoring of health-related Millennium Development Goals that meet agreed standards |
| | **BASELINE 2008** |
| | 30% |
| | **TARGETS TO BE ACHIEVED BY 2009** |
| | 35% |
| | **TARGETS TO BE ACHIEVED BY 2011** |
| | 45% |
| | **TARGETS TO BE ACHIEVED BY 2013** |
| | 66% |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 34 352 | 26 574 | 58 000 |

**JUSTIFICATION**

*The increasing demand for health information is likely to continue, and only through a major effort will countries' health-information systems become stronger. Through major partnerships, notably the Health Metrics Network, more resources have become available in 2006-2007. It is expected that growth will continue modestly beyond 2010 because strengthening health-information systems in countries will take many years, especially for some neglected areas such as vital registration systems.*

**10.5.** Better knowledge and evidence for health decision-making assured through consolidation and publication of existing evidence, facilitation of knowledge generation in priority areas, and global leadership in health research policy and coordination, including with regard to ethical conduct.

| INDICATORS | | |
|---|---|---|
| **10.5.1** Proportion of countries for which high quality profiles with core health statistics are available from its open-access databases | **10.5.2** Number of countries in which WHO plays a key role in supporting the generation and use of information and knowledge, including primary data collection through surveys, civil registration or improvement or analysis and synthesis of health facility data for policies and planning | **10.5.3** Effective research for health coordination and leadership mechanisms established and maintained at global and regional levels |
| **BASELINE 2008** | | |
| 66% | 20 | Mechanisms operating at global and some regional levels |
| **TARGETS TO BE ACHIEVED BY 2009** | | |
| 80% | 30 | Mechanisms operating at global and all regional levels |
| **TARGETS TO BE ACHIEVED BY 2011** | | |
| 85% | 35 | Mechanisms operating at global and all regional levels |
| **TARGETS TO BE ACHIEVED BY 2013** | | |
| Over 90% | 45 | Mechanisms operating at global and all regional levels |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Programme budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 36 484 | 37 751 | 38 000 |

**JUSTIFICATION**

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

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

**INDICATORS**

| 10.6.1 | 10.6.2 |
|---|---|
| **10.6.1** Proportion of low- and middle-income countries in which national health-research systems meet internationally agreed minimum standards | **10.6.2** Number of Member States complying with the recommendation to dedicate at least 2% of their health budget to research (Commission on Health Research for Development, 1990) |
| **BASELINE 2008** | |
| 10%–15% (to be refined) | Less than 25% (to be refined) |
| **TARGETS TO BE ACHIEVED BY 2009** | |
| 25% | 10% increase from baseline 2008 |
| **TARGETS TO BE ACHIEVED BY 2011** | |
| 33% | 8% increase from 2009 target |
| **TARGETS TO BE ACHIEVED BY 2013** | |
| 50% | 25% increase from baseline 2008 |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 21 088 | 17 028 | 38 000 |

**JUSTIFICATION**

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

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

**INDICATORS**

| 10.7.1 | 10.7.2 | 10.7.3 |
|---|---|---|
| **10.7.1** Number of Member States adopting knowledge management policies in order to bridge the "know-how" gap particularly aimed to decrease the digital divide | **10.7.2** Number of Member States with access to electronic international scientific journals and knowledge archives in health sciences as assessed by the WHO Global Observatory for eHealth biannual survey | **10.7.3** Proportion of Member States with eHealth policies, strategies and regulatory frameworks as assessed by the WHO Global Observatory for eHealth biannual survey |
| **BASELINE 2008** | | |
| 15 | 60 | 15 |
| **TARGETS TO BE ACHIEVED BY 2009** | | |
| 30 | 90 | 30 |
| **TARGETS TO BE ACHIEVED BY 2011** | | |
| 45 | 100 | 50 |

**TARGETS TO BE ACHIEVED BY 2013**

| | | |
|---|---|---|
| 70 | 120 | 70 |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Budget 2008–2009 |
|---|---|---|
| 39 064 | 24 774 | 39 064 |

**JUSTIFICATION**

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

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

**INDICATORS**

| **10.8.1** Number of countries reporting two or more national data points on human resources for health within the past five years, reported in the Global Atlas of the Health Workforce | **10.8.2** Number of Member States with an national policy and planning unit for human resources for health |
|---|---|

**BASELINE 2008**

| | |
|---|---|
| 63 | 40 |

**TARGETS TO BE ACHIEVED BY 2009**

| | |
|---|---|
| 75 | 50 |

**TARGETS TO BE ACHIEVED BY 2011**

| | |
|---|---|
| 85 | 55 |

**TARGETS TO BE ACHIEVED BY 2013**

| | |
|---|---|
| 96 | 60 |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 76 216 | 37 058 | 67 000 |

**JUSTIFICATION**

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

**10.9** Technical support provided to Member States, with a focus on those facing severe health-workforce difficulties in order to improve the production,

**INDICATORS**

| **10.9.1** Proportion of 57 countries with critical shortage of health workforce, as identified in *The world health report 2006* with a multi-year HRH plan | **10.9.2** Proportion of 57 countries with critical shortage of health workforce, as identified in *The world health report 2006* which have an investment plan for scaling up training and education of health workers |
|---|---|

**BASELINE 2008**

| | |
|---|---|
| Less than 10% | Less than 10% |

distribution, skill mix and retention of the health workforce.

**TARGETS TO BE ACHIEVED BY 2009**

| | |
|---|---|
| At least 10% | At least 10% |

**TARGETS TO BE ACHIEVED BY 2011**

| | |
|---|---|
| At least 20% | At least 20% |

**TARGETS TO BE ACHIEVED BY 2013**

| | |
|---|---|
| At least 50% | At least 50% |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 40 041 | 53 979 | 62 000 |

**JUSTIFICATION**

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

**10.10** Evidence-based policy and technical support provided to Member States in order to improve health-system financing in terms of the availability of funds, social and financial-risk protection, equity, access to services and efficiency of resource use.

**INDICATORS**

| | |
|---|---|
| **10.10.1** Number of Member States provided with technical and policy support to raise additional funds for health; to reduce financial barriers to access, incidence of financial catastrophe, and impoverishment linked to health payments; or to improve social protection and the efficiency and equity of resource use | **10.10.1** Number of key policy briefs prepared, disseminated and their use supported, which document best practices on revenue-raising, pooling and purchasing, including contracting, provision of interventions and services, and handling of fragmentation in systems associated with vertical programmes and inflow of international funds |

**BASELINE 2008**

| | |
|---|---|
| 15 | 6 technical briefs for policy-makers |

**TARGETS TO BE ACHIEVED BY 2009**

| | |
|---|---|
| 40 | 12 technical briefs |

**TARGETS TO BE ACHIEVED BY 2011**

| | |
|---|---|
| 75 | 16 technical briefs |

**TARGETS TO BE ACHIEVED BY 2013**

| | |
|---|---|
| 90 | 20 technical briefs |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 31 249 | 25 941 | 41 000 |

**JUSTIFICATION**

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

| **10.11** Norms, standards and measurement tools developed for tracking resources, estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe, impoverishment, and social exclusion, and their use supported and monitored. | | |
|---|---|---|
| | **INDICATORS** | |
| | **10.11.1** Key tools, norms and standards to guide policy development and implementation developed, disseminated and their use supported, according to expressed need, that comprise resource tracking and allocation, budgeting, financial management, economic consequences of disease and social exclusion, organization and efficiency of service delivery, including contracting, or the incidence of financial catastrophe and impoverishment | **10.11.2** Number of Member States provided with technical support for using WHO tools to track and evaluate the adequacy and use of funds, to estimate future financial needs, to manage and monitor available funds, or to track the impact of financing policy on households |
| | **BASELINE 2008** | |
| | Tools produced and disseminated on national health accounts, costing, financial catastrophe and impoverishment, cost-effectiveness, implications of health-insurance design, and contracting | 15 |
| | **TARGETS TO BE ACHIEVED BY 2009** | |
| | Additional tools developed for resource tracking, additionality and economic burden; existing tools revised where necessary; framework drawn up for formulation of financing policy | 30 |
| | **TARGETS TO BE ACHIEVED BY 2011** | |
| | Tools and frameworks modified, updated and disseminated as necessary | 40 |
| | **TARGETS TO BE ACHIEVED BY 2013** | |
| | Tools and frameworks modified, updates and disseminated as necessary | 50 |

| **RESOURCES** (US$ THOUSAND) | | |
|---|---|---|
| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
| 23 896 | 15 697 | 28 000 |

**JUSTIFICATION**

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

<table>
<tr><td rowspan="14">**10.12** Steps taken to advocate additional funds for health where necessary; to build capacity in framing of health-financing policy and interpretation and use of financial information; and to stimulate the generation and translation of knowledge to support policy development.</td><td colspan="3">**INDICATORS**</td></tr>
<tr><td>**10.12.1** WHO presence and leadership in international, regional and national partnerships and use of its evidence in order to increase financing for health in low-income countries, or provide support to countries in design and monitoring of Poverty Reduction Strategy Papers, sector-wide approaches, medium-term expenditure frameworks, and other long-term financing mechanisms capable of providing social health protect consistent with primary health care</td><td colspan="2">**10.12.2** Number of Member States provided with support to build capacity in the formulation of health financing policies and strategies and the interpretation of financial data, or with key information on health expenditures, financing, efficiency and equity to guide the process</td></tr>
<tr><td colspan="3">**BASELINE 2008**</td></tr>
<tr><td>WHO participation in 2 global or regional partnerships on financing options; support provided on long-term financing options in 6 countries</td><td colspan="2">Technical support provided to 25 countries and annual updates on health expenditure to all 193 Member States</td></tr>
<tr><td colspan="3">**TARGETS TO BE ACHIEVED BY 2009**</td></tr>
<tr><td>WHO participation in 4 partnerships; country support provided on long-term financing options in 16 countries</td><td colspan="2">Technical support provided to 55 countries, and annual updates of health expenditures to all Member States, together with information on the incidence of catastrophic expenditures in 90 countries</td></tr>
<tr><td colspan="3">**TARGETS TO BE ACHIEVED BY 2011**</td></tr>
<tr><td>WHO participation in 6 partnerships; country support provided on long-term financing options in 28 countries</td><td colspan="2">Technical support provided to 75 countries, and annual updates of health expenditures to all Member States, together with new information on the incidence of catastrophic expenditures in 20 countries</td></tr>
<tr><td colspan="3">**TARGETS TO BE ACHIEVED BY 2013**</td></tr>
<tr><td>WHO participation in 8 partnerships; support provided to 40 countries</td><td colspan="2">Technical support provided to 90 countries, annual updates of health expenditures to all Member States, and revised and updated information on catastrophic expenditures to an additional 20 countries</td></tr>
<tr><td colspan="3">**RESOURCES** (US$ THOUSAND)</td></tr>
<tr><td>Budget 2008–2009</td><td>Proposed budget 2010–2011</td><td>Estimates 2012–2013</td></tr>
<tr><td>35 000</td><td>15 209</td><td>47 000</td></tr>
<tr><td colspan="3">**JUSTIFICATION**<br>*WHO has contributed to international and national efforts to raise additional financing for health in poor countries and for vulnerable groups everywhere. It is important to build up momentum internationally and to provide active support to countries so as to incorporate health into economic plans such as medium-term expenditure frameworks. Capacity of country offices and other levels of WHO needs to be strengthened in support of these efforts.*</td></tr>
</table>

<table>
<tr><td rowspan="14">10.13 Evidence based norms, standards and measurement tools developed to support Member States to quantify and decrease the level of unsafe health care provided.</td><td colspan="3">INDICATORS</td></tr>
<tr><td colspan="2">10.13.1 Key tools, norms and standards to guide policy development, measurement and implementation disseminated and their use supported</td><td>10.13.2 Number of Member States participating in global patient safety challenges and other global safety initiatives, including research and measurement</td></tr>
<tr><td colspan="3">BASELINE 2008</td></tr>
<tr><td colspan="2">Not available</td><td>Not available</td></tr>
<tr><td colspan="3">TARGETS TO BE ACHIEVED BY 2009</td></tr>
<tr><td colspan="2">1 global safety standard and 10 major supporting tools</td><td>30</td></tr>
<tr><td colspan="3">TARGETS TO BE ACHIEVED BY 2011</td></tr>
<tr><td colspan="2">2 global safety standards and 20 major supporting tools</td><td>45</td></tr>
<tr><td colspan="3">TARGETS TO BE ACHIEVED BY 2013</td></tr>
<tr><td colspan="2">4 global safety standards and 40 major supporting tools</td><td>90</td></tr>
<tr><td colspan="3">RESOURCES (US$ THOUSAND)</td></tr>
<tr><td>Budget 2008–2009</td><td>Proposed budget 2010–2011</td><td>Estimates 2012–2013</td></tr>
<tr><td></td><td>44 975</td><td></td></tr>
<tr><td colspan="3">JUSTIFICATION<br>Patient safety has become a global health agenda. WHO will provide norms and guidelines to support Member States in estimating and tracking the nature and the size of the problem. WHO will also provide evidence-based guidelines for improving safety in priority areas. The response of WHO needs to be comprehensive. The Secretariat and Member States must work together to improve safety and coordinate international expertise.</td></tr>
</table>

STRATEGIC OBJECTIVE 11

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

**Indicators and targets**

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

## ISSUES AND CHALLENGES

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

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

**Lessons learnt**

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

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

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

## STRATEGIC APPROACHES

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

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

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

Emphasis will also be laid on promoting a public health approach to innovation, providing support to countries for using the flexibilities provided for in the Agreement on Trade-Related Aspects of Intellectual Property Rights, and adapting interventions that have proved successful in high-income countries to the needs and conditions of low- and middle-income countries. The work of the Intergovernmental The Intergovernmental Working Group on Public Health, Innovation and Intellectual Property completed its work with the adoption by the Health Assembly of the global strategy and plan of action on public health, innovation and intellectual property (resolution WHA61.21). The global strategy and plan of action aim to promote new thinking on innovation and access to medicines. They respond to the need to identify ways in which appropriate levels of research and development can be funded and undertaken on diseases that disproportionately

**The Secretariat will focus on:**

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

affect developing countries; and they focus on the need to generate innovative health products and make them available to those that require them. Many of the specific actions within the global plan fall under the responsibility of WHO, including regular monitoring of global implementation and reporting on progress made. Within the Secretariat, implementation of the plan of action will concern a number of strategic objectives and involve activities at all levels of the Organization. In addition, monitoring access, safety, quality, effectiveness and use of products and technologies through independent assessments will be encouraged. The Secretariat will combine its recognized technical leadership role and unique global normative functions with international advocacy, policy guidance and targeted country support.

**The Secretariat will focus on:**

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

## ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

The following risks may hinder achievement of the strategic objective:

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

## ORGANIZATION-WIDE EXPECTED RESULTS

**11.1** Formulation and monitoring of comprehensive national policies on access, quality and use of essential medical products and technologies advocated and supported.

**INDICATORS**

| 11.1.1 | 11.1.2 | 11.1.3 | 11.1.4 |
|---|---|---|---|
| **11.1.1** Number of Member States receiving support to formulate and implement official national policies on access, quality and use of essential medical products or technologies | **11.1.2** Number of Member States receiving support to design or strengthen comprehensive national procurement or supply systems | **11.1.3** Number of Member States receiving support to formulate and/or implement national strategies and regulatory mechanisms for blood and blood products or infection control | **11.1.4** Publication of a biennial global report on medicine prices, availability and affordability, based on all available regional and national reports |
| **BASELINE 2008** | | | |
| 62 | 20 | 46 | Report published in 2007 |
| **TARGETS TO BE ACHIEVED BY 2009** | | | |
| 68 | 25 | 52 | Report published |
| **TARGETS TO BE ACHIEVED BY 2011** | | | |
| 73 | 30 | 58 | Report published |
| **TARGETS TO BE ACHIEVED BY 2013** | | | |
| 78 | 35 | 64 | 2 reports published (2011 and 2013) |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 39 305 | 46 230 | 44 000 |

**JUSTIFICATION**

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

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

**INDICATORS**

| 11.2.1 | 11.2.2 | 11.2.3 | 11.2.4 |
|---|---|---|---|
| **11.2.1** Number of new or updated global quality standards, reference preparations, guidelines and tools for improving the provision, management, use, quality, or effective regulation of medical products and technologies | **11.2.2** Number of assigned International Nonproprietary Names for medical products | **11.2.3** Number of priority medicines, vaccines, diagnostic tools and items of equipment that are prequalified for United Nations procurement | **11.2.4** Number of Member States for which the functionality of the national regulatory authorities has been assessed or supported |
| **BASELINE 2008** | | | |
| 30 per biennium | 8900 | 150 | 20 |

| | | | | |
|---|---|---|---|---|
| | **TARGETS TO BE ACHIEVED BY 2009** | | | |
| | 30 additional | 9100 | 250 | 30 |
| | **TARGETS TO BE ACHIEVED BY 2011** | | | |
| | 15 additional | 9200 | 300 | 45 |
| | **TARGETS TO BE ACHIEVED BY 2013** | | | |
| | 15 additional | 9300 | 350 | 60 |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 69 172 | 50 313 | 104 000 |

**JUSTIFICATION**

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

**11.3** Evidence-based policy guidance on promoting scientifically sound and cost-effective use of medical products and technologies by health workers and consumers developed and supported within the Secretariat and regional and national programmes.

| | |
|---|---|
| **INDICATORS** | |
| **11.3.1** Number of national or regional programmes receiving support for promoting sound and cost-effective use of medical products or technologies | **11.3.2** Number of Member States using national lists, updated within the past five years, of essential medicines, vaccines or technologies for public procurement or reimbursement |
| **BASELINE 2008** | |
| 5 | 80 |
| **TARGETS TO BE ACHIEVED BY 2009** | |
| 10 | 90 |
| **TARGETS TO BE ACHIEVED BY 2011** | |
| 15 | 95 |
| **TARGETS TO BE ACHIEVED BY 2013** | |
| 20 | 100 |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 25 556 | 18 584 | 34 000 |

**JUSTIFICATION**

*It is important that continued attention should be paid to promoting the rational use of medicines by both prescribers and consumers – something that is seen as primarily being WHO's responsibility. Without improvements in this area health outcomes cannot be fully attained and much of the new funding may be wasted. This is an area where WHO, if so requested, could provide expertise to new funding mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the International Drug Purchase Facility – UNITAID.*

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

**Indicators and targets**

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

## ISSUES AND CHALLENGES

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

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

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

**Lessons learnt**

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

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

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

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

**Lessons learnt**

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

## STRATEGIC APPROACHES

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

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

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

### ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of the strategic objective:

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

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

## ORGANIZATION-WIDE EXPECTED RESULTS

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

**INDICATORS**

| | |
|---|---|
| **12.1.1** Proportion of documents submitted to governing bodies within constitutional deadlines in the six WHO official languages | **12.1.2** Level of understanding by key stakeholders of WHO's role, priorities and key messages as provided by a stakeholder survey |
| **BASELINE 2008** | |
| 50% | 76% of stakeholders familiar/very familiar with WHO roles and priorities |
| **TARGETS TO BE ACHIEVED BY 2009** | |
| 75% | 86% of stakeholders familiar/very familiar with WHO roles and priorities |
| **TARGETS TO BE ACHIEVED BY 2011** | |
| 85% | 91% of stakeholders familiar/very familiar with WHO roles and priorities |
| **TARGETS TO BE ACHIEVED BY 2013** | |
| 90% | 96% of stakeholders familiar/very familiar with WHO roles and priorities |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 87 222 | 151 192 | 108 128 |

**JUSTIFICATION**

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

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

**INDICATORS**

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

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

**TARGETS TO BE ACHIEVED BY 2011**

| | | |
|---|---|---|
| 115 | 60% | |

**TARGETS TO BE ACHIEVED BY 2013**

| | | |
|---|---|---|
| 145 | 80% | |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 71 128 | 24 182 | 87 481 |

**JUSTIFICATION**

*WHO's commitment to strengthen operations have greater impact at country level will be maintained and may require resources in the coming years in order, for example, to increase ability to collaborate more with country-level partners and harmonization mechanisms.*

**12.3** Global health and development mechanisms established to provide more sustained and predictable technical and financial resources for health on the basis of a common health agenda which responds to the health needs and priorities of Member States.

**INDICATORS**

| **12.3.1** Number of health partnerships in which WHO participates that work according to the best practice principles for Global Health Partnerships | **12.3.2** Proportion of health partnerships managed by WHO that comply with WHO partnership policy guidance | **12.3.3** Proportion of countries where WHO is leading or actively engaged in health and development partnerships (formal and informal), including in the context of reforms of the United Nations system |
|---|---|---|
| **BASELINE 2008** | | |
| 3 | 0% | Less than 20% |
| **TARGETS TO BE ACHIEVED BY 2009** | | |
| 10 | 14% | Over 50% |
| **TARGETS TO BE ACHIEVED BY 2011** | | |
| 30 | 50% | 70% |
| **TARGETS TO BE ACHIEVED BY 2013** | | |
| 50 | 100% | To be established by 2009 |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 21 030 | 20 143 | 26 058 |

**JUSTIFICATION**

*A slight increase of resources is foreseen in this Organization-wide expected result for the coming years, as it becomes increasingly important to collaborate more actively globally and regionally with other actors in health and development.*

**12.4** Essential multilingual health knowledge and advocacy material made accessible to Member States, health partners and other stakeholders through the effective exchange and sharing of knowledge.

**INDICATORS**

| **12.4.1** Average number of page views/visits per month to the WHO headquarters' web site | **12.4.2** Number of pages in languages other than English available on WHO country and regional offices' and headquarters' web sites |
|---|---|
| **BASELINE 2008** | |
| 28 million/3.5 million | 12 733 |
| **TARGETS TO BE ACHIEVED BY 2009** | |
| 48 million/5 million | 22 000 |

**TARGETS TO BE ACHIEVED BY 2011**

| | |
|---|---|
| 65 million/6 million | 30 000 |

**TARGETS TO BE ACHIEVED BY 2013**

| | |
|---|---|
| 80 million/7 million | 40 000 |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 34 964 | 27 200 | 43 333 |

**JUSTIFICATION**

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

STRATEGIC OBJECTIVE 13

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

**Indicators and targets**

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

## ISSUES AND CHALLENGES

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

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

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

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

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

**Lessons learnt**

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

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

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

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

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

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

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

**The Secretariat will focus on:**

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

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

### STRATEGIC APPROACHES

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

### ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of the strategic objective:

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

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

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

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

## ORGANIZATION-WIDE EXPECTED RESULTS

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

| INDICATORS | |
|---|---|
| **13.1.1** Proportion of country workplans that have been peer reviewed with respect to their technical quality, that they incorporate lessons learnt and reflect country needs | **13.1.2** Office Specific Expected Results (OSERs) for which progress status has been updated within the established timeframes for periodic reporting |
| **BASELINE 2008** | |
| 60% | 60% |
| **TARGETS TO BE ACHIEVED BY 2009** | |
| 75% | 80% |
| **TARGETS TO BE ACHIEVED BY 2011** | |
| 90% | 85% |
| **TARGETS TO BE ACHIEVED BY 2013** | |
| 95% | 90% |

| RESOURCES (US$ THOUSAND) | | |
|---|---|---|
| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
| 36 916 | 35 260 | 43 805 |

**JUSTIFICATION**

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

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

| INDICATORS | |
|---|---|
| **13.2.1** Degree of compliance of WHO with International Public Sector Accounting Standards | **13.2.2** Amount of voluntary contributions that are classified as fully and highly flexible |
| **BASELINE 2008** | |
| Accounting Standards not implemented | Not available |
| **TARGETS TO BE ACHIEVED BY 2009** | |
| International Public Sector Accounting Standards implemented | US$ 200 million |
| **TARGETS TO BE ACHIEVED BY 2011** | |
| Not available | US$ 300 million |
| **TARGETS TO BE ACHIEVED BY 2013** | |
| Not available | US$ 400 million |

| RESOURCES (US$ THOUSAND) | | |
|---|---|---|
| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
| 60 654 | 71 264 | 72 538 |

**JUSTIFICATION**

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

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

**INDICATORS**

| **13.3.1** Proportion of offices with approved human resources plans for a biennium | **13.3.2** Number of staff assuming a new position or moving to a new location during a biennium (delayed until biennium 2010–2011) | **13.3.3** Proportion of staff in compliance with the cycle of the Performance Management Development System |
|---|---|---|
| **BASELINE 2008** | | |
| 40% | 100 | 65% |
| **TARGETS TO BE ACHIEVED BY 2009** | | |
| 75% | 300 | 75% |
| **TARGETS TO BE ACHIEVED BY 2011** | | |
| 85% | 300 | 85% |
| **TARGETS TO BE ACHIEVED BY 2013** | | |
| 100% | 500 | 95% |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 29 630 | 37 863 | 35 549 |

**JUSTIFICATION**

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

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

**INDICATORS**

| **13.4.1** Number of information technology disciplines implemented Organization-wide according to industry-best-practices benchmarks | **13.4.2** Proportion of offices using consistent real-time management information |
|---|---|
| **BASELINE 2008** | |
| 0 | 0 |
| **TARGETS TO BE ACHIEVED BY 2009** | |
| 3 | Headquarters, 5 regional offices and associated country offices |
| **TARGETS TO BE ACHIEVED BY 2011** | |
| 5 | Headquarters, 5 regional offices and associated country offices |
| **TARGETS TO BE ACHIEVED BY 2013** | |
| 7 | All relevant WHO locations, including sub-country and field offices, where appropriate |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 106 228 | 109 393 | 127 483 |

**JUSTIFICATION**

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

**13.5** Managerial and administrative support services[1] necessary for the efficient functioning of the Organization provided in accordance with service-level agreements that emphasize quality and responsiveness.

**INDICATORS**

**13.5.1** Proportion of services delivered by the global service centre according to criteria in service-level agreements

**BASELINE 2008**

0%

**TARGETS TO BE ACHIEVED BY 2009**

75%

**TARGETS TO BE ACHIEVED BY 2011**

90%

**TARGETS TO BE ACHIEVED BY 2013**

100%

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 149 647 | 133 818 | 179 217 |

**JUSTIFICATION**

*The overall workload is increasing throughout the Organization, and support services must reflect that. At the same time, efforts to find more cost-effective ways of working will lead to some savings. However, over the biennium 2008–2009, the level of resources need to be increased slightly. Costing will be refined over the next few months in the context of a global review of service delivery.*

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

**13.6** Working environment conducive to the well-being and safety of staff in all locations.

**INDICATORS**

| | 13.6.1 Degree of satisfaction with quality of services in all major offices resulting from the provision of effective infrastructure support | 13.6.2 Proportion of offices that have conducted regular building evacuation exercises |
|---|---|---|
| BASELINE 2008 | None | 30% |
| TARGETS TO BE ACHIEVED BY 2009 | 60% | 50% |
| TARGETS TO BE ACHIEVED BY 2011 | 75% | 80% |
| TARGETS TO BE ACHIEVED BY 2013 | 85% | 100% |

**RESOURCES (US$ THOUSAND)**

| Budget 2008–2009 | Proposed budget 2010–2011 | Estimates 2012–2013 |
|---|---|---|
| 159 297 | 136 289 | 181 408 |

**JUSTIFICATION**

*The increase for this expected result stems mainly from increased security costs incurred in reaching compliance with Minimum Operating Safety Standards. The overall resource requirement will be refined over the coming months as the capital master plan is drawn up. Resource requirements includes the security fund as well as the Real Estate Fund.*