

MTSP/2008-2013  
PPB/2008-2009

Original: English

**DRAFT MEDIUM-TERM STRATEGIC PLAN 2008-2013**

**DRAFT PROPOSED PROGRAMME BUDGET 2008-2009**

The designations employed and the presentation of the material in this document do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

Geneva, November 2006

*... I want us to be judged by the impact we have on the health of the people of Africa, and the health of women.*

*All regions, all countries, all people are equally important. This is a health organization for the whole world. Our work must touch on the lives of everyone, everywhere. But we must focus our attention on the people in greatest need.*

*... Our commitment to results is only relevant if we can demonstrate an impact in these two populations.<sup>1</sup>*

I said these words in my acceptance speech to the special session of the World Health Assembly on being elected as Director-General, to demonstrate my personal commitment to making our work even more relevant and significant. All people benefit from the work of WHO. We must do our utmost to maximize these broad benefits, while never losing sight of those who need us most.

I have stressed the importance of knowing our strengths and concentrating on those activities that WHO is uniquely well suited to perform. To meet the increasing demands and challenges in international health requires reviewing ever more critically which expected results and core functions are the most important for WHO and the people we serve. By being selective, we can be more effective.

This commitment to “attaining results for health” is reflected throughout the proposed medium-term strategic plan for 2008–2013, which provides the strategic direction for the Organization for the six-year period. This direction is based on the global health agenda and core functions identified in the Eleventh General Programme of Work. I view our global health agenda as especially important, as it brings cohesion to the work of our many partners implementing programmes within countries.

The six areas for results that I emphasized in my acceptance speech are clearly reflected in this proposed strategic plan: health development, health security, capacity, evidence, partnership, and performance.

Within the strategic objectives, several specific areas important to WHO during the coming six-year period are reflected as priorities in the plan. These respond both to emerging health concerns and to the priorities of Member States, as expressed in recent resolutions adopted by the Health Assembly. These areas include:

- implementing the International Health Regulations (2005) in order to respond rapidly to public health emergencies of international concern (including those caused by outbreaks of emerging and epidemic-prone diseases), building on eradication of poliomyelitis to develop an effective surveillance and response infrastructure
- addressing the epidemic of chronic noncommunicable diseases, with an emphasis on measures to reduce risk factors such as tobacco consumption, improper diet, and physical inactivity
- addressing the broader aspects of health and its interaction with other sectors, through use of the future report of the Commission on Social Determinants of Health
- reducing maternal mortality, by scaling up activities aimed at universal access to, and coverage with, effective interventions, and strengthening health services
- improving health systems, focusing on human resources, financing and health information.

---

<sup>1</sup> Document SSA1/DIV/6.

The resources needed to achieve the expected results set out in the Proposed programme budget 2008–2009 amount to US\$ 4263 million, an increase of 16% over the expected expenditures in the previous biennium. This increase is a reflection of higher expectations of the Organization and corresponding demands arising from our governing bodies and from the growing number of partners working to make this world a healthier place.

I am proposing changes in the way the programme budget is financed. A substantial part of the programme budget needs to be financed by assessed contributions, in order to demonstrate the shared commitment and responsibility of all Member States. By the end of the six-year period, a third of the budget should be financed by assessed contributions, a third by negotiated core voluntary contributions (non-earmarked), and a third by specified voluntary contributions. The changes will improve alignment between voluntary contributions and budgetary needs, promote efficiency, and enhance the integrity of the Organization's work. Management reform will continue, with results-based management at its core.

The fact that two thirds of the programme budget continues to be financed by voluntary contributions reflects the confidence and commitment of Member States and other partners. I sincerely appreciate this support and recognize its importance as we strive to attain results for health.

I am pleased to submit this Medium-term strategic plan 2008–2013 and Proposed programme budget 2008–2009 to the Executive Board.

A handwritten signature in black ink, appearing to read 'M. Lehoucq', is centered on the page. The signature is fluid and cursive, with a small dot at the end.

Director-General elect

**DRAFT MEDIUM-TERM STRATEGIC PLAN 2008-2013**



## CONTENTS

	<b>Page</b>
I. Challenges, gaps and future needs .....	1
II. Lessons learnt.....	3
III. Strategic direction for 2008–2013 .....	5
IV. WHO’s framework for results-based management .....	9
V. Effective financing of the Medium-term strategic plan .....	12
VI. Monitoring and evaluation .....	17
VII. Strategic objectives .....	18
1. To reduce the health, social and economic burden of communicable diseases .....	18
2. To combat HIV/AIDS, tuberculosis and malaria .....	27
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries.....	35
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.....	41
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact. ....	48
6. To promote health and development, prevent and reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex .....	53
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches .....	60
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health. ....	65
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development.....	73
10. To improve the organization, management and delivery of health services.....	79
11. To strengthen leadership, governance and the evidence base of health systems .....	83
12. To ensure improved access, quality and use of medical products and technologies...	88
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes.....	92
14. To extend social protection through fair, adequate and sustainable financing. ....	98
15. To provide leadership, strengthen governance and foster partnership and collaboration with countries in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work. ....	104
16. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively.....	109

	<b>Page</b>
Figure 1. Medium-term strategic plan .....	9
Figure 2. Biennial programme budget .....	10
Figure 3. Budget distribution between regional offices and headquarters.....	16
Figure 4. Monitoring and evaluation instruments.....	17
Table 1. Financing of the Proposed programme budget: evolution during the period of the Medium-term strategic plan.....	14
Table 2. Proposed programme budget 2008-2009 compared to Programme budget 2006–2007, by office and main source of funding.....	15
Table 3. Budget distribution between regional offices and headquarters.....	16



## I. CHALLENGES, GAPS AND FUTURE NEEDS

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

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

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

- **gaps in social justice:** efforts have been insufficient to ensure equity, health-related human rights and gender equality in health policy and action
- **gaps in responsibility:** the increasing number of sectors, actors and partners involved in health work has led to gaps in accountability and lack of synergy in the coordination of actions to improve health
- **gaps in implementation:** many populations still do not have adequate access to essential public-health interventions; international assistance is often insufficiently aligned to national priorities and systems or harmonized across organizations
- **gaps in knowledge:** knowledge of ways to tackle some of the major health challenges is still weak; research is not always focused on areas of greatest need, and health policy is not always based on best available evidence.

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

5. In September 2000, the United Nations Millennium Declaration committed countries to a global partnership to reduce poverty and improve health and education, along with promoting peace, human rights, gender equality and environmental sustainability. The seven-point **global health agenda** contained in the Eleventh General Programme of Work reflects this and other agreements adopted by world leaders, and requires action from many different players across the international community, across society and across government, in the following areas:

- investing in health to reduce poverty
- building individual and global health security
- promoting universal coverage, gender equality and health-related human rights
- tackling the determinants of health

- strengthening health systems and equitable access
- harnessing knowledge, science and technology
- strengthening governance, leadership and accountability.

## II. LESSONS LEARNT

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

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

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

9. Over the past 60 years WHO has played a prominent role in launching, coordinating, and implementing public-health programmes and initiatives. Some examples are eradication of smallpox, the Expanded Programme on Immunization, the Action Programme on Essential Drugs, the Stop TB Partnership, and efforts to eradicate poliomyelitis, to eliminate leprosy, and to control SARS and avian influenza. WHO has been able to adapt or transform itself in order to meet the needs of specific public-health programmes. For Member States, however, these and other challenges are placing increasing demands on health systems in critical areas related to health workforce, financing, and information. In this regard, work during 2004-2005 revealed the pressing need for greater international consensus about the way health systems should function and how their core functions can be strengthened.

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

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

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

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

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

15. The biennium 2004-2005 saw an unprecedented shift in the pattern of expenditure across the three levels of the Organization, with more resources being put to work in countries and regions. This positive trend needs to be supported by increased managerial skills and capacities in countries and regions and by more robust accountability.

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

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

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

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

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

### III. STRATEGIC DIRECTION FOR 2008-2013

21. During the six years 2008–2013, WHO will continue to provide leadership in matters of public health, optimizing its impartiality and near universal membership. Guidance from governments through the Executive Board, the Health Assembly and the regional committees ensures legitimacy for the work of the Organization; in turn, the Secretariat's reporting to the governing bodies ensures its accountability for implementation. WHO's convening power enables diverse groups to stimulate collective action worldwide.
22. WHO's role in tackling diseases is unparalleled, whether it acts by marshalling the necessary scientific evidence, promoting global strategies for eradication, elimination or prevention, or by identifying and helping to control outbreaks.
23. WHO will promote evidence-based debate, analysis and framing of policy development for health through the work of the Secretariat, expert and advisory groups, collaborating centres, and the numerous formal and informal networks in which it participates.
24. The structure of WHO's Secretariat assures involvement with countries. Headquarters focuses on issues of global concern and technical backstopping for regions and countries. Regional offices focus on technical support and building of national capacities. WHO's presence in countries allows it to have a close relationship with ministries of health and with its partners inside and outside government. The Organization collaborates closely with bodies of the United Nations system and provides channels for emergency support.
25. Through its decentralized structure and close working relations with governments, the Secretariat is able to gather health information and monitor trends over time, across countries, regions, and worldwide.
26. Within the framework of the Eleventh General Programme of Work, the pressing need to address the global burden of communicable diseases is reflected in the formulation of several WHO strategies for expanding interventions to reduce the burden of HIV, tuberculosis, malaria and vaccine-preventable diseases, and to make rapid progress in eradicating, eliminating or controlling diseases such as poliomyelitis, leprosy, dracunculiasis, onchocerciasis, schistosomiasis, and lymphatic filariasis. Implementation of the International Health Regulations (2005) will provide a framework for strengthening surveillance of, preparedness for, and response to, communicable diseases.
27. Several high-level strategies endorsed by Member States will guide the work of the Organization in improving sexual and reproductive health and child health, increasing immunization coverage, and tackling noncommunicable diseases, such as cancer and cardiovascular diseases. Interventions related to the health of mothers and children will be linked through a continuum of care throughout the life-cycle.
28. Provision of support to Member States is carried out largely in collaboration with other organizations of the United Nations system and partners. In the above-mentioned areas it involves mostly technical assistance – direct implementation by WHO is rarely needed or appropriate.
29. WHO has established infrastructures and mechanisms for disease-outbreak alert and response, and for addressing other public health emergencies when they arise. Clear responsibilities and time frames for action for WHO, both Member States and Secretariat, are set out in the International Health Regulations (2005). New in the Regulations are provisions for detecting and responding to threats from emerging diseases and the central importance given to surveillance. Once poliomyelitis is eradicated, the infrastructure established to ensure surveillance and programme delivery will adapt to the growing needs for outbreak alert and response, and disease surveillance.

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

31. The report of the Commission on Social Determinants of Health, due in early 2008, will provide an agenda for tackling the factors that influence the health of populations, highlighting ways in which the Organization can effectively collaborate with sectors other than health on the basis of a shared commitment to achieving equity and reducing poverty.

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

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

34. The Eleventh General Programme of Work emphasizes the increased number of stakeholders working in health at both national and international levels and the need for WHO to respond flexibly and rapidly to this evolution. WHO will use its convening power to stimulate action across sectors, while building the capacity of governments to take on this role nationally. It will take the lead in promoting effective partnerships for health, in shaping the global health environment, and operationalizing reform of the United Nations system at global, regional and country levels. To meet these challenges, WHO will continue to evolve as a learning organization and to strengthen its managerial capacity.

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

- providing **leadership** on matters critical to health and engaging in partnerships where joint action is needed
- shaping the **research** agenda, and stimulating the generation, dissemination and application of valuable knowledge
- setting **norms and standards**, and promoting and monitoring their implementation
- articulating ethical and evidence-based **policy options**

---

<sup>1</sup> *The world health report 2006. Working together for health.* Geneva, World Health Organization, 2006.

- providing **technical support**, catalysing change and building sustainable institutional capacity
- **monitoring** the health situation and assessing health trends.

36. Expected achievements over the period of the Medium-term strategic plan are described in 16 **strategic objectives** set out below, which reflect the results-based management framework, and provide clear, measurable and budgeted expected results for the Organization. They promote collaboration across disease-specific programmes by capturing the multiple links among the determinants of health and health outcomes, policies, systems and technologies.

1. To reduce the health, social and economic burden of communicable diseases
2. To combat HIV/AIDS, tuberculosis and malaria
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health
9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development
10. To improve the organization, management and delivery of health services
11. To strengthen leadership, governance and the evidence base of health systems
12. To ensure improved access, quality and use of medical products and technologies
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes
14. To extend social protection through fair, adequate and sustainable financing
15. To provide leadership, strengthen governance and foster partnership and collaboration with countries in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work

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

Flexibility and responsiveness are essential to address effectively the rapid changes foreseen in health needs and opportunities. WHO will continue to monitor trends, and modify plans and expected results accordingly.



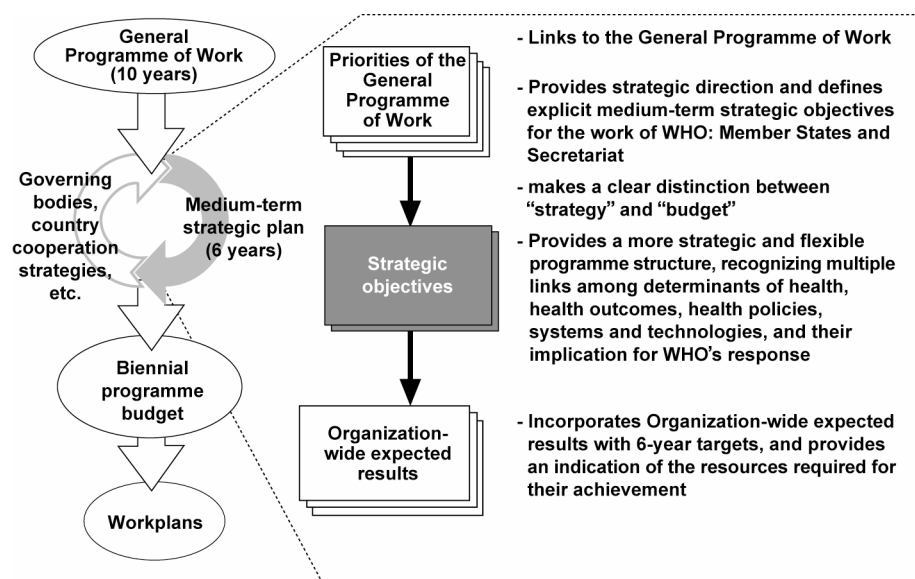
#### IV. WHO'S FRAMEWORK FOR RESULTS-BASED MANAGEMENT

37. The Eleventh General Programme of Work provides a long-term perspective on the determinants of health and the measures required for improving health while setting forth a global health agenda.<sup>1</sup>

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

39. The 16 strategic objectives set out above take into account the complementarities between strategic objectives. For example, they recognize that for health interventions effectively to achieve better health outcomes and reduce the burden of disease, it is as essential to strengthen health systems as it is to develop norms and standards for specific diseases and work with other sectors in tackling determinants of health. These broad strategic objectives provide a flexible programme structure that better reflects the needs of countries and regions. They facilitate collaboration throughout the Organization, through Organization-wide teams built around strategic objectives.

**Figure 1. Medium-term strategic plan**



WHO 06.150

40. For each strategic objective, the plan identifies a series of Organization-wide expected results for which the Secretariat will be accountable over the three bienniums. It provides indicators, targets and resources required for their achievement.

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

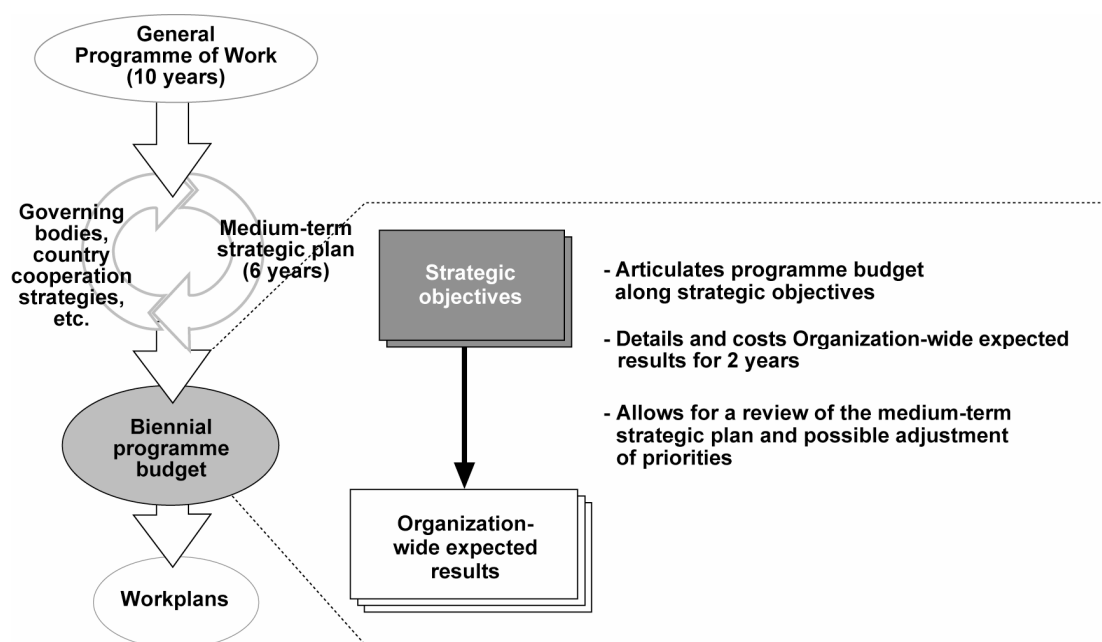
42. The Proposed programme budget makes the Medium-term strategic plan operational, identifying the scope of activities and specifying achievements expected in the two years. It provides

<sup>1</sup> Document A59/25.

for each of the Organization-wide results the targets for 2008-2009 and the resources required for their achievement.

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

**Figure 2. Biennial programme budget**



WHO 06.151

44. Comprehensive reform is under way to improve management of the Organization, the main thrust of which is set out in strategic objective 16. It is captured also in an Organization-wide guide, which is continuously under review to ensure that it effectively addresses the changing needs of the Organization.<sup>1</sup> Managerial reform also is a standing item on the agenda of the Programme, Budget and Administration Committee of the Executive Board. The scope of these reforms spans the results-based management framework, management of financial resources, provision of effective operational support, and assurance of robust accountability.

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

46. As a decentralized organization, efficient and effective programme management requires balancing the need to assure an Organization-wide approach and responsibility, and to recognize regional specificities. Transparent governance mechanisms and common systems and approaches across the Organization will be increasingly adopted, linked to further devolution of decision-making

<sup>1</sup> Increasing managerial effectiveness and efficiency: an organizational roadmap, 2nd edition, April 2006.

and greater accountability. This trend will be facilitated by moving from managing through tight bureaucratic controls to greater reliance on monitoring.

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

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

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

## V. EFFECTIVE FINANCING OF THE MEDIUM-TERM STRATEGIC PLAN

50. To achieve the strategic objectives as set out in the Medium-term strategic plan requires effective financing. The draft plan has been costed with an overall budget of US\$ 14 000 million over the period of six years and a budget of US\$ 4263 million over the two years of the proposed programme budget 2008–2009.<sup>1</sup> On the basis of expected expenditure in the biennium 2006–2007, the budget proposed would increase by 16%. This increase is justified by the ambitious yet realistic targets to be achieved in response to the growing demands and expectations made on the Organization.

51. The increase is primarily intended to address the following **priorities**:

- implementing the International Health Regulations (2005), so as to respond rapidly to outbreaks of known and new diseases and emergencies, building on eradication of poliomyelitis to develop an effective surveillance and response infrastructure
- addressing the epidemic of chronic noncommunicable diseases, with an emphasis on measures to reduce risk factors such as tobacco consumption, poor diet, and physical inactivity
- using the future report of the Commission on Social Determinants of Health to address the broader aspects of health and its interaction with other sectors
- reducing maternal and child mortality, by aiming at universal access to, and coverage with, effective interventions, and strengthening of health services
- improving health systems, focusing on human resources, financing and health information.

### Sources of income and financial plan

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

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

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

---

<sup>1</sup> The proposed 2008–2009 budget includes major partnerships and special programmes such as the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases; the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction; and others, as was the case in the Programme budget 2006–2007.

55. For the next six-year period, WHO will continue to finance the Medium-term strategic plan through these sources, but will move towards categorizing them according to three sources of funds: **assessed** contributions, including miscellaneous income, **negotiated core voluntary** contributions, and **other voluntary** contributions. This acknowledges the continuing work with partners and donors better to align voluntary contributions with the achievement of results as set out in the Programme budget.

### **Assessed contribution and miscellaneous income**

56. An assessed contribution amounting to US\$ 970 million is proposed for the biennium 2008-2009 in order to maintain a reasonable balance between the two sources of funding. This represents an increase of 8.6% compared to the biennium 2006–2007. Even at this level, assessed contributions would account for only 23% of the overall budget in 2008–2009.

57. Miscellaneous income is derived mainly from interest earnings on assessed-contribution funds, collections of arrears of assessed contributions, and unspent assessed contributions at the end of a biennium. The overall level of miscellaneous income is expected to increase to approximately US\$ 30 million per biennium.

58. Thus the total of assessed contribution and miscellaneous income proposed for the Programme budget 2008–2009 is US\$ 1000 million. The aim is for assessed contributions to finance one third of the total biennial budget by the end of the six-year period. Assuming that miscellaneous income remains constant, reflecting a more efficient and effective Organization, this would mean a gradual increase of assessed contributions in each of the three bienniums.

### **Negotiated core voluntary contributions**

59. In the biennium 2004–2005 about 74% of the total income came from voluntary contributions. Less than a dozen different sources accounted for more than 75% of all voluntary contributions received, with the remaining 25% coming from more than 420 different sources.

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

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

62. Core negotiated voluntary contributions are those that provide predictable amounts for a set length of time, aligned to strategic objectives or Organization-wide expected results in the Medium-term strategic plan, and are negotiated at an Organization-wide level. Their reporting requirements follow the WHO reporting norms through the results-based framework and the official audited financial reports.

63. Currently, slightly more than 10% of voluntary contributions can be considered as negotiated core voluntary contributions. WHO will seek to increase the share of core voluntary contributions to a third of total resources by 2013. For the biennium 2008–2009, the aim is to double the level of core voluntary contributions from current expectations to roughly US\$ 600 million, representing about 14% of total resources.

### Other voluntary contributions

64. Currently the Organization is financed largely from voluntary contributions intended for a specific purpose. For the biennium 2008-2009, after taking into account the regular budget and negotiated core voluntary contributions, about US\$ 2600 million in other voluntary contributions will need to be raised. On the basis of past trends this is a realistic target.

65. A high degree of specificity is attached to much of the voluntary funding, including approximately US\$ 1000 million related to partnerships or specific appeals. Such financing includes partnerships hosted by WHO, response to emergencies and epidemic outbreaks, special disease-eradication campaigns, and procurement on behalf of Member States. These resources are an important part of the financing of priority programmes of the Organization.

66. Table 1 below summarizes WHO's financial plan over the six-year period. Beyond the biennium 2008-2009, figures are indicative only and may be revised during preparation of the next biennial cycle. The table shows the Programme budget 2006-2007 and the currently higher expected expenditures. Since adoption of the Programme budget, overall expected expenditures have in effect risen because of increased activity in the areas of pandemic-influenza preparedness and WHO's participation in both existing and new partnerships such as the Global Drug Facility of the Stop TB Partnership, the World Alliance for Patient Safety, the Alliance for Health Policy and Systems Research, and several other partnerships. Such expenditures should be considered as the de facto baseline against which the Proposed programme budget should be compared.

**Table 1. Financing of the Proposed programme budget: evolution during the period of the Medium-term strategic plan (US\$ million)**

Sources of income	Baseline, 2006-2007		Proposed programme budgets, 2008-2013			
	Programme budget 2006-2007	Expected expenditure 2006-2007	Proposed programme budget 2008-2009	Increase over expected expenditure 2006-2007 %	Estimates 2010-2011	Estimates 2012-2013
Assessed contributions 2008-2009	893	893	970	8.6		
Miscellaneous income	22	22	30	36.4		
<b>Total assessed contribution</b>	<b>915</b>	<b>915</b>	<b>1 000</b>	<b>9.3</b>		
Negotiated core	---	300	600	100.0		
Other voluntary	---	2 455	2 663	8.5		
<b>Total voluntary contributions</b>	<b>2 398</b>	<b>2 755</b>	<b>3 263</b>	<b>18.4</b>		
<b>Total financing</b>	<b>3 313</b>	<b>3 670</b>	<b>4 263</b>	<b>16.2</b>		

## Proposed budgets

67. Calculated on the basis of the estimated cost of meeting the Organization-wide expected results, the proposed programme budget, broken down by location and main source of funding, is indicated in Table 2 below.

**Table 2. Proposed programme budget 2008–2009 compared to Programme budget 2006–2007 by office and main source of funding (US\$ million)**

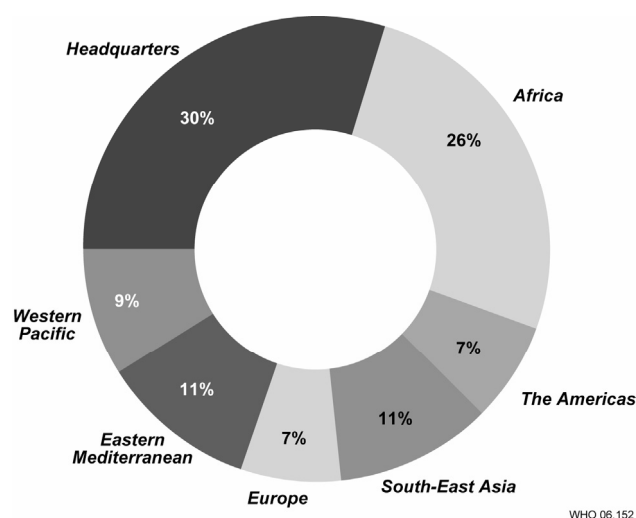
Location	Programme budget 2006–2007			Proposed programme budget 2008–2009		
	Assessed contribution <sup>a</sup>	Voluntary contribution	Total	Assessed contribution <sup>a</sup>	Voluntary contribution	Total
Regional office:						
Africa	204	746	950	222	966	1 188
The Americas	78	121	199	85	197	282
South-East Asia	99	258	357	108	388	496
Europe	58	142	200	64	213	277
Eastern Mediterranean	87	294	381	96	373	469
Western Pacific	77	156	233	84	268	352
Headquarters	312	681	993	341	858	1 199
<b>Total</b>	<b>915</b>	<b>2 398</b>	<b>3 313</b>	<b>1 000</b>	<b>3 263</b>	<b>4 263</b>

<sup>a</sup> Includes miscellaneous income.

68. In pursuance of the Organization's strategy to strengthen first-line support to countries with adequate back-up at regional and global levels, most of the budget will be spent in regions and countries, while maintaining headquarters functions, particularly in the normative areas.

69. Resource distribution between regions reflect programme needs that follow a results-based approach, and are in line with indications from the validation mechanism for strategic resource allocation reviewed by the Executive Board.<sup>1</sup> Subsequent biennial programme budgets will reflect programmatic changes between regions, but should remain relatively similar over the six-year period. Figure 3 below illustrates distribution of the budget between regional offices and headquarters. Table 3 below shows the shift in distribution from 2006–2007 to 2008–2009, excluding the poliomyelitis eradication initiative and WHO's response to emergencies, so as to be comparable with the validation mechanism.

<sup>1</sup> See document EB118/2006/REC/2, Summary record of the fourth meeting, section 4.

**Figure 3. Budget distribution between regional offices and headquarters****Table 3. Budget distribution between regional offices and headquarters<sup>a</sup>**  
(US\$ million)

Location	Approved 2006–2007	Percentage of total	Proposed 2008–2009	Percentage of total	Validation mechanism Ranges as a percentage	
					Minimum	Maximum
Regional office:						
Africa	768.9	26.5	986.7	26.0	25.2	30.8
The Americas	181.6	6.3	258.1	6.8	6.3	7.7
South-East Asia	290.7	10.0	432.0	11.4	10.9	13.3
Europe	188.2	6.5	250.9	6.6	6.2	7.5
Eastern Mediterranean	287.6	9.9	402.7	10.6	9.1	11.2
Western Pacific	222.7	7.7	327.2	8.6	7.1	8.7
Headquarters	962.7	33.2	1 132.5	29.9	25.2	30.8
<b>Total<sup>a</sup></b>	<b>2 902.3</b>	<b>100.0</b>	<b>3 790.1</b>	<b>100.0</b>		

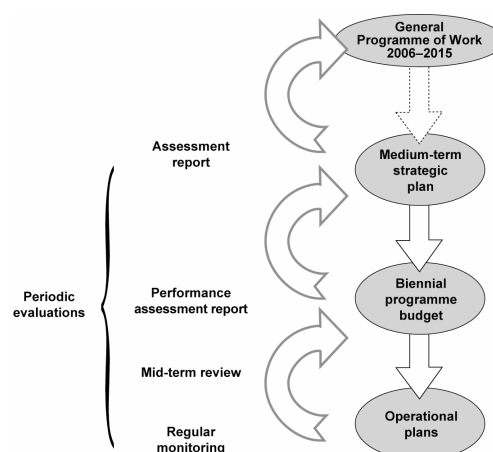
<sup>a</sup> Excludes the Global Poliomyelitis Eradication Initiative and WHO's response to emergencies, so as to facilitate comparison with the validation mechanism.



## VI. MONITORING AND EVALUATION

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

**Figure 4. Monitoring and evaluation instruments**



WHO 06.153

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

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

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

74. The Medium-term strategic plan is monitored through the assessment of programme budget performance. At the end of the six-year period, the extent to which the 16 strategic objectives in the Medium-term strategic plan have been achieved will be assessed. Data on the strategic-objective indicators will be collected to establish the degree to which the targets have been reached. Performance will be analysed and the main achievements in delivery of the strategic objectives, factors contributing to, or impeding, success, and lessons learnt will be summarized to help in drawing up subsequent strategic plans.

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

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

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

## VII. STRATEGIC OBJECTIVES

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

#### Indicators and targets

- The mortality rate due to vaccine-preventable diseases. Target: two thirds reduction by 2013
- Coverage of interventions targeted at the control, elimination or eradication of tropical diseases. Target: 80% in 49 at-risk Member States by 2013
- The proportion of countries achieving and maintaining certification of poliomyelitis eradication and destruction or appropriate containment of all polioviruses. Target: 100% by 2010.

#### ISSUES AND CHALLENGES

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

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

Epidemics can place sudden and intense demands on health systems. They expose existing weaknesses in health systems and, in addition to their impact on morbidity and mortality, can disrupt economic activity and development. The need for rapid response drains resources, staff and supplies away from previously defined public health priorities and routine disease-control activities, such as childhood immunization. WHO has a primary role in preparedness, detection, risk assessment and communications and response to public health emergencies. It has verified more than

#### Lessons learnt

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

1000 epidemics of international concern over the past five years.

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

WHO's response to the outbreak of severe acute respiratory syndrome demonstrated the importance of coordination, leadership and transparency in dealing with epidemics and pandemics. The poliomyelitis eradication initiative has highlighted the need to couple targeted disease-control measures, such as campaigns, with overall strengthening of health systems.

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

## STRATEGIC APPROACHES

To achieve this objective, Member States will have to invest human, political and financial resources into ensuring and expanding equitable access to high-quality and safe interventions for the prevention, early detection, diagnosis, treatment and control of communicable diseases among all populations. A key component in the financial and operational sustainability of prevention and control in this context will be the establishment and maintenance by Member States of effective coordination mechanisms with partners and across relevant sectors at the country level, and a willingness to work with the Secretariat in extending these coordination mechanisms to the regional and international spheres. Given that less than 10% of health-research resources globally are spent on health problems that affect 90% of the world's population, increased national involvement in research, through achievement of the objectives for investment in health research, research-capacity strengthening and integration of research into the mainstream of national programmes and plans, will be crucial for improving access to, and use of, research findings. The International Health Regulations (2005) require Member States to adopt the necessary legal, administrative, financial, technical and political provisions for activities including the development, strengthening and maintenance of integrated surveillance systems at primary, intermediate and national levels, in order to enable them to detect, report on, and respond to public health risks and potential public health emergencies, and to generate information for

### Lessons learnt

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

### The Secretariat will focus on:

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

evidence-based policy decisions on public health interventions.

### ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

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

- that increased pressure diverts resources away from communicable diseases and towards other aspects of health;
- that prevention and control of communicable diseases are not recognized and visibly maintained as health priorities, particularly in the least developed countries. Such interventions will not remain a priority on national and international health agendas unless harmonized policy messages from the Secretariat and international partners support this item on the global health agenda;
- that financial and political investment in implementation of the International Health Regulations (2005) is insufficient, and the approach of governments towards their implementation is fragmented. These risks can be countered through development of, and adherence to, regional commitments, such as the Kabul Declaration on Regional Collaboration in Health (2006);
- that private-sector and unilateral efforts are inadequate to secure funding to meet the shortfall in investment in research. Without promotion and coordination of policies and actions based on the premise of global public goods, the return on the investment will not be maximized;
- that transmission of polioviruses will not be interrupted by the end of 2007, a failure that will necessitate additional supplemental immunization activities and incur extra costs. The risk can be mitigated through the use of new tools and strategies to accelerate interruption of transmission of wild-type poliovirus, as well as heightened advocacy and social mobilization efforts at all levels;
- that an influenza pandemic causes unprecedented morbidity and mortality, and serious economic harm. Advanced planning for appropriate detection and response strategies,

#### The Secretariat will focus on:

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

including containment and control strategies and research into the development of vaccines and medicines, is central to minimizing the potentially disruptive impact of a pandemic.

## ORGANIZATION-WIDE EXPECTED RESULTS

1.1 Policy and technical support provided to Member States in order to maximize equitable access of all people to vaccines of assured quality, including new immunization products and technologies, and to integrate other essential child-health interventions with immunization.	INDICATORS			
	1.1.1 Number of developing countries with at least 90% national vaccination coverage and at least 80% vaccination coverage in every administrative unit	1.1.2 Number of developing countries supported to make decisions about appropriate changes and additions to the immunization schedule, including the introduction of new vaccines and/or new technologies	1.1.3 Number of essential child-health interventions integrated with immunization for which guidelines on common programme management are available	1.1.4 Number of countries that have established either legislation or a specified national budget line in order to ensure sustainable financing of immunization
	BASELINE			
	39 countries	25 countries	1 intervention	166 countries
	TARGETS TO BE ACHIEVED BY 2009			
	90/165 countries	60/165 countries	5 interventions	180/193 countries
	TARGETS TO BE ACHIEVED BY 2013			
	140/165 countries	117/165 countries	9 interventions	193/193 countries
	RESOURCES (US\$ THOUSAND)			
	Costs 2008-2009 154 494	Estimates 2010-2011 166 000	Estimates 2012-2013 181 000	
	JUSTIFICATION			
	In resolution WHA58.15 the Health Assembly welcomed the Global Immunization Vision and Strategy, with its approaches to protecting more people by making immunization available to all eligible people, introducing new vaccines and technologies, and linking immunization to the delivery of other health interventions and overall development of the health sector. It also requested policy and technical support to Member States in implementing the strategy. More than 75% of the resources are for activities at regional and country levels. Global health partnerships, such as the Global Alliance for Vaccines and Immunization, and increasing availability of resources to Member States for implementing immunization programmes through initiatives such as the International Financing Facility for Immunization raise the pressure on the Secretariat to provide policy and technical support to Member States in implementing evidence-based health-system approaches so as to ensure that the resources are used in a financially sustainable way in the long term.			

1.2 Effective coordination and support provided in order to achieve certification of poliomyelitis eradication, and destruction, or appropriate containment, of polioviruses, leading to a simultaneous cessation of oral poliomyelitis vaccination globally.	INDICATORS			
	1.2.1 Percentage of countries using oral poliomyelitis vaccine according to an internationally agreed time-line and process for cessation of routine use of oral poliomyelitis vaccine	1.2.2 Percentage of final country reports or updates submitted to and reviewed by appropriate regional certification commissions	1.2.3 Number of facilities worldwide storing or handling poliovirus after cessation of use of poliomyelitis vaccine globally	1.2.4 Number of least-developed countries in which the WHO-funded infrastructure for surveillance of acute flaccid paralysis and experience contribute to national core-capacity building for the International Health Regulations (2005)
	BASELINE			
	0%	63% of reports	Between 1000 and 2000 facilities (estimated)	None

<b>TARGETS TO BE ACHIEVED BY 2009</b>			
100% of 135 countries	75% of reports	About 1000 facilities	20 countries
<b>TARGETS TO BE ACHIEVED BY 2013</b>			
100% of 135 countries	All reports	<20 facilities	35 countries
<b>RESOURCES (US\$ THOUSAND)</b>			
Costs 2008-2009 263 816	Estimates 2010-2011 260 000	Estimates 2012-2013 240 000	
<b>JUSTIFICATION</b>			
<i>Intense transmission of poliovirus in two countries endemic for poliomyelitis and recent outbreaks in poliomyelitis-free areas have delayed eradication of poliomyelitis. It is therefore expected that immunization campaigns in some countries will continue through 2008 and that WHO will need to provide more extensive technical assistance for those campaigns, as well as for the poliomyelitis surveillance infrastructure. Once poliovirus transmission has been interrupted, WHO's costs will decline, but activities will continue through 2013 because of global certification, cessation of use of oral poliomyelitis vaccine and containment of the virus. During this time, the poliomyelitis immunization and surveillance infrastructure will be further integrated into WHO's broader technical assistance to build national capacity for vaccine-preventable and epidemic-prone diseases, including in the context of the implementation of the International Health Regulations (2005).</i>			

1.3 Effective coordination and support provided to Member States in order to provide access for all populations to interventions for the prevention, control, elimination and eradication of neglected tropical diseases, including zoonotic diseases.	INDICATORS			
	1.3.1 Number of countries certified for eradication of dracunculiasis	1.3.2 Number of countries that have eliminated leprosy at national and subnational levels	1.3.3 Size of the target population at risk of lymphatic filariasis in endemic countries for mass drug administration or preventive chemotherapy	1.3.4 Coverage of at-risk school-age children in disease-endemic countries with regular treatment against schistosomiasis and soil-transmitted helminthiases
	BASELINE			
	3 countries	6 countries	700 million	30% coverage
	TARGETS TO BE ACHIEVED BY 2009			
	10 countries	22 countries	900 million	56% coverage
	TARGETS TO BE ACHIEVED BY 2013			
	20 countries	24 countries	1200 million	75% coverage
	RESOURCES (US\$ THOUSAND)			
	Costs 2008-2009 132 548	Estimates 2010-2011 170 000		Estimates 2012-2013 185 000
	JUSTIFICATION			
	Although cost-effective interventions are available and being implemented, the elimination of many neglected tropical diseases as public health problems requires facilitation of intercountry control programmes by WHO, development of new and improved interventions to combat drug resistance, and support from the private sector. Controlling these diseases is highly cost effective for society and thus interventions in this area can be very effective in alleviating poverty. As attainment of the goals of eliminating/eradicating dracunculiasis and leprosy and halving the mortality rate for rabies approaches, the Secretariat's efforts to reinforce its accomplishments and maintain momentum should be intensified, hence the need for increased resources in 2010-2013. The integrated approach to implementing solutions based on health systems for the control of tropical diseases requires a gradual, sustainable scaling up of support to Member States during the period 2008-2013.			

1.4 Policy and technical support provided to Member States in order to enhance their capacity to carry out surveillance and monitoring of all communicable diseases of public health importance.	INDICATORS			
	1.4.1 Percentage of countries with integrated surveillance of all communicable diseases of public health importance	1.4.2 Number of countries receiving technical assistance from WHO to adapt generic surveillance and communicable disease-monitoring tools or protocols to specific country situations	1.4.3 Percentage of countries for which joint reporting forms on immunization surveillance and monitoring are received on time at global level in accordance with established time-lines	1.4.4 Percentage of countries supported by WHO to establish a system at district level to record, analyse and evaluate the quality and safety of vaccine/drug/ intervention delivery
	BASELINE			
	30% of countries	40 countries	50% of countries	Not currently monitored
	TARGETS TO BE ACHIEVED BY 2009			
	50% of 193 countries	65 countries	75% of 193 countries	25% of 193 countries
	TARGETS TO BE ACHIEVED BY 2013			
	75% of 193 countries	117 countries	95% of 193 countries	75% of 193 countries
	RESOURCES (US\$ THOUSAND)			
	Costs 2008-2009 80 160	Estimates 2010-2011 79 000	Estimates 2012-2013 87 000	
	JUSTIFICATION			
	Surveillance is essential for decisions about the allocation of resources and for the effective and efficient management of public health interventions by health and finance ministries and donors, as well as for ensuring that data are collected on equity of access to interventions by all populations, particularly women and children. WHO plays a key role in the process of integrating vertical surveillance programmes, establishing consensus on critical elements of surveillance, and coordinating partnerships between countries, funding partners and multilateral organizations in order to generate appropriate levels of investment in surveillance systems infrastructure. WHO must take the lead in promoting both integrated disease surveillance as a vital component in fully functioning health systems, and the increased use of data to improve alert and response reactions in public health emergencies, in the monitoring of communicable diseases of public health importance, and as the basis for decision-making. Steps must be taken to build better links between all surveillance mechanisms for communicable diseases, including HIV/AIDS, tuberculosis and malaria, as well as noncommunicable diseases.			

<b>1.5</b> New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed and validated, with scientists from developing countries increasingly taking the lead in this research.	<b>INDICATORS</b>			
	<b>1.5.1</b> Number of consensus reports published on global research needs and priorities for a disease or type of intervention	<b>1.5.2</b> Number of new and improved tools (e.g. medicines, vaccines or diagnostics) receiving internationally recognized approval for use	<b>1.5.3</b> Number of new and improved interventions and implementation strategies whose effectiveness has been determined and the evidence made available to appropriate institutions for policy decisions	<b>1.5.4</b> Proportion of peer-reviewed publications based on WHO-supported research where the main author's institution is in a developing country
	<b>BASELINE</b>			
	None	None	None	48% of publications
	<b>TARGETS TO BE ACHIEVED BY 2009</b>			
	3 reports	2 tools	3 interventions	55% of publications

	TARGETS TO BE ACHIEVED BY 2013			
	6 reports	6 tools	8 interventions	60% of publications
	RESOURCES (US\$ THOUSAND)			
	Costs 2008-2009 73 359	Estimates 2010-2011 38 000	Estimates 2012-2013 42 000	
JUSTIFICATION				
Even though 85% of the global burden of disability and premature mortality affects the developing world, less than 4% of global research funding is devoted to the disorders that constitute the major burden of disease in developing countries. Increases in funds for research, and the expanding role of public-private partnerships make it essential for the Secretariat to define the global health research agenda, facilitate harmonization of research activities and support countries to make evidence-based policy decisions.				

1.6 Support provided to Member States in order to achieve the minimum core capacities required by the International Health Regulations (2005) for the establishment and strengthening of alert and response systems for use in epidemics and other public health emergencies of international concern.	INDICATORS			
	1.6.1 Number of countries that have completed the assessment or self-assessment of core capacities for surveillance and response, in line with their obligations under the International Health Regulations (2005)	1.6.2 Number of countries supported by WHO to develop national plans of action or strategy papers to meet minimum core capacity requirements for early warning and response in line with their obligations under the International Health Regulations (2005)	1.6.3 Number of countries whose national laboratory system is engaged in at least one internal and one external quality-control programme for epidemic-prone communicable diseases	1.6.4 Number of countries participating in training programmes focusing on strengthening early-warning systems or mechanisms, public health laboratories and outbreak-response capacities
	BASELINE			
	100 countries	80 countries	90 countries	100 countries
	TARGETS TO BE ACHIEVED BY 2009			
	150 countries	115 countries	135 countries	150 countries
	TARGETS TO BE ACHIEVED BY 2013			
	193 countries	193 countries	193 countries	193 countries
	RESOURCES (US\$ THOUSAND)			
	Costs 2008-2009 77 191	Estimates 2010-2011 98 000		Estimates 2012-2013 120 000
	JUSTIFICATION			
	Under the International Health Regulations (2005) all States Parties have made a commitment to assess their national core capacities for surveillance and response within two years of the Regulations' entry into force in May 2007, and to develop and maintain the same core capacities for five years (with a two-year extension if needed) after that date. The definition of these core capacities includes surveillance and early warning for epidemic-prone diseases and essential diagnostic, response and communication capacities. During the biennium 2008-2009, WHO's technical and financial resources will have to support the national assessments and preparation of action plans. During the period 2010-2013, resources will be applied mainly for implementation and the monitoring and evaluation of achievements.			



<b>1.7 Member States and the international community</b> equipped to detect, assess, respond to and cope with major epidemic and pandemic-prone diseases (e.g. influenza, meningitis, yellow fever, haemorrhagic fevers, plague and smallpox) through the development and implementation of tools, methodologies, practices, networks and partnerships for prevention, detection, preparedness and intervention.	<b>INDICATORS</b>		
	<b>1.7.1</b> Number of countries having national preparedness plans that are funded and standard operating procedures in place for major epidemic-prone diseases (e.g. pandemic influenza)	<b>1.7.2</b> Number of international support mechanisms for diagnosis and mass intervention (e.g. international laboratory surveillance networks and vaccine-stockpiling mechanisms)	<b>1.7.3</b> Number of countries with basic capacity in place for safe laboratory handling of dangerous pathogens and safe isolation of patients who are contagious
	<b>BASELINE</b>		
	90 countries	5 mechanisms	70 countries
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	135 countries	7 mechanisms	100 countries
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	193 countries	9 mechanisms	193 countries
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009 61 929	Estimates 2010-2011 69 000	Estimates 2012-2013 76 000
	<b>JUSTIFICATION</b>		
	<p><i>Strong programmes and projects on diseases or specific themes are vital for WHO to ensure that serious threats are dealt with systematically and that WHO maintains its much-needed global expertise in vital areas (e.g. influenza, smallpox, biosafety, epidemics caused by deliberate release of pathogens, and yellow fever). The avian influenza crisis has highlighted the need for the Secretariat to accelerate work with Member States in order to ensure that their ability to detect, assess, respond to and cope with the threat of known epidemic-prone and emerging infectious diseases. The development of standard operating procedures and stockpiling of necessary medicines and vaccines are crucial for mitigating the potential impact of these diseases. Maintaining and expanding existing networks and partnerships providing support to Member States in the different aspects of preparedness and response to specific epidemic risks, and developing new ones where required, are essential elements of WHO's strategy. By the end of 2007, all Member States will have national preparedness plans devised, implemented and tested, thus providing the backbone to the response to a potential pandemic.</i></p>		

<b>1.8 Regional and global capacity</b> coordinated and made rapidly available to Member States for detection, verification, risk assessment and response to epidemics and other public health emergencies of international concern.	<b>INDICATORS</b>			
	<b>1.8.1</b> Number of locations with global event-management system in place to support coordination of risk assessment, communications and field operations for headquarters, regional and country offices	<b>1.8.2</b> Number of partner institutions participating in the global outbreak alert and response network and other relevant regional subnetworks	<b>1.8.3</b> Proportion of requests for assistance from Member States for which WHO mobilizes comprehensive and coordinated international support for disease-control efforts, investigation and characterization of events, and sustained containment of outbreaks	<b>1.8.4</b> Median time to verification of outbreaks of international importance, including laboratory confirmation of etiology
	<b>BASELINE</b>			
	7 (headquarters and each regional office)	150 institutions	90% of requests	5 days
	<b>TARGETS TO BE ACHIEVED BY 2009</b>			
	60 (headquarters, regional offices and selected country offices)	200 institutions	100% of requests	4 days

<b>TARGETS TO BE ACHIEVED BY 2013</b>			
120 (headquarters, regional offices and most country offices)	400 institutions	100% of requests	2 days
<b>RESOURCES (US\$ THOUSAND)</b>			
Costs 2008-2009 56 737	Estimates 2010-2011 64 000	Estimates 2012-2013 71 000	
<b>JUSTIFICATION</b>			
<i>WHO faces a continuing and increasing demand to operate an effective global system of epidemic intelligence gathering, verification, risk assessment, information management and rapid field response using innovative information technology, standard operating procedures and the resources of partners in the Global Outbreak Alert and Response Network and other relevant regional networks. This service is mandated and obligated according to the International Health Regulations (2005). WHO is focusing on strengthening its epidemic alert and response operations at country and regional levels, while increasing standardization and coordination of operations across the Organization, and increasing the level of accountability for decision-making especially when these decisions affect travel and trade.</i>			

## To combat HIV/AIDS, tuberculosis and malaria

### Indicators and targets

- HIV-related deaths averted annually in low- and middle-income countries owing to use of antiretroviral therapy by 2013 (baseline: 400 000 deaths averted in 2005)
- HIV incidence reduction (proxy). Target: all countries with generalized HIV epidemics (56 countries) having achieved and maintained at least a 25% reduction in HIV prevalence in young people (aged 15-24 years) since the United Nations Declaration of Commitment on HIV/AIDS (2001) (baseline: six countries in 2005)
- Reduction in mother-to-child transmission of HIV. Target: by 2013, reduce percentage of HIV-infected infants born to HIV-infected mothers to 10% (baseline: 25% in 2005)
- Reduction in HIV prevalence in vulnerable populations. Target: by 2013, all (136) countries with low-prevalence or concentrated HIV epidemics having halted or reversed HIV prevalence among most populations with risk behaviours (injecting drug users, sex workers and men who have sex with men) (baseline: no country in 2005)
- Reduction of tuberculosis incidence. Target: by 2013, have halted and begun to reverse the incidence of tuberculosis (baseline: 1990 figure)
- Reduction in tuberculosis mortality in countries with epidemics of the disease. Target: by 2013, 50% reduction (baseline: 1990 figure)
- Reduction in mortality due to malaria in countries endemic for the disease. Target: 50% reduction by 2013 (baseline: 1.2 million deaths globally in 2002)
- Elimination of malaria from countries where that objective is currently considered feasible by 2013. Target: by 2013, seven countries certified or enrolled in a WHO certification process for malaria elimination (baseline: no country in 2005).

### ISSUES AND CHALLENGES

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

### STRATEGIC APPROACHES

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

### Lessons learnt

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

use of evidence, norms and standards in policy and programme formulation.

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

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

Efforts to ensure sustained political commitment, better engagement of communities and affected persons, and more effective partnerships will also be crucial. Advocacy for concerted efforts to combat the three diseases will be a major factor for success.

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

### ASSUMPTIONS, RISKS AND OPTIONS

Enabling prevention and control programmes against HIV, tuberculosis and malaria to be scaled up successfully will require a consistent and strong capacity at all national levels for formulating evidence-based policies, analysing their effects, and making adjustments as necessary. It will also require substantially increasing resources, reinforcing health systems and building institutional capacity for solving

#### Lessons learnt

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

#### The Secretariat will focus on:

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

operational constraints. The following assumptions underlie achievement of this strategic objective:

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

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

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

**The Secretariat will focus on:**

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

## ORGANIZATION-WIDE EXPECTED RESULTS

2.1 Guidelines, policy, strategy and other tools developed for prevention of, and treatment and care for patients with, HIV/AIDS, tuberculosis and malaria, including innovative approaches for increasing coverage of the interventions among poor people, and hard-to-reach and vulnerable populations.	INDICATORS			
	2.1.1 Number of supported countries that have achieved the national intervention targets for HIV/AIDS consistent with the goal of universal access to HIV/AIDS prevention, treatment and care	2.1.2 Number of supported countries that have achieved the national intervention targets for malaria	2.1.3 Number of countries that have achieved the targets for detection (70% case detection) and treatment (85% success rate) of tuberculosis	2.1.4 Proportion of high-burden countries that have achieved targets for prevention and control of sexually transmitted infections (70% of persons with sexually transmitted infections at primary point-of-care sites appropriately diagnosed, treated and counselled)
	BASELINE			
	No country	5/107 countries	50/211 countries and territories	30% of high-burden countries
	TARGETS TO BE ACHIEVED BY 2009			
	193 countries	53/107 countries	100/211 countries and territories	60% of high-burden countries
	TARGETS TO BE ACHIEVED BY 2013			
	193 countries	All countries endemic for malaria	All countries and territories	All high-burden countries

	having achieved 80% of intervention targets	exceeding 70% case detection and 85% treatment success rates	
RESOURCES (US\$ THOUSAND)			
Costs 2008-2009 147 405	Estimates 2010-2011 136 000	Estimates 2012-2013 150 000	
JUSTIFICATION			
WHO is firmly committed to maximizing access to interventions against HIV/AIDS, tuberculosis and malaria, pursuant to various Health Assembly resolutions, the global health-sector strategy for HIV/AIDS, the Stop TB strategy, the Global Plan to Stop TB 2006-2015, the Global Strategic Plan 2005-2015 to Roll Back Malaria; articulation of its contribution to scaling up towards universal access to HIV/AIDS prevention, care and treatment (and the need to advance work done under the “3 by 5” Initiative); and to achieving the Millennium Development Goals and other internationally agreed goals. Most of the resources are for country and regional level activities.			

<b>2.2 Policy and technical support</b> provided to countries towards expanded gender-sensitive delivery of prevention, treatment and care interventions for HIV/AIDS, tuberculosis and malaria, including integrated training and service delivery; wider service-provider networks; and strengthened laboratory capacities and better linkages with other health services, such as those for reproductive health, maternal, newborn and child health, sexually transmitted infections, nutrition, drug-dependence treatment services, respiratory care, neglected diseases and environmental health.	<b>INDICATORS</b>		
	<b>2.2.1</b> Number of targeted countries with integrated/coordinated gender-sensitive policies on HIV/AIDS, tuberculosis and malaria	<b>2.2.2</b> Number of countries with sound national strategic plans for the health workforce, including policies and management practices on incentives, regulation and retention, with attention to the specific issues raised by HIV/AIDS, tuberculosis and malaria	<b>2.2.3</b> Number of countries monitoring access to gender-sensitive, good-quality health services for HIV/AIDS, tuberculosis and malaria
	<b>BASELINE</b>		
	HIV/AIDS: to be established Tuberculosis: 63 countries Malaria: 32/43 countries	Baseline will be established in 2007 through a survey to determine the number of countries that have evidence-based health workforce policies/plans that incorporate response to HIV/AIDS, tuberculosis and malaria	HIV/AIDS: 30 countries Tuberculosis: 100/211 countries and territories Malaria: 43 countries
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	HIV/AIDS: 74 countries Tuberculosis: 74 countries Malaria: 43/43 countries	The number of countries with evidence-based health workforce policies/plans that incorporate response to HIV/AIDS, tuberculosis and malaria increased by 30% (compared to the baseline that will have been established in 2007)	HIV/AIDS: 75% of all countries Tuberculosis: all 211 countries and territories Malaria: 43/43 countries
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	HIV/AIDS: all countries Tuberculosis: 148 countries Malaria: 43/43 countries	The number of countries having evidence-based policies and plans for the health workforce that incorporate responses to HIV/AIDS, tuberculosis and malaria increased by 50% (compared with the 2008-2009 figure)	HIV: 75% of all countries Tuberculosis: all 211 countries and territories Malaria: 43/43 countries
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	259 441	280 000	300 000
	<b>JUSTIFICATION</b>		
	<p><i>WHO plays a critical role in supporting countries to scale up effective and gender-sensitive interventions to all those who need them; to remove the human resources obstacles to progress; to create or maximize synergies among existing programmes and service-delivery modes and to ensure that vulnerable and high-risk populations benefit from the interventions.</i></p>		

2.3 Global guidance and technical support provided on policies and programmes in order to promote equitable access to essential medicines, diagnostic tools and health technologies of assured quality for the prevention and treatment of HIV/AIDS, tuberculosis and malaria, and their rational use by prescribers and consumers, and, in order to ensure uninterrupted supplies of diagnostics, safe blood and blood products, injections and other essential health technologies and commodities.	INDICATORS				
	2.3.1 Number of new or updated global norms and quality standards for medicines and diagnostic tools for HIV/AIDS, tuberculosis and malaria	2.3.2 Number of priority medicines and diagnostic tools for HIV/AIDS, tuberculosis and malaria that have been assessed and pre-qualified for United Nations procurement	2.3.3 Number of targeted countries receiving support to increase access to affordable essential medicines for HIV/AIDS, tuberculosis and malaria whose supply is integrated into national pharmaceutical systems (the number of targeted countries is determined for the six-year period)	2.3.4 Cumulative number of patients with tuberculosis for whom treatment has been provided through the Global Drug Facility	2.3.5 Number of countries implementing quality-assured HIV/AIDS screening of all donated blood and administering all medical injections with safe equipment as part of strategy to prevent transmission of HIV associated with health care
	BASELINE				
	Five global standards	150 products (cumulative)	10 countries	10 million	77 countries with high-quality HIV/AIDS screening of all donated blood and 115 countries providing all medical injections with safe equipment
	TARGETS TO BE ACHIEVED BY 2009				
	10 new global standards	150 additional products	20 countries	14 million	134 countries with high-quality HIV screening of all donated blood and 154 countries where all medical injections are administered with safe equipment
	TARGETS TO BE ACHIEVED BY 2013				
	20 new global standards	400 products	All targeted countries supported	22 million	193 countries achieving high-quality HIV screening of all donated blood and administering all medical injections with safe equipment
	RESOURCES (US\$ THOUSAND)				
	Costs 2008-2009 58 568		Estimates 2010-2011 26 000		Estimates 2012-2013 29 000
JUSTIFICATION					
Progress against HIV/AIDS, tuberculosis and malaria depends significantly on provision of medicines, diagnostic tools and other essential health technologies. Expanding access to them and ensuring their quality are a major priority for WHO, as reflected in various Health Assembly resolutions. They represent an area of increasing priority for Member States and place an enormous demand on WHO for support. Most of the resources will be used for country and regional level activities.					

<b>2.4</b> Global, regional and national systems for surveillance, evaluation and monitoring strengthened and expanded to keep track of progress towards targets and allocation of resources for HIV/AIDS, tuberculosis and malaria control and to determine the impact of control efforts and the evolution of drug resistance.	<b>INDICATORS</b>		
	<b>2.4.1</b> Number of countries that regularly collect, analyse and report data on surveillance coverage, outcome and impact using WHO's standardized methodologies, including appropriate age- and sex-disaggregation	<b>2.4.2</b> Number of targeted countries providing WHO with annual data on surveillance, monitoring and financial allocation data for inclusion in the annual global reports on control of HIV/AIDS, tuberculosis and malaria and the achievement of targets	<b>2.4.3</b> Number of countries reporting age- and sex-disaggregated data from surveillance and monitoring of HIV/AIDS, tuberculosis and malaria drug resistance
	<b>BASELINE</b>		
	HIV/AIDS: 48/132 low- and middle-income countries Tuberculosis: 100/211 countries and territories Malaria: 30/107 countries	HIV/AIDS: all countries Tuberculosis: 211/211 countries and territories Malaria: 107/107 countries	HIV/AIDS: 8 countries (January 2006) and 16 countries (January 2007) Tuberculosis: 133/211 countries and territories Malaria: 107/107 countries
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	HIV/AIDS: 65/132 countries Tuberculosis: 150/211 countries and territories Malaria: 107/107 countries	HIV/AIDS: all countries Tuberculosis: 211/211 countries and territories Malaria: 107/107 countries	HIV/AIDS: all high-burden countries having set up drug-resistance surveillance systems using WHO methodology Tuberculosis: 152/211 countries and territories Malaria: all malaria-endemic countries having set up drug-resistance surveillance systems using WHO methodology
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	HIV/AIDS: 85/132 countries Tuberculosis: 211/211 countries and territories Malaria: 107/107 countries	HIV/AIDS: all countries Tuberculosis: 211/211 countries and territories Malaria: all targeted countries	HIV/AIDS: all countries requesting assistance providing annual national reports on HIV/AIDS drug resistance based on WHO guidelines Tuberculosis: 160/211 countries and territories Malaria: 107/107 countries
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	105 201	136 000	150 000
	<b>JUSTIFICATION</b>		
	<i>WHO has a crucial role in supporting and coordinating surveillance of HIV/AIDS, tuberculosis and malaria at the global and regional levels, including synthesis and dissemination of data for informing policy decisions and public health responses; shaping the research agenda; stimulating and supporting the generation, translation, and dissemination of knowledge, evidence and lessons learnt; and supporting countries in undertaking research and using the results for the development of tools and strategies for the prevention, early detection, diagnosis, treatment and control of the three diseases. All three levels of the Organization have a key role to play.</i>		

<b>2.5</b> Political commitment sustained and mobilization of resources ensured through advocacy and nurturing of partnerships on HIV/AIDS, tuberculosis and	<b>INDICATORS</b>		
	<b>2.5.1</b> Number of targeted countries with functional partnerships for HIV/AIDS, tuberculosis and malaria control	<b>2.5.2</b> Proportion of targeted countries that receive WHO support in accessing financial resources or increasing absorption of funds for HIV/AIDS, tuberculosis and malaria	<b>2.5.3</b> Proportion of countries involving communities, persons affected by the diseases, civil-society organizations and the private sector in planning, design, implementation and evaluation of HIV/AIDS, tuberculosis and malaria programmes



malaria at country, regional and global levels; support provided to countries as appropriate to develop or strengthen and implement mechanisms for resource mobilization and utilization and increase the absorption capacity of available resources; and engagement of communities and affected persons increased to maximize the reach and performance of HIV/AIDS, tuberculosis and malaria control programmes.	<b>BASELINE</b>		
	HIV/AIDS: 85% of 126 low- and middle-income countries reporting in 2005 had national HIV/AIDS coordinating bodies Tuberculosis: 30 targeted countries Malaria: 10/46 targeted countries	HIV/AIDS: 70 countries by September 2006 Tuberculosis: all high-burden countries Malaria: 30% of countries requesting support	HIV/AIDS: all countries Tuberculosis: 30/87 countries Malaria: 30% of targeted countries
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	HIV/AIDS: all countries Tuberculosis: 43/87 countries Malaria: 33/46 targeted countries	HIV/AIDS: all high-burden countries requesting support Tuberculosis: all tuberculosis high-burden and high-incidence countries requesting support Malaria: 50% of targeted countries requesting support	HIV/AIDS: all countries Tuberculosis: 43/87 countries Malaria: 50% of targeted countries
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	HIV/AIDS: all countries Tuberculosis: 87 countries Malaria: 42/46 targeted countries	HIV/AIDS: all countries requesting support Tuberculosis: all targeted countries requesting support Malaria: all targeted countries	HIV/AIDS: all countries Tuberculosis: all targeted countries Malaria: all targeted countries
	<b>RESOURCES (US\$ THOUSAND)</b>		
Costs 2008-2009 36 120	Estimates 2010-2011 28 000	Estimates 2012-2013 30 000	
<b>JUSTIFICATION</b>			
<i>Resources are required to ensure engagement and coordination with various partners for rapid scaling up of interventions for HIV/AIDS, tuberculosis and malaria, including advocacy, coordination, and collaboration with key partners, networks and stakeholders such as UNAIDS, the Stop TB Partnership including the Global Drug Facility and Roll Back Malaria Partnership, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States' President's Emergency Plan for AIDS Relief, the Malaria Medicines and Supply Service, and AIDS Medicines and Diagnostics Service. They are also needed for promoting funding of work on aspects of HIV/AIDS, tuberculosis and malaria that remain severely underfunded, such as laboratory capacity and human resources. The work cuts across all three levels of the Organization.</i>			

2.6 New knowledge, intervention tools and strategies developed and validated to meet priority needs for the prevention and control of HIV/AIDS, tuberculosis and malaria, with scientists from developing countries increasingly taking the lead in this research.	<b>INDICATORS</b>		
	<b>2.6.1</b> Number of new and improved tools (e.g. medicines, vaccines and diagnostic tools) receiving internationally recognized approval for use in HIV/AIDS, tuberculosis or malaria	<b>2.6.2</b> Number of new and improved interventions and implementation strategies for HIV/AIDS, tuberculosis and malaria, whose effectiveness has been determined and evidence made available to appropriate institutions for policy decisions	<b>2.6.3</b> Proportion of peer-reviewed publications arising from WHO-supported research on HIV/AIDS, tuberculosis or malaria and for which the main author's institution is based in a developing country
	<b>BASELINE</b>		
	1	2	48% of all peer-reviewed publications
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	2 (cumulative)	4 (cumulative)	55% of all peer-reviewed publications
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	4 (cumulative)	8 (cumulative)	60% of all peer-reviewed publications

	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	104 365	74 000	81 000
<b>JUSTIFICATION</b>			
<i>Appropriately directed research can have a significant impact on the control of HIV/AIDS, tuberculosis and malaria through the improvement, development and evaluation of new tools, interventions and strategies. WHO's facilitative role is crucial to finding the most effective measures for combating the three diseases and building a sustainable base in order to enable developing countries to undertake research of national and local relevance.</i>			

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

### Indicators and targets

- A 2% annual reduction – over and above current trends – in the global burden of disease due to the major chronic noncommunicable conditions, measured in disability-adjusted life years
- To halt and begin to reverse current trends towards increasing incidence rates of mental, behavioural, and neurological disorders, together with those provoked by psychoactive substance use
- To halt and begin to reverse current trends towards increased mortality from injuries.

### ISSUES AND CHALLENGES

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

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

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

### Lessons learnt

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

## STRATEGIC APPROACHES

To achieve this objective, tackling chronic noncommunicable conditions, mental disorders, violence and injuries will need to be made a priority for health and for development at both national and international levels. A comprehensive public health approach that includes the fostering of multisectoral collaboration and innovation is essential. Member States should develop coordinated but distinct responses to chronic noncommunicable diseases, mental disorders, violence and injuries, based on comprehensive and integrated action. Shifting the focus to concentrate on primary prevention, reorienting the emphasis towards prevention in health care and ensuring community participation are critical to successful outcomes in countries.

## ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

- that a high level of multisectoral cooperation will be sustained between global and national stakeholders, and that it is recognized that multisectoral action is more likely to be successful than individual actions;
- that countries recognize that integrated prevention and management of the conditions, disorders and injuries concerned is more likely to result in the achievement of this strategic objective than focusing on individual conditions and disorders;
- that it is recognized that countries need to give priority to primary care and prevention over tertiary care when allocating resources.

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

- that combating the growing threat to health and development posed by chronic noncommunicable conditions, mental and behavioural disorders, violence and injuries continues to be omitted from the high-level development schedule, as set out in the Millennium Development Goals;
- that new global threats, such as severe acute respiratory syndrome and avian influenza, may entail a reduction in both the importance attached and the resources allocated to tackling the conditions covered by this strategic objective.

### The Secretariat will focus on:

- advocating increased commitment and action;
- providing assistance for the collection, analysis and use of data on the magnitude, causes and consequences of chronic noncommunicable conditions, mental disorders, violence and injuries;
- developing technical guidance and training materials;
- supporting the development, implementation and monitoring of policies and programmes for prevention, management and rehabilitation in respect of the conditions, disorders and injuries concerned;
- assessing and strengthening health and other systems in order to enhance prevention and management and to provide services, including rehabilitation;
- building and supporting networks and partnerships with governmental and nongovernmental organizations, other United Nations and international agencies, professional and consumer/family groups, the private sector and the media.

## ORGANIZATION-WIDE EXPECTED RESULTS

3.1 Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic	INDICATORS			
	3.1.1 Number of targeted countries whose health ministries have a focal point or a unit for injuries and violence prevention with its own budget	3.1.2 <i>The world report on disability and rehabilitation</i> published and launched, in response to resolution WHA58.23	3.1.3 Number of targeted countries whose health ministries have a unit for mental health with its own budget	3.1.4 Proportion of targeted countries whose health ministries have a unit or department for chronic noncommunicable conditions with its own budget

<b>BASELINE</b>			
80 targeted countries	No report	90 targeted countries	10% of targeted countries
<b>TARGETS TO BE ACHIEVED BY 2009</b>			
120 targeted countries	Draft report prepared	120 targeted countries	30% of targeted countries
<b>TARGETS TO BE ACHIEVED BY 2013</b>			
193 countries	Report published in 6 languages	193 countries	85% of targeted countries
<b>RESOURCES (US\$ THOUSAND)</b>			
Costs 2008-2009 25 743	Estimates 2010-2011 24 000	Estimates 2012-2013 20 000	
<b>JUSTIFICATION</b>			
<i>The resources will be used to raise the profile of, and strengthen commitment for, action to tackle chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities at global, regional and national levels. Resources will also be used to support the creation and initial activities of units in national public health agencies for tackling such conditions. Finally, resources will be used for the elaboration of global tools and the preparation of reports and campaigns that describe the situation and make recommendations for action.</i>			

3.2 Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities.	INDICATORS				
	3.2.1 Number of targeted countries that have and are implementing national plans to prevent unintentional injuries and violence	3.2.2 Number of targeted countries that have and are implementing national plans in respect of disability and rehabilitation	3.2.3 Number of countries receiving and utilizing guidance on policies, strategies and regulations in respect of mental, behavioural and neurological disorders including those due to psychoactive substance use	3.2.4 Proportion of targeted countries that have and are implementing a nationally approved policy for the prevention and control of chronic noncommunicable conditions	3.2.5 Proportion of targeted countries that have and are implementing comprehensive national plans for the prevention of hearing and visual impairment, including blindness
	BASELINE				
	40 targeted countries	35 targeted countries	70 countries	10% of targeted countries	10% of targeted countries
	TARGETS TO BE ACHIEVED BY 2009				
	70 targeted countries	60 targeted countries	72 countries	30% of targeted countries	30% of targeted countries
	TARGETS TO BE ACHIEVED BY 2013				
	120 targeted countries	100 targeted countries	193 countries	85% of targeted countries	85% of targeted countries
	RESOURCES (US\$ THOUSAND)				
	Costs 2008-2009 30 185		Estimates 2010-2011 33 000	Estimates 2012-2013 33 000	
	JUSTIFICATION				
	National plans and policies are essential for coordinated multisectoral responses to chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities. To date, only a few countries have prepared the relevant documents and the resources will therefore be used to support regional and national efforts to develop and begin implementation of national plans.				

3.3 Improvements made in Member States' capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities.	INDICATORS				
	3.3.1 Number of targeted countries that have a published document containing a national compilation of data on the magnitude, causes and consequences of violence and injuries	3.3.2 Number of targeted countries that have a published document containing a national compilation of data on the prevalence and incidence of disabilities	3.3.3 Number of targeted countries establishing or substantially strengthening national or regional information systems on the magnitude, causes and consequences of mental, behavioural and neurological disorders, including those provoked by psychoactive substance use	3.3.4 Proportion of targeted countries with a national health reporting system and annual reports that include indicators of chronic, noncommunicable conditions	3.3.5 Proportion of targeted countries documenting the burden of hearing and visual impairment, including blindness
	BASELINE				
	40 targeted countries	60 targeted countries	24 targeted countries	10% of targeted countries	10% of targeted countries
	TARGETS TO BE ACHIEVED BY 2009				
	70 targeted countries	90 targeted countries	36 targeted countries	30% of targeted countries	30% of targeted countries
	TARGETS TO BE ACHIEVED BY 2013				
	120 targeted countries	140 targeted countries	72 targeted countries	85% of targeted countries	85% of targeted countries
	RESOURCES (US\$ THOUSAND)				
	Costs 2008-2009 23 778		Estimates 2010-2011 31 000	Estimates 2012-2013 35 000	
	JUSTIFICATION				
	Resources will be used to support countries' and regions' efforts to improve documentation of the public health impact and costs of chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities. More specifically, the resources will be used to set up data collection systems, and support data analysis and dissemination. Resources will also be used to monitor and provide feedback on global trends.				

<b>3.4</b> Improved evidence compiled by WHO on the cost-effectiveness of interventions to tackle chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities.	<b>INDICATORS</b>	
	<b>3.4.1</b> Availability of evidence on the cost-effectiveness of widely available interventions for the management of selected mental, behavioural and neurological disorders including those provoked by psychoactive substance use	<b>3.4.2</b> Availability of summarized evidence on the cost-effectiveness of a core package of interventions for chronic noncommunicable conditions together with an estimate of the global cost of implementation
	<b>BASELINE</b>	
	No evidence made available	Evidence for individual interventions available
	<b>TARGETS TO BE ACHIEVED BY 2009</b>	
	Evidence made available for 4 interventions	Core package completed
	<b>TARGETS TO BE ACHIEVED BY 2013</b>	
	Evidence made available for 12 interventions	Expanded and desirable packages completed, and approach adapted for country implementation

RESOURCES (US\$ THOUSAND)		
Costs 2008-2009 23 618	Estimates 2010-2011 24 000	Estimates 2012-2013 30 000
<b>JUSTIFICATION</b>		
<i>Resources will be used to support further research in low- and middle-income countries on the cost-effectiveness of interventions. This will include training and workshops to refine methodology, studies, and compilation of results at national, regional and global levels, including through documents on best practices and focused dissemination strategies. Resources will also be used to provide policy-makers at country level with information and support their use of such information for priority-setting.</i>		

3.5 Guidance and support provided to Member States for the preparation and implementation of multisectoral, population-wide programmes to prevent mental and behavioural disorders, violence and injuries, together with hearing and visual impairment, including blindness.	<b>INDICATORS</b>		
	<b>3.5.1</b> Number of guidelines published and widely disseminated on multisectoral interventions to prevent violence and unintentional injuries	<b>3.5.2</b> Availability of guidance on the prevention of selected mental, behavioural and neurological disorders including those provoked by psychoactive substance use	<b>3.5.3</b> Proportion of targeted countries implementing strategies recommended by WHO for population-wide prevention of hearing and visual impairment, including blindness
	<b>BASELINE</b>		
	4 guidelines published and disseminated	No guidance made available	10% of countries
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	12 guidelines published and disseminated	Guidance on 2 disorders prepared and made available	30% of countries
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	18 guidelines published and disseminated	Guidance on 4 disorders prepared and made available	85% of countries
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009 21 366	Estimates 2010-2011 51 000	Estimates 2012-2013 69 000
	<b>JUSTIFICATION</b>		
	<i>Resources will be used to support the implementation of prevention programmes at local, national and regional levels, including provision of the necessary training and workshops. Resources will also be used for global and regional guidelines and documents on best practices, and for global coordination and monitoring of country experiences and lessons learnt.</i>		

3.6 Guidance and support provided to Member States to improve the ability of their health and social systems to prevent and manage chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities.	<b>INDICATORS</b>				
	<b>3.6.1</b> Number of targeted countries whose health-care systems are better able to respond to unintentional injuries and violence as a result of using WHO's guidelines	<b>3.6.2</b> Number of countries with strengthened rehabilitation services as a result of using the recommendations in <i>The world report on disability and rehabilitation</i> and in related WHO guidelines	<b>3.6.3</b> Number of countries conducting a systematic assessment of their mental health systems by means of WHO's assessment instrument for mental health systems, and utilizing the information obtained to plan the strengthening of national mental health systems	<b>3.6.4</b> Proportion of targeted countries implementing integrated primary health-care strategies recommended by WHO in the management of chronic non-communicable conditions	<b>3.6.5</b> Number of countries with strengthened health-system services for the treatment of tobacco dependence as a result of using WHO's policy recommendations

	<b>BASELINE</b>				
	12 targeted countries	No country	48 countries	10% of targeted countries	No country
	<b>TARGETS TO BE ACHIEVED BY 2009</b>				
	30 targeted countries	10 countries	72 countries	30% of targeted countries	10 countries
	<b>TARGETS TO BE ACHIEVED BY 2013</b>				
	70 targeted countries	80 countries	144 countries	85% of targeted countries	30 countries
	<b>RESOURCES (US\$ THOUSAND)</b>				
	Costs 2008-2009 32 510	Estimates 2010-2011 33 000		Estimates 2012-2013 43 000	
	<b>JUSTIFICATION</b>				
	<i>Resources will be used for the provision of documents, training, workshops and direct support for the strengthening of health and rehabilitation services in low- and middle- income countries, in order to ensure that such countries improve their response to chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities.</i>				



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

**Indicators and targets**

- Proportion of births attended by skilled health personnel. Target: at least 85%
- Maternal mortality ratio. Target: less than 50 countries with maternal mortality ratio above 100 per 100 000 live births
- Under-five mortality rate. Target: 154 countries having met or on track to meet Millennium Development Goal Target 5 (reduce by two thirds, between 1990 and 2015, the under-five mortality rate)
- Access to reproductive health services, as measured by unmet need for family planning or contraceptive prevalence rate; the fertility of women aged 15-19 years as a proportion of total fertility among women of all ages; and syphilis screening for pregnant women. Target: 154 countries having met or on track to meet their national targets for all three indicators
- Adolescent health, as measured by fertility proportions, HIV prevalence in young people aged 15-24 years, obesity and overweight, tobacco use and injury rate. Target: 50 countries having met or on track to meet their national targets for two of the five indicators and showing no deterioration in the three other indicators.

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

**ISSUES AND CHALLENGES**

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

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

**Lessons learnt**

- The interventions that need to be scaled up are cost effective and can be so expanded even in resource-constrained settings, when sufficient attention is placed on developing an enabling policy environment and strengthening health systems, with a focus on human resources.
- The programmes concerned contribute to reducing inequities because they reach out to the most vulnerable and marginalized populations and serve as a critical entry point and platform for other key public health programmes.

fragmentation, missed opportunities and an inefficient use of the limited resources that are currently available. Lack of attention to gender inequality and health inequities undermine ongoing efforts to decrease mortality and morbidity globally. This pattern can be changed through concerted action by all involved.

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

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

## STRATEGIC APPROACHES

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

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

### Lessons learnt

- Because WHO is expected to lead work on defining strategic and technical approaches to attaining the Millennium Development Goals 4 and 5 and securing international commitments related to reproductive health, it must continue advocating for increased investment in these areas.
- Effective partnerships of all stakeholders at national, regional and international levels are crucial to avoiding duplication of effort and fragmentation of programmes and to increasing and sustaining momentum towards reaching internationally agreed goals.

### The Secretariat will focus on:

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

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

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

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

**The Secretariat will focus on:**

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

### **ASSUMPTIONS, RISKS AND OPTIONS**

The following assumptions underlie attainment of this strategic objective:

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

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

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

## ORGANIZATION-WIDE EXPECTED RESULTS

<b>4.1</b> Support provided to Member States to formulate a comprehensive policy, plan and strategy for scaling up towards universal access to effective interventions in collaboration with other programmes, paying attention to reducing gender inequality and health inequities, providing a continuum of care throughout the life course, integrating service delivery across different levels of the health system and strengthening coordination with civil society and the private sector.	<b>INDICATORS</b>		
	<b>4.1.1</b> Number of targeted countries that have an integrated policy on universal access to effective interventions for improving maternal, newborn and child health	<b>4.1.2</b> Number of countries that have a policy on universal access to sexual and reproductive health	<b>4.1.3</b> Number of countries that have a policy on the promotion of active and healthy ageing
	<b>BASELINE</b>		
	10 countries	20 countries	None
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	20 countries	30 countries	25 countries
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	100 countries	80 countries	40 countries
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009 36 076	Estimates 2010-2011 55 000	Estimates 2012-2013 75 000
	<b>JUSTIFICATION</b>		
	<i>Achievement of targets will require: advocacy and coordination of effective international efforts and the strengthening of collaboration with partners (e.g., through the Maternal Newborn and Child Health Partnership); promotion of key initiatives and approved actions such as the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health, the Global Strategy for the Prevention and Control of Sexually Transmitted Infections, the strategy for child and adolescent health and development, the Global Strategy for Infant and Young Child Feeding, the integrated management of pregnancy and childbirth, the integrated management of childhood illness, and the Child Health Policy Initiative; promotion of national policies and laws that conform to international human-rights norms and standards and that will help to remove inequities; strengthening of health systems, with particular attention paid to human resources and the provision and rational use of essential medicines, safe blood, health technologies and commodities; stronger links between maternal and child health services and other programmes (including those for nutrition, HIV infection, tuberculosis and malaria); and contribution to health management systems for monitoring progress towards national targets and benchmarks relevant to Millennium Development Goals 4 and 5 and sexual and reproductive health goals.</i>		
<b>4.2</b> National research capacity strengthened as necessary and new evidence, products, technologies, interventions and delivery approaches of global and/or national relevance available to improve maternal, newborn, child and adolescent health, to promote active and healthy ageing, and to improve sexual and reproductive health.	<b>INDICATORS</b>		
	<b>4.2.1</b> Number of new research centres strengthened through comprehensive institutional development and support	<b>4.2.2</b> Number of completed studies on priority issues in the relevant field of health	<b>4.2.3</b> Number of new or updated systematic reviews on best practices, policies and standards of care
	<b>BASELINE</b>		
	None	None	None
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	4 centres	12 studies	15 reviews
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	10 centres	34 studies	40 reviews
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009 73 169	Estimates 2010-2011 75 000	Estimates 2012-2013 80 000

	<b>JUSTIFICATION</b>		
	<i>Country-led identification of research priorities and opportunities for strengthening national research capacity will have to be given greater attention, and the setting of those research priorities, done in close consultation with national research partners and other stakeholders, will have to be improved. Support will be needed for use of research findings in informing policies and programmes.</i>		
	<b>INDICATORS</b>		
	<b>4.3.1</b> Number of countries with at least 50% of target districts implementing strategies to ensure skilled care for every birth	<b>4.3.2</b> Number of countries adapting and utilizing policy, technical and managerial norms and guidelines on integrated management of pregnancy and childbirth	
	<b>BASELINE</b>		
	10 countries	10 countries	
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	20 countries	20 countries	
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
75 countries	75 countries		
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009 65 470	Estimates 2010-2011 107 000	Estimates 2012-2013 130 000
	<b>JUSTIFICATION</b>		
	<i>Attention needs to be paid to strengthening human resources capacity, providing a supportive environment to ensure skilled care for every birth, and ensuring a continuum of care between communities and facilities, with referral care at all times in particular for marginalized populations and communities in order to enhance their participation in designing approaches that improve access to essential health services and referral care. Further, attainment of these results will need monitoring and auditing systems that identify maternal deaths and detect failures of the system to meet needs, especially those of marginalized and underserved populations.</i>		
	<b>INDICATORS</b>		
	<b>4.4.1</b> Number of countries with at least 50% of target districts implementing strategies for neonatal survival and health	<b>4.4.2</b> Number of countries that have adapted, and in which 50% or more of target districts are implementing, the packages of interventions for integrated management of both childhood illness and pregnancy and childbirth, which include those for the full newborn period	
	<b>BASELINE</b>		
	20 countries	20 countries	
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
40 countries	40 countries		
<b>TARGETS TO BE ACHIEVED BY 2013</b>			
75 countries	75 countries		
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009 50 875	Estimates 2010-2011 88 000	Estimates 2012-2013 115 000
	<b>JUSTIFICATION</b>		
	<i>Achievement of this expected result will require a continuum of care between maternal, newborn and child health services and strengthened links between these and other programmes such as immunization, family planning, nutrition, HIV/AIDS, syphilis elimination and malaria control. Furthermore, it will need community involvement and promotion of contact between mothers, their families and health workers, a continuum of care between communities and health facilities, provision of suitable facilities for maternal and newborn care at community and primary-care levels, especially for low birth-weight infants and systems for monitoring trends in neonatal survival, disaggregated by sex, that allow the detection of subpopulations at high risk.</i>		

<b>4.5</b> Guidelines, approaches and tools for improving child health and development applied at the country level, with technical support provided to Member States for intensified action towards universal coverage of the population with effective interventions and for monitoring progress, taking into consideration international and human-rights norms and standards, notably those stipulated in the Convention on the Rights of the Child.	<b>INDICATORS</b>		
	<b>4.5.1</b> Number of countries implementing strategies for increasing coverage with child health and development interventions		<b>4.5.2</b> Number of countries that have expanded geographical coverage of the integrated management of childhood illness to more than 75% of target districts
	<b>BASELINE</b>		
	20 countries		10 countries
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	40 countries		30 countries
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	60 countries		60 countries
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	41 923	75 000	93 000
<b>JUSTIFICATION</b>			
<i>Achievement of this expected result will depend on the following: a continuum of care from mothers and newborns to children, and between different levels of the health system; capacity building at all levels; links with work on addressing the underlying social, environmental and behavioural determinants of ill-health and poor nutrition; promotion of child development and healthy lifestyles; enhanced building of community capacity and involvement in support of the integrated management of childhood illness; and systems for monitoring trends in child survival, disaggregated by age and sex, that allow the detection of subpopulations at high risk.</i>			

<b>4.6</b> Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, and for the scaling up of a package of prevention, treatment and care interventions in accordance with established standards.	<b>INDICATORS</b>		
	<b>4.6.1</b> Number of countries with a functioning adolescent health and development programme <sup>1</sup>		
	<b>BASELINE</b>		
	15 countries		
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	50 countries		
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	100 countries		
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	34 733	55 000	74 000
<b>JUSTIFICATION</b>			
<i>Achievement of this expected result will depend on capacity being built at the country level for collecting and disseminating the data necessary for programme implementation and for health services, with the participation of young people, the engagement of community structures and a focus on particularly vulnerable groups and settings, in order to respond to the priority health needs of adolescents and to increase their access to services. Moreover, the policy environment will need to be supportive in order to ensure that the health sector provides evidence on effective interventions and examples of good practice. Systems will be needed to monitor trends in adolescent health and development, with data disaggregated by age and sex, and to allow the detection of subpopulations at high risk.</i>			

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

4.7 Guidelines, approaches and tools made available, with provision of technical support to Member States for accelerated action towards implementing the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health, with particular emphasis on ensuring equitable access to good-quality sexual and reproductive health services, particularly in areas of unmet need, and with respect for human rights as they relate to sexual and reproductive health	INDICATORS		
	4.7.1 Number of countries implementing the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health		4.7.2 Number of targeted countries having reviewed their existing national laws, regulations or policies relating to sexual and reproductive health
	BASELINE		
	20 countries		3 countries
	TARGETS TO BE ACHIEVED BY 2009		
	30 countries		8 countries
	TARGETS TO BE ACHIEVED BY 2013		
	80 countries		15 countries
	RESOURCES (US\$ THOUSAND)		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	48 313	80 000	113 000
	JUSTIFICATION		
	Achievement of this result will depend on capacity being built at the country level for collecting, analysing and disseminating the data necessary for programme implementation; stronger links between sexual and reproductive health services and other health programmes, such as those on HIV/AIDS and nutrition; and monitoring and evaluation of sexual and reproductive health programmes within and outside the health system, along with the establishment of accountability mechanisms.		

4.8 Guidelines, approaches, tools, and technical assistance provided to Member States for increased advocacy for consideration of ageing as a public health issue, for the development and implementation of policies and programmes aiming at maintaining maximum functional capacity throughout the life course and for the training of health-care providers in approaches that ensure healthy ageing.	INDICATORS		
	4.8.1 Number of targeted countries that have implemented community-based policies with a focus on strengthening primary health-care capacity to deal with ageing issues		4.8.2 Number of targeted countries that have implemented multi-sectoral policies reflecting the Secretariat’s active ageing policy framework
	BASELINE		
	None		None
	TARGETS TO BE ACHIEVED BY 2009		
	10 countries		15 countries
	TARGETS TO BE ACHIEVED BY 2013		
	20 countries		25 countries
	RESOURCES (US\$ THOUSAND)		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
10 641	16 000	22 000	
JUSTIFICATION			
Achievement of this expected result will depend on building the capacity of health services to support active and healthy ageing; support for the establishment of age-friendly primary health-care centres; ensuring the participation of older persons in the national policy development and programme planning process, with an emphasis on their contribution to society; and support for multisectoral initiatives that promote active ageing, such as “age-friendly cities”.			

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

### Indicators and targets

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

### ISSUES AND CHALLENGES

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

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

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

### STRATEGIC APPROACHES

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

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

### Lessons learnt

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



information services; and restoration of the health infrastructure.

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

### ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

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

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

#### The Secretariat will focus on:

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

### ORGANIZATION-WIDE EXPECTED RESULTS

5.1 Norms and standards developed, capacity built and technical support provided to Member States for the development and strengthening of national emergency preparedness plans and programmes.	INDICATORS			
	5.1.1 Proportion of countries with national emergency preparedness plans that cover multiple hazards	5.1.2 Proportion of countries where comprehensive mass-casualty management plans are in place	5.1.3 Proportion of countries in humanitarian emergencies that have norms, guidelines and strategies developed for reducing the impact of health emergencies on mothers, neonates and children	5.1.4 Number of countries developing and implementing programmes for reducing the vulnerability of health, water and sanitation infrastructures
	BASELINE			
	25% of countries	15% of countries	40% of countries	20 countries

	TARGETS TO BE ACHIEVED BY 2009			
	60% of countries	40% of countries	80% of countries	40 countries
	TARGETS TO BE ACHIEVED BY 2013			
	70% of countries	55% of countries	90% of countries	60 countries
	RESOURCES (US\$ THOUSAND)			
	Costs 2008-2009	Estimates 2010-2011		Estimates 2012-2013
	45 828	49 000		51 000
JUSTIFICATION				
Efforts will be intensified in the biennium 2010-2011 and again in the biennium 2012-2013.				

<b>5.2</b> Norms and standards developed, capacity built and technical support provided to Member States for a timely response to disasters associated with natural hazards and to conflict-related crises.	<b>INDICATORS</b>		
	<b>5.2.1</b> Proportion of emergencies for which health and nutrition assessments and tracking exercises are being implemented	<b>5.2.2</b> Number of global and regional training programmes on health operations in emergency response	<b>5.2.3</b> Proportion of emergencies for which interventions for maternal, newborn and child health are in place
	<b>BASELINE</b>		
	15% of emergencies	5 training programmes	30% of emergencies
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	60% of emergencies	16 training programmes	75% of emergencies
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	80% of emergencies	20 training programmes	85% of emergencies
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	68 112	71 000	74 000
	<b>JUSTIFICATION</b>		
	<i>Efforts will be intensified in the biennium 2010-2011 and again in the biennium 2012-2013.</i>		

<b>5.3</b> Norms and standards developed, capacity built and technical support provided to Member States for assessing needs and for planning and implementing interventions during the transition and recovery phases of conflicts and disasters.	<b>INDICATORS</b>		
	<b>5.3.1</b> Number of post-conflict and post-disaster needs assessments conducted that contain a gender-responsive health component	<b>5.3.2</b> Number of humanitarian action plans for complex emergencies and formulation processes for consolidated appeals with strategic and operational components for health included	<b>5.3.3</b> Number of countries in transition or recovery situations benefiting from needs assessments and technical support in the areas of maternal and newborn health, mental health and nutrition
	<b>BASELINE</b>		
	2 needs assessments	8 plans	5 countries
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	6 needs assessments	20 plans	15 countries
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	8 needs assessments	25 plans	20 countries
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	46 728	59 000	65 000
	<b>JUSTIFICATION</b>		
	<i>Efforts will be intensified in the biennium 2010-2011 and again in the biennium 2012-2013.</i>		

<b>5.4</b> Coordinated technical support provided to Member States for communicable disease control in natural disaster and conflict situations.	<b>INDICATORS</b>	
	<b>5.4.1</b> Proportion of emergency-affected countries where a comprehensive communicable disease-risk assessment has been conducted and an epidemiological profile and toolkit developed and disseminated to partner agencies	<b>5.4.2</b> Proportion of situations involving acute natural disasters or conflicts for which a disease-surveillance and early-warning system has been activated and where communicable disease-control interventions have been implemented
	<b>BASELINE</b>	
	50% of countries	60% of situations
	<b>TARGETS TO BE ACHIEVED BY 2009</b>	
	100% of countries	100% of situations
	<b>TARGETS TO BE ACHIEVED BY 2013</b>	
	100% of countries	100% of situations
	<b>RESOURCES (US\$ THOUSAND)</b>	
	Costs 2008-2009	Estimates 2010-2011
	23 080	45 000
	Estimates 2012-2013	
	53 000	
	<b>JUSTIFICATION</b>	
	Efforts will be intensified in the biennium 2010-2011 and again in the biennium 2012-2013.	

5.5 Support provided to Member States for strengthening national preparedness and for establishing alert and response mechanisms for food-safety and environmental health emergencies.	INDICATORS				
	5.5.1 Number of expert networks in place for responding to food-safety and environmental public health emergencies	5.5.2 Proportion of countries with national plans for preparedness, and alert and response activities in respect of chemical, radiological and environmental health emergencies	5.5.3 Number of countries with focal points for the International Food Safety Authorities Network and for environmental health emergencies	5.5.4 Proportion of food-safety and environmental health emergencies benefiting from intersectoral collaboration and assistance	5.5.5 Proportion of countries achieving a state of preparedness and completing stockpiling of necessary items in order to ensure a prompt response to chemical and radiological emergencies
	BASELINE				
	10 networks	30% of countries	50 countries	25% of emergencies	20% of countries
	TARGETS TO BE ACHIEVED BY 2009				
	20 networks	60% of countries	75 countries	65% of emergencies	50% of countries
	TARGETS TO BE ACHIEVED BY 2013				
	30 networks	70% of countries	100 countries	100% of emergencies	100% of countries
	RESOURCES (US\$ THOUSAND)				
	Costs 2008-2009		Estimates 2010-2011	Estimates 2012-2013	
	19 276		17 000	18 000	
	JUSTIFICATION				
	Efforts will be intensified in the biennium 2010-2011 and again in the biennium 2012-2013.				

<b>5.6</b> Effective communications issued, partnerships formed and coordination developed with other organizations in the United Nations system, governments, local and international nongovernmental organizations, academic institutions and professional associations at the country, regional and global levels.	<b>INDICATORS</b>		
	<b>5.6.1</b> Proportion of affected or pilot countries in which the United Nations Inter-Agency Standing Committee Humanitarian Health Cluster is operational (in addition to the functioning Health Cluster at global level) and that have annual action plans in place	<b>5.6.2</b> Number of emergency-related interagency mechanisms and working groups where WHO is actively involved	<b>5.6.3</b> Proportion of disasters and crises covered with a comprehensive communication strategy
	<b>BASELINE</b>		
	60% of countries	8 mechanisms	35% of disasters and crises
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	100% of countries	16 mechanisms	100% of disasters and crises
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	100% of countries	20 mechanisms	100% of disasters and crises
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	16 476	16 000	17 000
<b>JUSTIFICATION</b>			
<i>Efforts will be intensified in the biennium 2010-2011 and again in the biennium 2012-2013.</i>			

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

### **Indicators and targets**

- Proportion of Member States reporting a 10% reduction in the prevalence rate of tobacco use. Target: 50% of Member States reporting a 10% reduction by the end of 2013
- Number of Member States with a stabilized or reduced level of harmful use of alcohol. Target: 10% increase in number of Member States reporting a stabilized or reduced level by the end of 2013
- Proportion of Member States with a high burden of adult obesity halting the rise in prevalence. Target: 10% of Member States halting the rise in prevalence by the end of 2013.

### **ISSUES AND CHALLENGES**

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

Tobacco use is the leading cause of preventable deaths worldwide, with at least 50% of tobacco-attributable deaths occurring in developing countries. Tobacco use and poverty are closely linked and prevalence rates are higher among the poor. Fortunately, measures that are both successful and cost effective are available for reducing tobacco use. The WHO Framework Convention on Tobacco Control is an evidence-based treaty designed to help to reduce the burden of disease and death caused by tobacco use. Every year, alcohol consumption is linked to 1.8 million deaths globally and 58.3 million years of life lost. In developing countries with low overall mortality, alcohol use is the leading risk factor, accounting for 6.2% of the total burden of disease. In a growing number of countries, injecting drug use is the driving force behind the rapid spread of HIV infection. Despite evidence of the substantial burden on health and society arising from alcohol and other psychoactive substance use, there are limited resources at WHO and in countries for preventing and treating substance use disorders, even though US\$ 1 invested in treatment produces at least US\$ 7 of savings in health and social costs.

### **Lessons learnt**

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

Globally, 17% of the population are estimated to be physically inactive and an additional 41% to be insufficiently active to benefit their health. It has been estimated that the resultant annual death toll is 1.9 million.<sup>1</sup>

Unsafe sexual behaviour significantly increases the burden of disease through unintended pregnancy, sexually transmitted infections (including HIV), and other social, emotional and physical consequences that have been seriously underestimated. WHO estimates that unsafe sex is the second most important global risk factor to health in countries with high mortality rates. Each year, 80 million women have an unwanted pregnancy, 46 million opt for termination, and 340 million new cases of sexually transmitted infections and five million new HIV infections are reported. Risky behaviour does not often occur in isolation; for example, hazardous use of alcohol and other drugs and unsafe sex frequently go together. Many of these behaviours are not the result of individual decision-making, but reflect existing policies, social and cultural norms, inequities and low education levels. For that reason, WHO recognizes the need for a comprehensive, integrated approach to health promotion together with effective preventive strategies.

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

## STRATEGIC APPROACHES

Taking an integrated approach to health promotion and preventing or reducing major risk factors will enhance synergies, improve the overall efficiency of interventions and replace existing vertical approaches.

In countries, it is essential to strengthen institutions and build national capacities for surveillance and prevention or reduction in respect of the common risk factors and the health conditions with which they are associated. Furthermore, strong leadership and stewardship by health ministries are necessary to ensure that all sectors of society participate effectively. Action at the multisectoral level is vital because the main determinants of the major risk factors lie outside the health sector.

In the area of health promotion, significant efforts are required to strengthen leadership and build capacity to take account of increased needs and activities across all relevant health programmes, as well as the recommendations made at

### Lessons learnt

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

### The Secretariat will focus on:

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

<sup>1</sup> *The world health report 2002. Reducing risks, promoting healthy life.* Geneva, World Health Organization, 2002.

the 6th Global Conference on Health Promotion (Bangkok, 7-11 August 2005). In order to ensure lasting success there is a need for comprehensive approaches that use a combination of strategies to resolve policy issues and build capacities at individual, family and community levels.

### ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

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

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

### The Secretariat will focus on:

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

## ORGANIZATION-WIDE EXPECTED RESULTS

6.1 Advice and support provided to Member States to build their capacity for health promotion across all relevant programmes, and to establish effective multisectoral and multidisciplinary collaborations for promoting health and preventing or reducing major risk factors.	INDICATORS		
	6.1.1 Number of countries receiving support to develop outcome-oriented health-promotion activities or strategies to expand the finance base of health promotion		6.1.2 Level(s) at which multisectoral mechanisms or networks strengthened for health-promotion and prevention activities in respect of major risk factors at national level
	BASELINE		
	24 countries		No partnership established
	TARGETS TO BE ACHIEVED BY 2009		
	50 countries		Global health-promotion partnership established
	TARGETS TO BE ACHIEVED BY 2013		
	100 countries		Health-promotion interagency groups established at regional and country levels
	RESOURCES (US\$ THOUSAND)		
	Costs 2008-2009		Estimates 2010-2011
40 408		52 000	66 000
JUSTIFICATION			
The 7th Global Conference on Health Promotion, to be held in Africa in 2009, will provide an opportunity to review progress and revise WHO's global health-promotion approach. During 2010-2013, the work will focus on cementing WHO's leadership role in health promotion and ensuring that mechanisms are in place at country level so that policies and strategies are kept up to date. In order to meet these objectives, a significant increase in resources will be required to ensure that developments in global, regional and national health promotion make an effective contribution to reducing the burden of disease and death associated with these major risk factors.			

6.2 Guidance and support provided in order to strengthen national systems for surveillance of major risk factors through development and validation of frameworks, tools and operating procedures and their dissemination to Member States where a high or increasing burden of death and disability is attributable to these risk factors.	INDICATORS		
	6.2.1 Proportion of eligible countries receiving support with, as a result, a functioning national surveillance system for major health risk factors in adults, or that are producing regular reports on such risk factors		6.2.2 Proportion of eligible countries receiving support with, as a result, a functioning national surveillance system for major health risk factors in youth, or that are producing regular reports on such risk factors
	BASELINE		
	10% of eligible countries		10% of eligible countries
	TARGETS TO BE ACHIEVED BY 2009		
	35% of eligible countries		35% of eligible countries
	TARGETS TO BE ACHIEVED BY 2013		
	85% of eligible countries		85% of eligible countries
	RESOURCES (US\$ THOUSAND)		
	Costs 2008-2009		Estimates 2010-2011
24 100		25 000	31 000
JUSTIFICATION			
Much of the work has already begun, but a substantial number of Member States have yet to implement reliable systems for the surveillance of risk factors and of efforts to control them; many will therefore require WHO's support in the future. Furthermore, Member States that completed surveys previously will require technical support for repeat surveys; additional surveillance tools may also be required. It is expected that the level of effort – and consequently resources – that will be required for development, modification, validation and dissemination of standards and operating procedures will increase significantly.			



6.3 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease and death associated with tobacco use, enabling them to strengthen institutions in order to tackle or prevent the public health problems concerned; support also provided to the Conference of the Parties to the WHO Framework Convention on Tobacco Control for implementation of the provisions of the Convention and development and implementation of protocols and guidelines.	INDICATORS			
	6.3.1 Number of countries with legislation, or its equivalent, in relation to the following: smoking bans in health-care and educational facilities, bans on direct and indirect advertising of tobacco products in national media, and health warnings on tobacco products consistent with the relevant articles of the WHO Framework Convention on Tobacco Control	6.3.2 Number of countries with comparable national data – disaggregated by age and sex – on prevalence of tobacco use	6.3.3 Number of countries that have established or reinforced a national coordinating mechanism or focal point for tobacco control	6.3.4 Number of guidelines agreed and number of protocols adopted by the Conference of the Parties
	BASELINE			
	10 countries	10 countries	20 countries	1 output
	TARGETS TO BE ACHIEVED BY 2009			
	30 countries	35 countries	40 countries	2 outputs
	TARGETS TO BE ACHIEVED BY 2013			
	100 countries	70 countries	130 countries	5 outputs
	RESOURCES (US\$ THOUSAND)			
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013	
	39 000	54 000	72 000	
	JUSTIFICATION			
	The Secretariat will be working closely with the Conference of the Parties and the Convention Secretariat to provide the necessary support to States Parties as they develop comprehensive tobacco-control policies and programmes and surveillance systems that will allow them to fulfil their obligations under the Convention, and under its future protocols. The Health Assembly, in resolution WHA59.17, called for continued support for and, where appropriate, strengthening of the Secretariat's work			

6.4 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease or death associated with alcohol, drugs and other psychoactive substance use, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.	INDICATORS		
	6.4.1 Number of countries receiving support with, as a result, policies, plans and programmes for preventing public health problems caused by alcohol, drugs and other psychoactive substance use		6.4.2 Number of policies, strategies, recommendations, standards and guidelines developed according to WHO's procedures in order to provide support to Member States in preventing or reducing public health problems caused by alcohol, drugs and other psychoactive substance use
	BASELINE		
	25 countries		5 outputs
	TARGETS TO BE ACHIEVED BY 2009		
	50 countries		15 outputs
	TARGETS TO BE ACHIEVED BY 2013		
	100 countries		25 outputs
	RESOURCES (US\$ THOUSAND)		
	Costs 2008-2009		Estimates 2010-2011
21 258		26 000	33 000

	<b>JUSTIFICATION</b> <i>In order to be credible, the Organization's response to public health problems attributable to use of alcohol, drugs and other psychoactive substances must be commensurate with the burden of disease and death with which such behaviours are associated. Significant additional investment is urgently needed, therefore, for work that includes capacity building and institutional strengthening at all levels of the Secretariat, including WHO collaborating centres, with particular emphasis on regional and country offices for effective responses to Member States' needs, and support for the implementation of relevant resolutions of the Health Assembly. A comprehensive and integrated approach to prevention and reduction efforts in respect of this group of risk factors will be encouraged, but provision of a substantial increase in resources remains a necessity.</i>		
6.5 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed and technical support provided to Member States with a high or increasing burden of disease or death associated with unhealthy diets and physical inactivity, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.	<b>INDICATORS</b>		
	6.5.1 Number of countries receiving support and, as a result, completing the development and implementation of policies, plans and programmes for improving diets and increasing physical activity, including the Global Strategy on Diet, Physical Activity and Health		6.5.2 Number of policies, strategies, recommendations, standards and guidelines developed according to WHO's procedures in order to provide support to Member States in promoting healthy diets and physical activity
	<b>BASELINE</b>		
	20 countries		4 outputs
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	50 countries		15 outputs
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	150 countries		30 outputs
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009		Estimates 2010-2011
	20 608		25 000
Estimates 2012-2013			
31 000			
	<b>JUSTIFICATION</b> <i>WHO's guidelines on interactions with external stakeholders will be revised and updated to provide a better reflection of the current environment, especially in relation to the food and the alcoholic and non-alcoholic beverage industries, thus ensuring that public health objectives are highlighted. WHO needs to strengthen its normative work on physical activity, and most of the work related to the revision of guidelines will involve consultations with Member States. Interactions also need to include international and national nongovernmental organizations and community groups.</i>		
6.6 Evidence-based and ethical policies, strategies, interventions, recommendations, standards and guidelines developed and technical support provided to Member States to promote safer sex and strengthen institutions in order to tackle and manage the social and individual consequences of unsafe sex.	<b>INDICATORS</b>		
	6.6.1 Number of countries with evidence available on the determinants and consequences of unsafe sex permitting the identification of effective interventions and subsequent preparation of guidelines		6.6.2 Number of countries receiving support that have initiated or implemented new or more effective interventions at individual, family and community levels in order to promote safer sexual behaviours
	<b>BASELINE</b>		
	5 countries		5 countries
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	Research implemented on determinants and consequences of unsafe sex in order to develop 3 evidence-based guidelines for promoting safer sexual behaviours		10 countries supported in developing evidence-based interventions and in assessing the implementation of interventions at individual, family and community levels in order to promote safer sexual behaviours
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	10 countries supported by WHO that have validated and implemented 3 new or adapted guidelines		10 countries supported by WHO that have implemented WHO's guidelines and scaled up interventions to promote safer sexual behaviours

<b>RESOURCES (US\$ THOUSAND)</b>		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
18 826	24 000	30 000
<b>JUSTIFICATION</b>		
<p><i>Significant additional resources are required to continue and expand urgently needed interventions to tackle unsafe sex, whose consequences constitute the second most common cause of death and disability in high-mortality countries. The actions required range from generating relevant evidence to providing countries with support to implement policies, strategies and interventions. Investments to achieve this expected result, will also help efforts to reach the goals for other risky behaviours. More resources will be made available for generating and building an evidence base and strengthening WHO's normative role.</i></p>		

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

### **Indicators and targets**

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

### **ISSUES AND CHALLENGES**

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

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

### **Lessons learnt**

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

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

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

## STRATEGIC APPROACHES

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

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

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

Redressing the root causes of health inequities will need WHO – both Secretariat and Member States – to ensure that the perspectives of gender equality, poverty, ethics and human rights are incorporated into preparation of health guidelines, policy making and programme implementation.

## Lessons learnt

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

## The Secretariat will focus on:

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

## ASSUMPTIONS, RISKS AND OPTIONS

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

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

The main risks that prevent achieving this strategic objective are:

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

### The Secretariat will focus on:

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

## ORGANIZATION-WIDE EXPECTED RESULTS

7.1 Significance of social and economic determinants of health recognized throughout the Organization and incorporated into normative work and technical collaboration with Member States and other partners.	INDICATORS		
	7.1.1 Number of countries that have implemented key policy recommendations of the Commission on the Social Determinants of Health	7.1.2 Number of countries whose WHO Country Cooperation Strategy documents include action on the social and economic determinants of health	7.1.3 Number of WHO regions with a strategy for action on the social and economic determinants of health
	BASELINE		
	8 countries	7 countries	2 regions
	TARGETS TO BE ACHIEVED BY 2009		
	12 countries	14 countries	5 regions
	TARGETS TO BE ACHIEVED BY 2013		
	42 countries	28 countries	6 regions
	RESOURCES (US\$ THOUSAND)		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	18 029	20 800	23 100

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

7.2 Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels in order to address social and economic determinants of health and to encourage poverty-reduction and sustainable development.	INDICATORS		
	7.2.1 Number of countries whose health policies target the social and economic determinants of health on an intersectoral basis	7.2.2 Number of subregional, regional and global forums organized (alone or with other international organizations) for policy-makers, programme-implementers and civil society on intersectoral actions to address the social and economic determinants of health and to achieve the Millennium Development Goals	7.2.3 Number of tools developed and disseminated for assessing the impact of non-health sectors on health and health equity
	BASELINE		
	2 countries	1 forum	None
	TARGETS TO BE ACHIEVED BY 2009		
	10 countries	2 forums	1 tool
	TARGETS TO BE ACHIEVED BY 2013		
	38 countries	6 forums	3 tools
	RESOURCES (US\$ THOUSAND)		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
16 685	19 300	21 400	
JUSTIFICATION			
Work across sectors at both global and local levels is essential for addressing the social and economic determinants of health; this requires a very modest increase in WHO activity for 2008-2009 and 2010-2011. In 2012-2013, activity should increase at all levels of the Organization.			

7.3 Social and economic data relevant to health collected, collated and analysed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).	INDICATORS							
	7.3.1 Number of countries having health data of sufficient quality to assess and track health equity among key population groups	7.3.2 Number of countries with at least one national policy on health equity that incorporates an analysis of disaggregated data	7.3.3 Number of countries with at least one national programme on health equity that uses disaggregated data					
	BASELINE							
	39 countries	None	None					
	TARGETS TO BE ACHIEVED BY 2009							
	45 countries	27 countries	27 countries					
	TARGETS TO BE ACHIEVED BY 2013							
	55 countries	55 countries	55 countries					
	RESOURCES (US\$ THOUSAND)							
Costs 2008-2009			Estimates 2010-2011			Estimates 2012-2013		
13 612			15 700			17 500		

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

7.4 Ethics- and rights-based approaches to health promoted within WHO and at national and global levels.	INDICATORS		
	7.4.1 Number of tools and guidance documents produced for Member States and other stakeholders on use of human rights to advance health and to reduce gaps in health equity		7.4.2 Number of tools and guidance documents produced for Member States and other stakeholders on use of ethical analysis to improve health policies
	BASELINE		
	20		8
	TARGETS TO BE ACHIEVED BY 2009		
	28		12
	TARGETS TO BE ACHIEVED BY 2013		
	45		20
	RESOURCES (US\$ THOUSAND)		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	7 550	8 700	9 700
	JUSTIFICATION		
In addition to normative work on ethics and human rights carried out by core teams, more work will be carried out by staff with relevant background at all levels of the Organization; they will also translate global documents into actions at country level. This growth in expertise and activity across the Organization accounts for the modest biennium-to-biennium budget increase.			

7.5 Gender analysis and responsive actions incorporated into WHO's normative work and support provided to Member States for formulation of gender-sensitive policies and programmes.	INDICATORS		
	7.5.1 Number of publications that contribute to building evidence on the impact of gender on health and on effective strategies to address it		7.5.2 Number of tools and guidance documents produced for Member States on use of gender analysis in health
	BASELINE		
	50		20
	TARGETS TO BE ACHIEVED BY 2009		
	56		25
	TARGETS TO BE ACHIEVED BY 2013		
	63		28
	RESOURCES (US\$ THOUSAND)		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	10 923	12 500	13 900
	JUSTIFICATION		
	The increased support for gender-related activities across WHO in 2008-2009 reflects commitment to the goal of incorporating this area into the mainstream of work throughout the Organization. In subsequent bienniums, growth is accounted for by increased staff and activities at regional and country levels.		



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

### **Indicators and targets**

- Proportion of the urban and rural populations with access to improved water sources and improved sanitation. Targets: by 2013, 94% of urban populations and 78% of rural populations will have access to improved drinking water sources (baselines, 2004 estimates: 95% and 73%, respectively); by 2013, 81% of urban populations and 48% of rural populations will have access to improved sanitation facilities (baselines, 2004 estimates: 80% and 39%, respectively)
- Proportion of the population using solid fuels (as indicator of the unhealthy use of energy sources for cooking and heating). Target: by 2013, 30% of the global population will be using solid fuels (baseline: 52% in 2003)
- Burden of disease (measured in disability-adjusted life years) due to environmental risks in key sectors (e.g. transport, energy, water and agriculture). Targets: by 2013, 2.8% of the global burden of disease will be attributed to transportation (baseline, 2002 estimate: 3.1%) and 3.0% attributable to inadequate access to improved water supply and sanitation (baseline, 2006 estimate: 3.8%)
- Burden of disease measured in disability-adjusted life years) from selected occupational risks. Target: by 2013, 1.2% of the global burden of disease will be attributed to selected occupational risks – noise, injuries, back pain, carcinogens, and airborne particles (baseline: 1.5% in 2000)
- Proportion of the working population with access to occupational health services. Target: by 2013, 25% of the working population will have access to basic occupational health services (baseline: 15% in 2006).

### **ISSUES AND CHALLENGES**

About one quarter of the global disease burden and one third of that in developing countries could be reduced through available environmental health interventions and strategies. Health systems are on the whole not even identifying the environmental determinants of health as part of their remit, let alone as a priority for improving public health. The few existing data indicate that only about 2% of a typical national health budget is currently invested in preventive health strategies. Clearly, health institutions face both the challenge of controlling health costs and the opportunity to do so through more effective environmental health strategies and interventions.

Rapid changes in lifestyles, increasing urbanization, production and energy consumption, climatic changes and pressures on ecosystems could, in both the short and long term, have even greater consequences for public health and health costs than is already the case, if the health sector fails to act on currently emerging environmental hazards to health. These hazards range from the global spread of new infections to new or more widespread exposures to physical and chemical agents, radiation or psychosocial pressures. Finally, for effective health sector action, risks have to be reduced in the sectors and the settings where they

### **Lessons learnt**

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

occur – homes, schools, workplaces and cities, and in sectors such as energy, transport, industry and agriculture. In order to counter the economic and developmental determinants of environmental health risks, health must be at the centre of intersectoral activity. A range of actions is thus required both in the health sector itself and across sectors.

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

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

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

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

## STRATEGIC APPROACHES

In order to achieve this strategic objective the health sector will need to provide leadership on health aspects of international environment and sectoral policies; advocate and establish partnerships for coordinated multisectoral activities and integrated policies to reduce health risks from the environment; and promote development frameworks and strategies that benefit health.

Management of public health risks requires intensifying institutional and technical capacities for assessing environmental and occupational health risks and for evaluating the impacts of policies. Preparedness for, and

### Lessons learnt

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

### The Secretariat will focus on:

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

response to, environmental emergencies and disasters and emerging threats deserve particular attention in health sector development.

Putting environmental health interventions into practice as part of public health policy and preventive health strategies will underpin expansion of primary prevention, as will strengthening the capabilities of environmental health professionals to provide a preventive arm within the health sector, identifying and responding to inequities in environmental health risks and outcomes related to gender, age, ethnicity and social circumstance.

Focusing action through an integrated approach to healthy settings is essential for reducing health risks in specific areas of human activity, while engaging communities and individuals in the protection of their health and environment.

### **ASSUMPTIONS, RISKS AND OPTIONS**

The following assumptions underlie the achievement of this strategic objective:

- that health sector personnel become increasingly cognizant of the mounting burden of disease from environmental health risks in light of new evidence;
- that decision-makers (such as policy-makers, banks and civil society) in sectors of the economy with the greatest impact on public health will increasingly prioritize health and put the health costs and benefits of their actions at the centre of their decision-making processes;
- that development partners (banks, cooperation agencies, foundations and recipient countries) will increasingly recognize that reducing environmental hazards to health makes a major contribution to the achievement of the relevant Millennium Development Goals;
- that the climate remains favourable, in the context of United Nations system reform, for WHO to show more global leadership in public health and the environment, setting health more explicitly in humanitarian response and goals of environmental sustainability and economic development.

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

- that expectations from other sectors for quick results and reductions of environmental health risks may exceed the capacity of the health sector to provide support for their actions. This pitfall can be avoided by selecting realistic, achievable aims;

#### **The Secretariat will focus on:**

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

- that information about the best options for sectoral interventions to improve occupational and environmental health is inaccessible. This danger can be overcome through investment by health agencies in analysis and documentation of the most effective and cost-beneficial interventions;
- that global leaders and partners in the arenas of development and/or the environment show weak or transient commitment to improving environmental health. Investments in partnerships, outreach and more strategic global communications on environmental health issues (such as flagship reports on global environmental health and prospects) can overcome this problem;
- that health systems continue to respond weakly in reducing the range of occupational and environmental health risks and rooting out their causes. This weakness can be overcome by establishing global and regional forums and focused initiatives in order to give health and the environment a high priority and to push for action through partnerships; by outreach and communications targeted to health-sector interests and needs; and by strengthening the capability of health systems to integrate health and environmental issues into traditional health-sector agendas.

## ORGANIZATION-WIDE EXPECTED RESULTS

<b>8.1</b> Evidence-based assessments made, and norms and guidance formulated and updated on major environmental hazards to health (e.g., poor air quality, chemical substances, electromagnetic fields, radon, poor-quality drinking-water and waste-water reuse); technical support provided for the implementation of international environmental agreements and for monitoring progress towards achievement of the Millennium Development Goals.	INDICATORS			
	<b>8.1.1</b> Number of new or updated assessments of risk and/or environmental burden of disease	<b>8.1.2</b> Number of new or updated norms, standards and good practice guidelines	<b>8.1.3</b> Number of monitored Millennium Development Goal indicators relating to environmental hazards	<b>8.1.4</b> Number of international environmental agreements whose implementation is supported by WHO
	BASELINE			
	3 assessments per year	5 outputs per year	3 Millennium Development Goal indicators monitored/reported each year	2 agreements supported technically
	TARGETS TO BE ACHIEVED BY 2009			
	10 assessments per year	10 outputs per year	3 Millennium Development Goal indicators monitored/reported each year	4 conventions or international policy frameworks supported technically
	TARGETS TO BE ACHIEVED BY 2013			
	15 assessments per year	15 outputs per year	3 Millennium Development Goal indicators monitored/reported each year	6 conventions or international policy frameworks supported technically
RESOURCES (US\$ THOUSAND)				
Costs 2008-2009 33 488		Estimates 2010-2011 40 000		Estimates 2012-2013 44 000

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

<p><b>8.2</b> Technical support and guidance provided to Member States for the implementation of primary prevention interventions that reduce environmental hazards to health, enhance safety and promote public health, including in specific settings and among vulnerable population groups.</p>	<b>INDICATORS</b>			
	<p><b>8.2.1</b> Establishment of global or regional initiatives for primary prevention of environmental health hazards in specific settings (workplaces, homes, schools, human settlements and health-care settings) in targeted countries with WHO technical and logistic support</p>	<p><b>8.2.2</b> Number of new or maintained global or regional initiatives to prevent occupational and environmentally-related diseases (e.g. cancers from ultraviolet irradiation or exposure to asbestos, and poisoning by pesticides or fluoride) that are being implemented with WHO technical and logistics support</p>	<p><b>8.2.3</b> Number of studies evaluating the costs and benefits of primary prevention interventions in specific settings that have been conducted and whose results have been disseminated</p>	<p><b>8.2.4</b> Number of target countries following WHO's guidance to prevent and mitigate emerging occupational and environmental health risks, promote equity in those areas of health and protect vulnerable populations</p>
	<b>BASELINE</b>			
	Global strategy for reducing risk in 1 setting established	3 regional initiatives on occupational health	Results of 2 cost-benefit studies disseminated	No target country; activities in support of environmental health for children developed in one region
	<b>TARGETS TO BE ACHIEVED BY 2009</b>			
	Global strategies to reduce risk in at least 3 settings established, with country support actions in at least 20 locations	2 global interventions (on asbestosis and hepatitis B) and 2 regional initiatives (on occupational health and silicosis) started and maintained, with WHO support	5 cost-benefit studies conducted and results disseminated	5 countries; activities in support of environmental health for children developed in at least two regions
	<b>TARGETS TO BE ACHIEVED BY 2013</b>			
	Global strategies to reduce risk in at least 5 settings established, with country support actions in at least 30 locations	2 additional global and 2 additional regional interventions started and maintained, with WHO support	10 cost-benefit studies conducted and results disseminated	10 countries; activities in support of environmental health for children developed in at least three regions
<b>RESOURCES (US\$ THOUSAND)</b>				
Costs 2008-2009		Estimates 2010-2011		Estimates 2012-2013
35 672		26 000		29 000

	<b>JUSTIFICATION</b> <i>Following successes in tackling occupational environmental health hazards in specific settings in close connection with local partners, there is a strong demand for the Secretariat to revitalize and extend its support to developing and implementing primary prevention interventions in specific settings and to reducing the major risks. New global initiatives have been planned to support interventions for reducing risks and promoting health in the workplace, school, municipality, home and health-care settings, and to document and inform about costs and benefits of different interventions.</i>		
<b>8.3</b> Technical assistance and support provided to Member States for strengthening occupational and environmental health policy-making, planning of preventive interventions, service delivery and surveillance.	<b>INDICATORS</b>		
	<b>8.3.1</b> Number of high-priority countries receiving technical and logistical support for developing and implementing policies for strengthening the delivery of occupational and environmental health services and surveillance	<b>8.3.2</b> Number of national organizations or universities implementing WHO-led initiatives to reduce occupational risks (e.g. among workers in the informal economy, to implement the WHO global strategy for occupational health for all, or to eliminate silicosis)	
	<b>BASELINE</b>		
	No country receiving specific support for strengthening environmental health services; 5 countries receiving advice on strengthening surveillance	2 organizations	
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	10 countries receiving advice on strengthening occupational and environmental health services; 10 countries receiving advice on strengthening surveillance	10 organizations	
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	15 countries receiving advice on strengthening occupational and environmental health services; 15 countries receiving advice on strengthening surveillance	15 organizations	
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	21 541	30 000	33 000
	<b>JUSTIFICATION</b> <i>The ability of health systems to deal with occupational and environmental health risks is limited and not commensurate with the great potential for primary prevention of disease through better working and living environments. The planned work will strengthen the health sector's ability to plan and deliver good-quality occupational and environmental health services and expand interventions and surveillance through a better evidence base, logistical and technical support, the engagement of a range of organizations in executing initiatives to reduce risks and promote health, for instance among workers in the informal economy.</i>		

<b>8.4</b> Guidance, tools and initiatives created in order to support the health sector to influence policies in priority sectors, assess health impacts, determine costs and benefits of policy alternatives in those sectors, and select investments in non-health sectors that improve health, the	<b>INDICATORS</b>			
	<b>8.4.1</b> Establishment of initiatives to develop and implement health-sector policies at the global and national levels, using WHO's technical and logistical support	<b>8.4.2</b> Production and promotion in target countries of sector-specific guidance and tools for assessment of health impacts and economic costs and benefits and promotion of health and safety	<b>8.4.3</b> Establishment of networks and partnerships to drive change in specific sectors or settings, including an outreach and communications strategy	<b>8.4.4</b> Number of regional or national events conducted with WHO's technical support with the aim of building capacity and strengthening institutions in health and other sectors for improving policies relating to occupational and environmental health in at least 3 economic sectors

environment and safety.	<b>BASELINE</b>			
	Initiatives implemented globally for 1 sector and nationally in 2 countries	Tools and guidance produced for 1 sector	Networks established for 1 sector	One regional event conducted
	<b>TARGETS TO BE ACHIEVED BY 2009</b>			
	Initiatives implemented globally for 3 sectors and nationally in at least 10 countries	Tools and guidance produced for 3 sectors	Networks established for 3 sectors, with communications strategy implemented	10 regional or national events conducted with WHO technical support
	<b>TARGETS TO BE ACHIEVED BY 2013</b>			
	Initiatives implemented globally for 5 sectors, and nationally in at least 15 countries	Tools and guidance produced for 5 sectors	Networks established for 5 sectors, with communications strategy implemented	20 regional or national events conducted with WHO technical support
	<b>RESOURCES (US\$ THOUSAND)</b>			
Costs 2008-2009		Estimates 2010-2011	Estimates 2012-2013	
21 273		29 000	32 000	
<b>JUSTIFICATION</b>				
<i>The health sector is only poorly able to influence policies in other sectors to promote occupational and environmental health and lacks the tools, knowledge and skills to engage other sectors. New activities will build on institutional experience with health impact assessment, cost-benefit analysis and environmental health in other sectors in order to create, and provide access to, a substantial knowledge base on the impacts on occupational and environmental health of sectoral policies, on the costs and benefits of sectoral interventions and on experiences of implementing sectoral change. Work will include the development of global initiatives – using networks, partnerships, communities of practice and strategic communication – to encourage the targeted sectors to change their policy-making culture so that the prevention of risks to occupational and environmental health is considered and included as a priority. The Secretariat will provide technical assistance and support to countries for strengthening institutions through skills-building in order to enhance the ability of the health sector to lead change in other sectors. The Secretariat will also facilitate setting baselines for, and evaluating, performance and policy change towards the adoption of healthy sector policies.</i>				

8.5 Health-sector leadership enhanced for creating a healthier environment and changing policies in all sectors so as to tackle the root causes of environmental threats to health, through means such as responding to emerging and re-emerging consequences of development on environmental health, climate change, and altered patterns of consumption and production and to the damaging effect of evolving technologies.	<b>INDICATORS</b>			
	<b>8.5.1</b> Establishment of a research institute on key emerging and re-emerging occupational and environmental health concerns in development	<b>8.5.2</b> Impact, in terms of coverage by mass media, of outreach and communications strategy on occupational and environmental issues implemented globally and in partnership	<b>8.5.3</b> Availability of biennial report on trends, scenarios, and key development issues and their health impacts	<b>8.5.4</b> Organization of a regular high-level forum on health and environment for global and regional policy-makers and stakeholders
	<b>BASELINE</b>			
	No institute	Mass media citation of work by WHO or partners on priority issues in occupational and environmental health in 2007	No report	No global forum; three regional forums held
<b>TARGETS TO BE ACHIEVED BY 2009</b>				
Institute under development		5% increase in citations	First “Global Environmental Health Outlook” published	First global forum and 4 regional forums held

TARGETS TO BE ACHIEVED BY 2013			
Functioning institute	10% increase over baseline in citations	Second and third issues of “Global Environmental Health Outlook” published	Second global forum and 5 regional forums held
RESOURCES (US\$ THOUSAND)			
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013	
20 326	21 000	23 000	
JUSTIFICATION			
<i>Environmental and occupational health risks are directly linked to patterns of consumption and production and to policies in different sectors of the economy; at present, however, there is no consensus on the trends in these patterns and policies or their implications for risks to health. The consequence is short-term thinking and responses to environmental risks to health and inadequate prevention and responses. The Secretariat’s work will put in place a global, multi-year strategy for outreach and communication; produce strategic analyses; result in high-impact publications (including reports on the global outlook for environmental health); provide approaches to knowledge management; and engage governments and high-level stakeholders in the response to the issues through global and regional forums and links with networks of practitioners. It will build on existing economic and environmental analyses, reviewing the potential impacts of social and economic trends, monitoring the impact of policies, disseminating information on good practice and making recommendations for action that improves equity in occupational and environmental health.</i>			



## **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 underweight children under five
- Proportion of overweight and obese children and adolescents under 20 years of age
- Under-five mortality caused by diarrhoea.

### **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, many of which are fatal or lead to severe sequelae, or to micronutrient deficiencies (so-called “hidden hunger”) especially of iron, vitamin A, iodine and zinc. 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, sometimes in the same households.

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 strategic objective set out above, 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

### **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, which failure will seriously compromise achievement of all other Goals.
- An increase in income does not automatically lead to an improvement in nutrition, food safety and food security, nor does it necessarily lead to reduction in micronutrient deficiencies (hidden hunger), which affect a far greater number of people. 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.
- Collaboration throughout the United Nations system is urgently needed on an unprecedented scale. 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 will make a difference.

and emergency situations, that is intersectoral, science-based, comprehensive, integrated and action-oriented. Such an agenda should address the whole spectrum of nutrition, food safety and food security issues related to 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 for the target for reduction of child malnutrition set out in the first Millennium Development Goal to be achieved by 2015. 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 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 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;

### The Secretariat will focus on:

- building partnerships, alliances and effective interactions with organizations of the United Nations System in the context of the reform process; establishing collaboration between the different organizations on an unprecedented scale in order to promote the integration of nutrition, food-safety and food-security programmes at country level and incorporate them into national development policies; and to strengthen the participation of WHO's country offices in joint planning and programming processes at national level;
- maximizing WHO's convening role in order to strengthen its normative function in an inclusive way, and to imbue relevant partners with a sense of ownership of WHO's norms so as to ensure their dissemination and use;
- increasing investment in normative functions in order to fill gaps in scientifically sound norms, standards, recommendations and technical guidance relating to nutrition, food safety and the prevention of food- and water-related and zoonotic illnesses;
- communicating effectively the need for integrated policies and a single agenda, whose aim is to improve nutrition and food safety and to promote healthy dietary practices in relation to the whole spectrum of nutritional disorders – from under- to over-nutrition and diet-related chronic diseases – while ensuring that access to safe and nutritious food includes a human rights' perspective;
- 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.

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.

#### The Secretariat will focus on:

- promoting policy development through broad-based alliances in inclusive processes at all levels to achieve sustainable and effective implementation; increasing technical support to Member States to strengthen their national capabilities in identifying problems and best policy options; implementing the requisite nutrition, food-safety and food-security interventions, including in relevant intersectoral actions; monitoring progress and assessing impacts;
- 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;
- enhancing institutional and human capacity and develop leadership in nutrition and food safety, building and maintaining an interactive network of practitioners at global, regional and local levels;
- 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.

### ORGANIZATION-WIDE EXPECTED RESULTS

<b>9.1 Partnerships and alliances</b> 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-	<b>INDICATORS</b>	
	<b>9.1.1</b> Number of selected low-income countries that have institutionalized and functional coordination mechanisms to promote intersectoral approaches and actions in the area of food safety, food security and nutrition	<b>9.1.2</b> Number of targeted low-income countries that have included nutrition, food-safety and food-security activities in their sector-wide approaches, Poverty Reduction Strategy Papers and/or development policies, plans and budgets, including a mechanism for financing nutrition and food-safety activities
	<b>BASELINE</b>	
	No information available	14 countries (for Poverty Reduction Strategy Papers)
	<b>TARGETS TO BE ACHIEVED BY 2009</b>	
	30 countries	30 countries
	<b>TARGETS TO BE ACHIEVED BY 2013</b>	
	50 countries	50 countries

## DRAFT MEDIUM-TERM STRATEGIC PLAN 2008-2013

safety and food-security interventions, and develop and support a research agenda.	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	16 964	15 000	10 000
<b>JUSTIFICATION</b>			
<i>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.</i>			

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 and training manuals produced and disseminated to countries 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			
	None		None	
	TARGETS TO BE ACHIEVED BY 2009			
	15 norms		3 norms	
	TARGETS TO BE ACHIEVED BY 2013			
	50 norms		10 norms	
	RESOURCES (US\$ THOUSAND)			
	Costs 2008-2009		Estimates 2010-2011	Estimates 2012-2013
	30 250		30 000	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.	<b>INDICATORS</b>	
	9.3.1 Number of countries that have adopted and implemented the WHO Child Growth Standards	9.3.2 Number of countries that have nationally representative surveillance data on major forms of malnutrition
	<b>BASELINE</b>	
	20 countries	90 countries
	<b>TARGETS TO BE ACHIEVED BY 2009</b>	
	50 countries	100 countries
	<b>TARGETS TO BE ACHIEVED BY 2013</b>	
	100 countries	150 countries

<b>RESOURCES (US\$ THOUSAND)</b>		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
18 395	15 000	15 000
<b>JUSTIFICATION</b>		
<p><i>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.</i></p>		

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 selected countries receiving WHO support that have developed and implemented at least three high-priority actions recommended by the Global Strategy for Infant and Young Child Feeding	9.4.2 Number of selected countries receiving WHO support that have developed and implemented strategies to prevent and control micronutrient malnutrition	9.4.3 Number of selected countries receiving WHO support that have developed and implemented strategies to promote healthy dietary practices in order to prevent diet-related chronic disease	9.4.4 Number of selected low-income countries receiving WHO support that have included nutrition in their comprehensive responses to HIV/AIDS and other epidemics	9.4.5 Number of selected countries receiving WHO support that have strengthened national preparedness and response to nutritional emergencies
	BASELINE				
	30 countries	10 countries	10 countries	35 countries	None
	TARGETS TO BE ACHIEVED BY 2009				
	60 countries	30 countries	30 countries	35 countries	15 countries
	TARGETS TO BE ACHIEVED BY 2013				
	90 countries	50 countries	50 countries	50 countries	40 countries
	RESOURCES (US\$ THOUSAND)				
	Costs 2008-2009		Estimates 2010-2011		Estimates 2012-2013
	24 219		40 000		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 countries that have established or strengthened intersectoral collaboration for the prevention, control and surveillance of foodborne zoonotic diseases	9.5.2 Number of countries that have initiated or strengthened programmes for the surveillance and control of at least one major foodborne zoonotic disease	
	BASELINE		
	20 countries	50 countries	
	TARGETS TO BE ACHIEVED BY 2009		
	20 countries	50 countries	
	TARGETS TO BE ACHIEVED BY 2013		
	40 countries	70 countries	
	RESOURCES (US\$ THOUSAND)		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
16 907	30 000	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 countries 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 countries receiving support from WHO that have built national systems for food safety and foodborne zoonoses with international links to emergency systems	
	BASELINE		
	90 countries	None	
	TARGETS TO BE ACHIEVED BY 2009		
	90 countries	None	
	TARGETS TO BE ACHIEVED BY 2013		
	110 countries	50 countries	
	RESOURCES (US\$ THOUSAND)		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
19 965	30 000	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 the organization, management and delivery of health services

### Indicators and targets

Improved health, as reflected in the achievement of other strategic objectives, is the best indicator of the successful functioning of a health service. Overall progress towards this particular strategic objective will be assessed by the number of countries that can demonstrate progress in terms of the following composite indicators:

- coverage for a range of priority health interventions (for communicable and noncommunicable diseases). Target: significant improvement over 2006-2007 baseline scores in at least 50% of countries
- equitable accessibility within a country to various priority health interventions, by socioeconomic status. Target: significant reduction in inequity compared to the 2005-2006 baseline in at least 50% of countries
- technical and organizational quality, including compliance with minimum standards of care and patient safety and improved responsiveness. Target: significant improvement over the 2005-2006 baseline in at least 50% of countries
- efficiency as measured by a score for outputs of health services related to a given set of financial and human resources inputs. Target: significant improvement compared with the 2005-2006 baseline in at least 50% of countries.

### ISSUES AND CHALLENGES

In too many countries, people do not get care when they need it for various reasons: (i) services exist but are inaccessible, inconvenient, of poor quality or unaffordable; (ii) services, staff and supplies do not exist or are in short supply; (iii) social exclusion prevents access by individuals or groups to the services they need; and (iv) service providers fail to adapt to the population's care-seeking behaviour.

Funds are often directed to work on achieving disease-specific health outcomes, but many interventions are delivered by the same (often limited) group of health workers and facilities. The way in which services are organized and managed determines access, the extent to which service coverage is genuinely pro-poor or equitable, and whether improved health outcomes are achieved.

Many services are delivered in unstable and changing conditions. In countries with some form of decentralization, roles are changing and relations between the centre and other levels are shifting. Central health ministry policies may be moving to commissioning of services and facilities from both the public and private sector.

Although there is no single universal model for organizing service delivery, there are some well-established principles. First, attention needs to be paid to demand as well as to the supply of services: individuals and communities need sufficient knowledge to use services when needed, and not to be deterred by cultural, social or financial barriers. Secondly, it is important to take into account the full

### Lessons learnt

- Throughout the world, access to good-quality health services is considered to be vital for the proper functioning of society. The breakdown of health-services delivery contributes to social and political instability. In crises, restoring access to good-quality health services is critical for the construction of peace and stability.
- In judging the quality of health services populations do not merely look at the effectiveness of the interventions provided, but attach value to other features: continuity of care; integration; a patient-centered, close-to-client approach; safety; and choice. Whether care is provided by public or non-public services, these characteristics (or the absence thereof) strongly influence demand, uptake and coverage.
- For service delivery to meet the expectations of the general public and professionals, choosing contextually-appropriate models of organization and management is as important as proper resourcing.

range of providers, and not merely those working in the public sector. Public-sector managers have to understand and engage with different non-State providers in order to allay concerns about quality, effectiveness and cost and to maximize any potential contribution to the attainment of public health goals. Thirdly, there is a growing need to ensure that services are close to the client, and avoid unnecessary duplication and fragmentation.

In order to improve quality, training – for clinical, managerial or support tasks – is necessary but usually not sufficient. Whether managers work in the public sector or not, they all have to deal with the volume and coverage of services, allocation and efficient use of resources (staff, budgets, medicines and equipment), and a variety of partners and stakeholders. To do this well they need good-quality information, functioning support systems, and enough autonomy to be able to encourage local decision-making and innovation; at the same time the mechanisms need to be in place to ensure proper accountability.

### STRATEGIC APPROACHES

In order to achieve this objective Member States will need to set up mechanisms, procedures and incentives that encourage all stakeholders – including public and non-public providers and provider organizations – to work together on improving service delivery and eliminating exclusion from access to care. Member States should strive to upgrade their organizational and managerial practices, put into place mechanisms to ensure synergy between public and non-public providers, embed disease-specific programmes within general health services, and noticeably improve service delivery.

### ASSUMPTIONS, RISKS AND OPTIONS

Service delivery cannot be improved without the basic conditions of economic, social and political stability. Yet, for many low-income countries these conditions do not prevail. There is thus a need for a close synergy with work on strategic objective 5.

Much of the increase in health funding from external sources is focused on the achievement of disease-specific outcomes (particularly in relation to AIDS). There is thus a risk that programme implementation reinforces separate vertical programmes. Although some functions need to be carried out separately, most service delivery needs to be carried out by a single network of facilities. The objective of reducing exclusion is likely to be compromised if governments focus only on the public-sector network. Similarly, there is a risk that they will concentrate exclusively on primary or first-contact care at the expense of dealing with inequities and inefficiencies in the hospital sector.

#### The Secretariat will focus on:

- maintaining a country-specific approach, acknowledging that health services and systems usually mirror the broader problems of the societies of which they are a part. Support and advice to Member States needs to be sensitive to the political, cultural and social context in which health services are strengthened, including the potential for empowering families and communities to take better advantage of promotive, preventive and curative health services;
- disseminating information on best practices and facilitating mechanisms for learning from the experience of others. In the absence of a single universal model for service delivery, WHO has a leading role of facilitating such learning and exchange, particularly in relation to innovative models for expanding access and improving the quality of health services;
- fostering engagement between non-State and public providers, to promote greater mutual understanding and, as a result, better-informed policies and approaches in the pursuit of public health goals. WHO will collate and assess evidence on alternative models of service delivery so as to ensure evidence-based guidance and support to Member States;
- assessing the potential impact of new technologies – such as telemedicine – particularly to the extent that they can improve the effectiveness or reach of services in resource-poor settings, and providing support to Member States for preparing for the future;
- applying its normative function to work on service delivery; this will include defining service standards, measurement strategies and other approaches to ensuring quality.



## ORGANIZATION-WIDE EXPECTED RESULTS

<b>10.1</b> Standards, best practices and principles of equity endorsed by, or developed with support from, WHO increasingly reflected in service-delivery policies and their implementation in Member States.	<b>INDICATORS</b>		
	<b>10.1.1</b> Coverage and access as measured through composite indicators over a range of interventions: equity in the distribution of a range of high-priority health interventions across a country and by socioeconomic status; technical and organizational quality, including compliance with minimum standards of care and patient safety and improved responsiveness; efficiency as measured by a score for outputs of health services related to a given set of financial and human resources inputs		
	<b>BASELINE</b>		
	Country-specific baselines to be established in 2006-2007		
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	Significant improvement compared to country-specific baseline in at least 25% of countries		
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	Significant improvement compared to country-specific baseline in at least 50% of countries		
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	53 500	50 000	60 000
<b>JUSTIFICATION</b>			
<i>The increase in resources required is due to the increased emphasis in the General Programme of Work on health systems. As WHO's capacity increases particularly at country and regional levels, it is expected that the demand for support and the level of support provided will have to increase accordingly.</i>			

<b>10.2</b> Organizational and managerial capacities of service-delivery institutions and networks in Member States strengthened.	<b>INDICATORS</b>		
	<b>10.2.1</b> Proportion of countries that demonstrate progress in identifying and correcting inadequacies in organizational and managerial capacity in their institutions and networks		
	<b>BASELINE</b>		
	To be determined by country-specific mapping exercises in 2006		
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	Major weaknesses remedied in 10% of countries		
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	Major weaknesses remedied in 25% of countries		
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	36 394	37 000	50 000
<b>JUSTIFICATION</b>			
<i>The increase in resources required is due to the increased emphasis in the General Programme of Work on health systems. As WHO's capacity increases, particularly at country and regional levels, it is expected that the demand for support will grow and the level of support provided will have to increase accordingly.</i>			

<b>10.3</b> Mechanisms and regulatory systems in place in Member States in order to ensure synergy between public and non-public service-delivery systems that lead to better overall service delivery.	<b>INDICATORS</b>		
	<b>10.3.1</b> Proportion of countries that show evidence of improved regulatory capacities		
	<b>BASELINE</b>		
	To be determined by country-specific mapping exercises in 2006		
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	Major weaknesses remedied in 10% of countries		
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	Major weaknesses remedied in 25% of countries		
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	22 172	35 000	40 000
	<b>JUSTIFICATION</b>		
	<i>The increase in resources required is due to the increased emphasis in the General Programme of Work on health systems. As WHO's capacity increases particularly at country and regional levels, it is expected that the demand for support will grow and the level of support provided will have to increase accordingly. The expectation that the potential growth of WHO's budget is limited explains the slower rate of increase in 2012–2013.</i>		

<b>10.4</b> Policy, structural and managerial changes in the health services architecture of Member States implemented in order to ensure that disease-specific programmes are adequately embedded in general health services so as to enhance overall performance of health service delivery.	<b>INDICATORS</b>		
	<b>10.4.1</b> Proportion of countries that demonstrate progress in embedding disease-specific programmes in general health services		
	<b>BASELINE</b>		
	To be determined by country-specific mapping		
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	Major fragmentation problems corrected in 10% of countries		
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	Major fragmentation problems corrected in 25% of countries		
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	31 934	40 000	36 000
	<b>JUSTIFICATION</b>		
	<i>This is an area in which currently much work is undertaken globally and an increased investment is necessary. Through combined country-level and global efforts it is expected that reforms in this area will have acquired momentum over the next five years, allowing for progressive reduction of funding.</i>		

## To strengthen leadership, governance and the evidence base of health systems

### Indicators and targets

- Within-country evidence of improved governance of health systems, including: diminished exclusion and inequities in access to services; improved performance of regulatory institutions and mechanisms within the health system; improved mechanisms to promote health outcomes of governmental action in other sectors, including through health and health system impact assessment exercises; improved division of responsibilities between different parts of government, levels of the health system and public and private sectors; and improved accountability and transparency arrangements. Methods for measuring these indicators of performance are under development. The focus will be on demonstrating progress within countries rather than on measuring countries against universal norms.
- The gap between knowledge and practice. Target: 25% increase in low- and middle-income countries in health research funding spent on countries' priority health problems, within the overall target of at least 2% of national health expenditures being devoted to research and research capacity strengthening by the year 2013; mechanisms for translating scientific evidence into practice functioning in support of decision-making in health systems in at least 45 low- and middle-income countries in all WHO regions by the year 2013.
- Increased availability and use of sound health statistics and evidence at global, regional and country levels. Target: at least two thirds of countries meeting internationally accepted standards for health information systems (baseline: half of countries).

### ISSUES AND CHALLENGES

Many countries experience the following weaknesses or difficulties.

Their capacities are inadequate to formulate clear policy objectives and strategies that correspond to the needs of their health systems, are based on scientific evidence and are compatible with the cultural and social values of concerned societies. It is hard to reconcile competing demands for limited resources across services and programmes, and to decide how to organize those services and programmes in ways that maximize use of resources and ensure provision of core public health functions, because evidence is limited about "what works", and sometimes external funds are earmarked. Health ministries often have limited capacity to manage the increasing number of financing and implementation partners and networks that they have to deal with, such as public bodies (e.g. ministries of finance and planning, and national legislatures), international agencies, multilateral, bilateral and nongovernmental agencies, and various types of private enterprises and civil society organizations.

They do not have adequate regulatory and legislative mechanisms to ensure socially responsible behaviour of all stakeholders, fair rules for all participants, and implementation of strategies leading to the attainment of policy objectives. There are no mechanisms to ensure effective interaction between the health sector and other sectors that influence the social, economic and environmental determinants of health. Further,

### Lessons learnt

- Governance and leadership have been recognized as core elements of successful health systems that are both efficient and effective. Investment in this area will catalyse change in an increasing number of countries. Progress is difficult to measure quantitatively, hence WHO is working with countries to apply a diagnostic tool that can be used for qualitative monitoring.
- Against the backdrop of increased demand for information, national health-information systems can be strengthened in low- and middle-income countries through the involvement of many partners besides WHO in a network with substantial resources.
- Improving on the piecemeal progress made in research in health (including health systems) over the past years requires leadership and coordination from WHO and its partners in order to enhance evidence-based decision-making in health.
- The rapid changes in information technology provide an unprecedented opportunity to change significantly the way in which societies and individuals deal with data, information and knowledge for better health.

mechanisms and information to ensure accountability and transparency are lacking

The capacity to generate nationally-relevant research findings for health (including health systems), to establish and maintain sound health-information systems, and to translate research findings into policy and practice is limited. Moreover, countries experience difficulties in finding a balance between responding to international demand for health information and meeting their own needs for information and knowledge.

## STRATEGIC APPROACHES

Achieving this objective will require Member States to set up structures and processes, with a range of parties, for defining how the health sector should operate and be managed. Health ministries should set enforceable regulations, standards and incentives that promote equal opportunities for all actors in the health system, and create mechanisms for better managing interactions with multiple partners. As governments decentralize so as to respond better to community concerns, efforts will be made to establish and promote effective accountability mechanisms that protect nationally agreed priorities.

Improving accountability will require the development of a culture of investing in knowledge, acting on information and evidence and establishing functional systems for timely, reliable and relevant health information. To ensure that the right knowledge gets to the right people (policy-makers, managers, practitioners, development partners and the general public), for effective decision-making and performance monitoring across the health system, countries need: to build and sustain human resources capacity and to undertake health research aimed at improving health systems and health overall; to develop and maintain sound health-information systems; and to translate research findings into policy and practice. eHealth platforms are necessary to support all three approaches.

## ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

- that a basic consensus exists that the State has a responsibility for the health of the whole population;
- that operational changes in external financing and implementation by partners (including application of the principles in the Paris Declaration on Aid Effectiveness: Ownership, Harmonization, Alignment, Results and Mutual Accountability) will help to reinforce, and not undermine, national efforts to strengthen governance and stewardship;
- that effective partnerships and involvement of stakeholders at national, regional and global levels are developed and maintained, with the international and regional agencies that invest in information and some bilateral donors having a particularly important role;

### The Secretariat will focus on:

- maintaining an approach to country support that is tailored to the political, cultural and social context in which governance is being strengthened;
- contributing to strengthening the capacity of health ministries to make health-sector policies that fit with broader national development policies and to allocate resources in line with policy objectives;
- providing support for building national information systems for generating, analysing and using reliable information from population-based sources (e.g. surveys and vital registration), and clinical and administrative data sources, through collaboration with partners (e.g. other bodies in the United Nations system and the Health Metrics Network partnership);
- contributing to building national capacity for research relevant to policy, and synthesizing country experience into evidence-based guidance, in collaboration with partners and the Alliance for Health Policy and Systems Research;
- providing global guidance on health resource allocation based on analysis and synthesis of country, regional and global data, including comprehensive databases, with a key role being played by international expert groups including ACHR;
- facilitating exchange and dissemination of information and experience within and between countries, and enhancing access to information and knowledge;
- bridging the “know-do gap” in global health by learning from experience, disseminating best practices, fostering an environment that encourages the creation, sharing and translating, and effective application of knowledge to improve health; and helping to close the information divide between rich and poor countries, for instance through international platforms such as the Global Observatory for eHealth.

- that improvements are seen in governance and in strategic management that integrates all sectors determining development, and not just in the health sector;
- that countries and development partners are increasingly committed to using evidence for resource allocation.

The risks that may prevent achievement of this strategic objective include the following:

- that international and national investment in this area is insufficient to meet increasing demands;
- that coordination and harmonization between major international partners are inadequate;
- that preference is shown for investing in short-term, non-sustainable solutions.

## ORGANIZATION-WIDE EXPECTED RESULTS

<b>11.1</b> Country capacity and practices improved in national and local health-sector policy-making, regulation, strategic planning, implementation of reforms, and intersectoral and interinstitutional coordination.	<b>INDICATORS</b>		
	<b>11.1.1</b> Proportion of countries with adequate capacity for, and practices in, national and local health-sector policy-making, regulation, strategic planning, implementation of reforms and interinstitutional coordination		<b>11.1.2</b> Proportion of countries with institutionalized health-impact assessment
	<b>BASELINE</b>		
	25% of countries (to be refined)		10% of countries (to be refined)
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	Increase by 10% from baseline		Increase by 10% from baseline
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	Increase by 25% from 2006 baseline		Increase by 20% from 2006 baseline
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	31 450	28 000	32 000
<b>JUSTIFICATION</b>			
<i>Contributing to the implementation of sound governance of health systems in Member States will take many years of work, not only to initiate the processes and build the necessary skills and competencies, but also to sustain progress. It is expected that WHO's work will expand, including provision of support to countries for institutionalized performance assessment of health systems.</i>			

<b>11.2</b> Coordination of donor assistance improved at the global and country levels in order to achieve national targets for health-system development and global health goals.	<b>INDICATORS</b>		
	<b>11.2.1</b> Proportion of countries where the priorities of major donors to the health sector are harmonized and aligned with those of the government		<b>11.2.2</b> The proportion of health priorities that are not adequately funded
	<b>BASELINE</b>		
	A quarter of major recipient countries		Half all priorities not well funded
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	Increase by 20%		Decrease by 15% from baseline
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	Increase by 30% from 2006 baseline		Decrease by 25% from 2006 baseline
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	4 771	5 000	5 000

	<b>JUSTIFICATION</b>		
	<i>Hitherto, only a few Member States have reached a level of highly-effective and efficient coordination of donor assistance. In the context of expanding the response and making progress towards attaining the Millennium Development Goals, WHO will continue to need to be involved in this area at country, regional and global levels.</i>		
<b>11.3</b> Member States' health-information systems strengthened to provide and use high-quality and timely information for health planning and monitoring of countries' and major international goals.	<b>INDICATORS</b>		
	<b>11.3.1</b> Proportion of low- and middle-income countries with adequate health-information systems in line with international standards, set by WHO and the Health Metrics Network		
	<b>BASELINE</b>		
	30% of countries		
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	35% of countries		
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	66% of countries		
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	34 986	55 000	58 000
	<b>JUSTIFICATION</b>		
	<i>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, many more resources have become available in 2006-2007 and 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.</i>		
<b>11.4</b> Knowledge and evidence for health decision-making enhanced by consolidation and publication of existing evidence, facilitation of knowledge generation in priority areas, and global leadership in health-research policy and coordination, including steps to ensure ethical conduct.	<b>INDICATORS</b>		
	<b>11.4.1</b> Use and quality of Organization-wide database system of core health statistics and evidence that covers all high-priority health issues	<b>11.4.2</b> Number of countries in which WHO plays a key role in supporting the generation and use of information and knowledge, including primary data collection and promotion of standards such as the International Statistical Classification of Diseases and Related Health Problems	<b>11.4.3</b> Establishment and maintenance of effective research for health coordination and leadership mechanisms at global and regional levels, including ACHR
	<b>BASELINE</b>		
	Two thirds of countries	20 countries	Mechanisms operating at global and some regional levels
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	Recent country health statistical profiles for 80% of Member States	30 countries	Mechanisms operating at global and all regional levels
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	Profiles for more than 90% of Member States	45 countries	Mechanisms operating at global and all regional levels
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	33 109	33 000	38 000

	<b>JUSTIFICATION</b> <i>WHO's core function of contributing to better knowledge and evidence for health decision-making will expand modestly in this area, maintaining and strengthening WHO's position as a world and regional leader in monitoring the health situation. Activities will include the continuation of the Organization's normative work on classifications in a new era of information technology, which 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 to meet the demand for WHO's work in this area.</i>			
<b>11.5</b> National health research for health-systems development strengthened, within the context of regional and international research and engagement of civil society.	<b>INDICATORS</b>			
	<b>11.5.1</b> Proportion of low- and middle-income countries in which national health-research systems meet internationally-agreed minimum standards (to be defined)	<b>11.5.2</b> Proportion of countries complying with the call for action in the Mexico Statement on Health Research for governments to commit to fund the necessary health research (at least 2% of their health budget to research recommended)		
	<b>BASELINE</b>			
	10% to 15% of countries (to be refined)	Less than 25% of countries (to be refined)		
	<b>TARGETS TO BE ACHIEVED BY 2009</b>			
	25% of countries	10% increase		
	<b>TARGETS TO BE ACHIEVED BY 2013</b>			
	50% of countries	25% increase from baseline		
	<b>RESOURCES (US\$ THOUSAND)</b>			
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013	
20 954	34 000	38 000		
	<b>JUSTIFICATION</b> <i>Overcoming the limitations of national health research for health-systems development, within the context of regional and international research and engagement of civil society, is a major objective of this expected result. Given the current situation in many Member States and at global level, improvement will be gradual and long term, with an increasing number of Member States involved during the next decade. The Alliance for Health Policy and Systems Research will play an important role in generating and channelling resources to fund high-priority health-systems research.</i>			
<b>11.6</b> Knowledge management and eHealth policies and strategies developed and implemented in order to strengthen health systems.	<b>INDICATORS</b>			
	<b>11.6.1</b> Number of countries (health ministries and schools of public health) adopting knowledge-management strategies to bridge the gap between knowledge and its application	<b>11.6.2</b> Number of low- and middle-income countries with access to essential scientific information and knowledge	<b>11.6.3</b> Proportion of countries with evidence-based eHealth frameworks and services	
	<b>BASELINE</b>			
	15 countries	60 countries	10% of countries	
	<b>TARGETS TO BE ACHIEVED BY 2009</b>			
	30 countries	90 countries	30% of countries	
	<b>TARGETS TO BE ACHIEVED BY 2013</b>			
	70 countries	120 countries	75% of countries	
	<b>RESOURCES (US\$ THOUSAND)</b>			
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013	
36 050	34 000	37 000		
	<b>JUSTIFICATION</b> <i>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 to include and support an increasing number of Member States.</i>			

## 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 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 through special vertical

### 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 insufficient attention to the need for national capacity building in quality assurance, procurement and supply management, rational use of medicines and technologies and pharmacovigilance; 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.



systems and long-term development of comprehensive national policies and supply systems for medical products and technologies.

### 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 and rational use of medical products and technologies 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 be put 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. 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.

### ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

- that expanding 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 Secretariat will focus on:

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

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;
- that insufficient recognition by the new global funding programmes of the need for national capacity building in quality assurance, procurement and supply management, rational use and pharmacovigilance and blood-safety systems will result in a large proportion of the new funds being wasted.

**The Secretariat will focus on:**

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

## ORGANIZATION-WIDE EXPECTED RESULTS

12.1 Formulation and monitoring of comprehensive national policies on access, quality and use of essential medical products and technologies advocated and supported.	INDICATORS			
	12.1.1 Number of countries receiving support to formulate and implement official national policies on access, quality and use of essential medical products and technologies	12.1.2 Number of countries receiving support to design or strengthen comprehensive national procurement and supply systems	12.1.3 Number of countries receiving support to formulate and implement national strategies and regulatory mechanisms for blood and blood products and infection control	12.1.4 Publication of a biennial global report on medicine prices, availability and affordability
	BASELINE			
	62 countries	20 countries	46 countries	Report published in 2007
	TARGETS TO BE ACHIEVED BY 2009			
	68 countries	25 countries	52 countries	Report published
	TARGETS TO BE ACHIEVED BY 2013			
	78 countries	35 countries	64 countries	2 reports published (2011 and 2013)
	RESOURCES (US\$ THOUSAND)			
	Costs 2008-2009	Estimates 2010-2011		Estimates 2012-2013
38 489	40 000		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.				

<b>12.2</b> 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.	<b>INDICATORS</b>			
	<b>12.2.1</b> Number of new or updated global quality standards, reference preparations, guidelines and tools for promoting the quality and effective regulation of medical products and technologies	<b>12.2.2</b> Number of assigned International Nonproprietary Names for medical products	<b>12.2.3</b> Number of priority medicines, vaccines, diagnostic tools and items of equipment that are prequalified for United Nations procurement	<b>12.2.4</b> Number of countries whose national regulatory authorities have been assessed, supported and accredited
	<b>BASELINE</b>			
	30 per biennium	8900 names	150 products	20 countries

<b>TARGETS TO BE ACHIEVED BY 2009</b>			
30 additional outputs	9100 names	100 products	30 countries
<b>TARGETS TO BE ACHIEVED BY 2013</b>			
A further 60 additional outputs	9500 names	500 products	80 countries
<b>RESOURCES (US\$ THOUSAND)</b>			
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013	
66 990	95 000	104 000	
<b>JUSTIFICATION</b>			
<i>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.</i>			

12.3 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		
	12.3.1 Number of national or regional programmes receiving support for promoting sound and cost-effective use of medical products and technologies		12.3.2 Number of countries using national lists, updated within the past five years, of essential medicines, vaccines and technologies for public procurement and/or reimbursement
	BASELINE		
	5 programmes		80 countries
	TARGETS TO BE ACHIEVED BY 2009		
	10 programmes		90 countries
	TARGETS TO BE ACHIEVED BY 2013		
	20 programmes		100 countries
	RESOURCES (US\$ THOUSAND)		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	24 896	30 000	34 000
	JUSTIFICATION		
	Most new funding agencies, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, pay insufficient attention to promoting the rational use by prescribers and consumers of the medicines they supply. This omission can lead to health outcomes not being fully attained and considerable waste of economic resources.		

## To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes

### Indicators and targets

- Population density of the health workforce (disaggregated by country, gender and occupational classification where possible)
- Rural/urban distribution of health workers (disaggregated by country, gender and occupational classification where possible).

### ISSUES AND CHALLENGES

There is a clear correlation between the population density of health-care providers and the levels of coverage attained with essential health interventions, such as immunization and skilled attendance at delivery. The evidence shows that as the number of health-care providers per 1000 population rises, so the rates of infant, child and maternal survival improve.

Many countries are not likely to meet the targets for coverage of essential interventions set in respect of the Millennium Declaration. For example, *The world health report 2006*<sup>1</sup> identified 57 countries, 36 of them in sub-Saharan Africa, in which the density of health workers falls below the threshold of 2.3/1000 population that is critical for achieving 80% skilled attendance at delivery. There is an estimated shortage of about 2.4 million health-service providers in these countries; when management and support workers are included, the gap increases to about four million.

The causes of these acute shortages are manifold. There is a limited production capacity in many developing countries that is the result of years of underinvestment in health-education institutions. There are also “push” and “pull” factors that encourage health workers to leave their workplaces, resulting in geographical imbalances between rural and urban areas within countries, and between countries and regions, with significant migration from developing countries to more developed ones. The migration of health personnel has dire consequences for the health systems in developing countries, which are already suffering the effects of years of neglect, poorly managed health-care reforms and economic stagnation.

Health-workforce development is further hindered by the following: poor skill mix and gender imbalance; a training output that is poorly aligned with the health needs of the population; unsatisfactory working conditions; a weak knowledge base; and lack of coordination between sectors.

These problems, particularly the migration of health personnel, are not new, but they have become acute in

### Lessons learnt

- The countries that need to strengthen their health workforce the most urgently are often those with the most limited monitoring capacity.
- Increased harmonization is required in order to improve data collection and simplify the task of making comparisons across sources, countries and time.
- Databases on the health workforce are worth maintaining if they are used to generate information and evidence in support of policy decisions. It is important for countries to use a standard set of indicators that facilitate comparability.
- Building knowledge and databases on the health workforce requires coordinated efforts across sectors, and should involve the regulatory system, the national statistical office, academic institutions and other stakeholders.
- Health systems cannot afford the risk of having a poorly trained health workforce. Nor can a health system function well if the training its workers receive does not match the health needs of the population.
- The lack of an appropriate infrastructure – dedicated buildings, specialized laboratories, suitable field sites and high-quality learning materials – can limit the number of students who can be taught and make it difficult for institutions to expand.
- Providing career-long training in support of an adaptable and appropriately skilled health workforce is costly.
- Beyond the influence of characteristics inherent in the population being served and in the health workers themselves, the performance of workers is strongly influenced by conditions related to their job, the support they receive and the nature of their workplace.

<sup>1</sup> *The world health report 2006: working for health*. Geneva, World Health Organization, 2006.

recent years as a result of accelerating trends in population ageing, changes in the epidemiological profile, and globalization. Efforts to meet these challenges have been limited in scope and have not received sufficiently wide promotion. Although recent advocacy has given the health-workforce crisis more prominence in relation to other international health issues, unless the current crisis is resolved, neither priority disease initiatives nor health-systems strengthening will succeed.

### STRATEGIC APPROACHES

As the human resources crisis has achieved a global dimension, WHO and its partners need to provide a global response. In support of that effort, the Secretariat will develop and share the data, information, and evidence that are needed in order to change current practices in order to tackle problems concerning the health workforce and ensure steady improvement in the overall performance of health personnel.

In order to achieve this strategic objective countries will have to create a workforce that is distributed in the right places, in the right numbers and with the right skills and that is, as a result, able to respond to the health needs of the population, within the context of the national health system.

In the context of this effort, advocacy will need to be strengthened in support of health-workforce improvement at global, regional and national levels, with partnerships created and promoted at all levels. Health-workforce information systems are required, as are evidence-based and comprehensive national workforce policies and strategic health-workforce plans, which must be developed and systematically implemented, monitored and evaluated. Evidence-based best practices on development, education and management of health workers need to be collated and disseminated. Similarly, adequate funding for the health workforce will be needed and this will require discussions and negotiations with finance ministries, labour and education ministries, and international development counterparts.

In addition, it will be necessary to expand the capacity and improve the quality of educational and training institutions; and ensure the appropriate skill mix and equitable geographical distribution of the health workforce through effective deployment and retention, by means of context-specific incentives.

### ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

- that recent international efforts to tackle the crisis in human resources for health, including the plan of action proposed in *The world health report 2006*, will be sustained. Cross-sectoral partnerships will continue to engage all stakeholders, including civil society, professional

#### The Secretariat will focus on:

- providing response to countries facing a crisis in human resources for health;
- facilitating agreements with other agencies on more effective financing mechanisms for health-workforce development, and on management of internal and international migration;
- supporting the development of national health workforce leadership at central and peripheral levels in order to mobilize resources for the health workforce and formulate, implement, monitor and evaluate health-workforce policies and plans in the light of health needs;
- strengthening national educational systems, including schools and universities, enabling them to support the training of all types of health workers, with the appropriate skills and competencies;
- strengthening the knowledge base by supporting national capacity to develop health-workforce information systems and promote health-workforce research;
- supporting mechanisms for regional networking of stakeholders, such as health-workforce observatories, in order to generate information for evidence-based policy-making, monitoring and evaluation;
- collaborating on the establishment of norms and standards for the health workforce, including internationally agreed-upon definitions, classification systems and indicators.

associations and the private sector in support of health-workforce development.

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

- that financing of health-workforce development will remain at low levels;
- that the issue of human-resources development will continue to be neglected;
- that the countries in which there is a health-workforce crisis will continue to have difficulty taking full responsibility for managing their response;
- that active recruitment by developed countries will continue to encourage uncontrolled migration;
- that market forces will continue to exert an excessive pressure in favour of out-migration and the brain drain.

## ORGANIZATION-WIDE EXPECTED RESULTS

13.1 Capacity of Member States strengthened for leading in health workforce development.	<b>INDICATORS</b>				
	<b>13.1.1</b> Number of countries with evidence-based policies, plans and strategies for strengthening the health workforce in the areas of production, distribution, retention and productivity	<b>13.1.2</b> Number of countries with strengthened planning and development capacities and their health ministries and allied national institutions for development of human resources for health	<b>13.1.3</b> Number of countries with strengthened national institutions for increasing production of different types of health workers	<b>13.1.4</b> Number of countries with effective accreditation mechanisms for health education institutions	<b>13.1.5</b> Number of countries with bilateral agreements and other mechanisms for managing migration
	<b>BASELINE</b>				
	Number of countries reached by 2007, out of the 57 countries in crisis	Number of countries reached by 2007, out of the 57 countries in crisis	Number of countries reached by 2007, out of the 57 countries in crisis	Number of countries reached by 2007, out of the 57 countries in crisis	Number of countries reached by 2007, out of the 57 countries in crisis
	<b>TARGETS TO BE ACHIEVED BY 2009</b>				
	At least 10 more countries over baseline	At least 10 more countries over baseline	At least 10 more countries over baseline	At least 10 more countries over baseline	At least 10 more countries over baseline
	<b>TARGETS TO BE ACHIEVED BY 2013</b>				
	At least 20 more countries over baseline	At least 20 more countries over baseline	At least 20 more countries over baseline	At least 20 more countries over baseline	At least 20 more countries over baseline
	<b>RESOURCES (US\$ THOUSAND)</b>				
	Costs 2008-2009	Estimates 2010-2011		Estimates 2012-2013	
	31 651	30 000		29 000	

13.2 Information and knowledge base for developing the health workforce strengthened at national, regional and global levels.	<b>JUSTIFICATION</b>			
	There is strong evidence that availability of skilled health workers contributes to improved health outcomes in areas such as maternal, infant and child survival. For this reason, capacity should be built in countries to enable them to take the lead in advocating for the health workforce and in creating and maintaining the political commitment and the enabling environment that are needed for formulating national policies and plans, and pursuing their implementation, in order to combat the shortage and inappropriate distribution of health workers. WHO's capacity needs to be strengthened at all levels in order to support health workforce development in countries.			
	<b>INDICATORS</b>			
	13.2.1 Number of countries with well maintained and regularly updated databases for health-workforce development	13.2.2 Provision by countries of good-quality data at least once a year for the global health atlas	13.2.3 Regional observatories established to assess and monitor the situation of the health workforce in countries	13.2.4 Proportion of comprehensive and coherent research programmes established to inform on human resources for health development and implementation of policy
	<b>BASELINE</b>			
	Number of countries reached by 2007, out of the 57 countries in crisis	Global atlas on the health workforce in use	2 regional observatories established by the end of 2007	Baselines to be determined after completion of assessment in 2007
	<b>TARGETS TO BE ACHIEVED BY 2009</b>			
	At least 10 more countries	Global atlas updated at least once a year	2 further regional observatories established	30% more programmes
	<b>TARGETS TO BE ACHIEVED BY 2013</b>			
	At least 20 more countries over baseline	Global atlas updated at least once a year	Regional observatories established in all 6 regions	50% more programmes than in 2009
<b>RESOURCES (US\$ THOUSAND)</b>				
Costs 2008-2009		Estimates 2010-2011	Estimates 2012-2013	
18 113		23 000	22 000	
<b>JUSTIFICATION</b>				
The knowledge base in human resources for health development is weak and uneven in comparison with other areas of health-systems research, such as health financing or health-sector reform. Areas concerning the health workforce, such as assessment, planning, production, regulation and management, need to be better understood. Common technical frameworks are necessary in order to permit analysis of comparable situations, as well as identification of trends. Data and information must be collected and analysed in order to monitor the health-workforce situation at global and regional levels and the trend therein. Research needs to be supported and further stimulated in order to expand the knowledge base and identify and promote best practices in health-workforce development.				

<b>13.3</b> Technical support provided to Member States in crisis to reduce their shortages by improving the production, distribution and skill mix of their health workforce.	<b>INDICATORS</b>		
	<b>13.3.1</b> Number of countries developing and using common technical frameworks, together with their accompanying tools and guidelines in order to facilitate the assessment, production, regulation and management of the health workforce (including in relation to its retention, performance and productivity)	<b>13.3.2</b> Number of countries adopting tools and guidelines for integrating human resources for health across priority programmes	<b>13.3.3</b> Number of countries adopting updated norms and standards related to the classification and licensing of different categories of health-care providers

	<b>BASELINE</b>		
	Existence of draft frameworks, tools and guidelines in all areas	Existence of tools and guidelines for integrating human resources for health across priority programmes	Norms and standards established for nursing and midwifery and other health professions
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	20 countries adopting the technical frameworks	20 countries adopting the tools and guidelines	20 countries adopting the norms and standards
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	30 more countries adopting the technical frameworks	30 more countries adopting the tools and guidelines	30 more countries adopting the norms and standards
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	44 986	65 000	62 000
	<b>JUSTIFICATION</b>		
	<i>Performance of health workers is measured against criteria involving availability, competence, responsiveness and productivity. Tools, guidelines and other technical support will be provided to ensure that countries can strengthen their health workforce across the continuum of entry, working life and exit. Country teams will be established that include: health-workforce experts from global, regional and country levels; representatives of other sectors, civil society and the professional associations; bilateral donors; and other relevant stakeholders.</i>		

<b>13.4</b> Networking and partnerships strengthened at global, regional, and country levels, in order to improve the institutional infrastructure in Member States experiencing a crisis in human resources for health.	<b>INDICATORS</b>		
	<b>13.4.1</b> Establishment of partnerships and alliances at global, regional and interregional levels to strengthen advocacy and resource mobilization for national health workforce development	<b>13.4.2</b> Number of WHO collaborating centres and various communities of practice for health-workforce development	<b>13.4.3</b> Number of twinning and exchange programmes between developed and developing countries
	<b>BASELINE</b>		
	One global alliance and one interregional alliance established	55 WHO collaborating centres, 44 of which relate to nursing and midwifery	Baselines to be determined after completion of assessment in 2007
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	Further interregional alliances established	27 more WHO collaborating centres designated on subjects including development of human resources for health, nursing and midwifery and research into human resources for health	30% more programmes than in 2007
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	Interregional alliances established that include all regions	A total of 80 WHO collaborating centres on human resources designated	50% more programmes than in 2009
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	25 002	17 000	16 000



**JUSTIFICATION**

*Health-workforce development cannot be dealt with in isolation; it requires cross-sectoral initiatives and dialogue between stakeholders so that human-resource constraints can be analysed and effective interventions identified and implemented. This is particularly important in the light of resolutions WHA59.23 and WHA59.27. Efforts to achieve the objectives of these resolutions, namely the rapid scaling up of health workforce production and the strengthening of nursing and midwifery, depend for their success on an adequate institutional infrastructure with a functioning set of key institutions, such as medical schools, nursing and midwifery schools and public health schools, together with professional associations and regulatory bodies.*

## To extend social protection through fair, adequate and sustainable financing

### Indicators and targets

- Increases in funds available for health in low-income countries
- Reduction in the proportion of households suffering from financial catastrophe and impoverishment as a result of health spending, especially due to out-of-pocket payments (while ensuring that use of needed services is maintained or increased)
- Reduction in the number of countries that have a high proportion of out-of-pocket spending in total health spending
- Increased equity and efficiency in the use of health resources.

### ISSUES AND CHALLENGES

It is now widely recognized that the way the health system is financed and organized 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. Common questions include the issue of how funds should be raised, how they should be pooled to spread risks, and how they should be used to provide the services and programmes needed by their populations in an efficient and equitable manner. In some countries, the level of spending is still insufficient to ensure equitable access to essential health services and interventions – personal, nonpersonal and intersectoral – so the major concern is to ensure adequate and equitable resource mobilization for health. Increased external flows channelled to health in poor countries have focused attention on how these flows can be sustained in a more predictable way. In many countries, across all levels of income, governments are concerned with restraining the rate at which health costs have been increasing while maintaining or improving quality. All countries are concerned with ensuring that the resources available for health are used efficiently and that they are distributed equitably, yet disparities in access to services remain between rural and urban areas and between the sexes. In many countries, health financing relies heavily on out-of-pocket payments, placing large, sometimes catastrophic financial burdens on households which can be pushed into poverty, or further into poverty, as a result.

In response, more funds need to be assured in poor countries, made available in a predictable manner and used equitably and efficiently. This sometimes requires complex adjustments to the way that health financing is raised, pooled to spread risks, and used to purchase and provide services. Although countries choose the mix of private and public providers and funders appropriate in their own settings, strong

### Lessons learnt

- Information on how much is spent on health, by whom, and on what it is spent has proved very valuable in many countries for framing and adapting health policies.
- Heavy reliance on raising of funds through user-charges and other forms of out-of-pocket payments made by households to providers deters some people from using health services because they cannot pay, and can lead to financial catastrophe and impoverishment for some users.
- Prepayment systems, through taxation, forms of insurance, or a mix of both, can protect people from financial catastrophe and impoverishment and improve access.
- Raising more funds for health in poor countries is a necessary, but not sufficient, condition for improving health. Ways of using funds more efficiently and equitably are crucial.
- Improving efficiency and equity requires actable decisions about how to pool funds, pay providers and select interventions, and how to interact with the nongovernment sector.

government stewardship is needed and ministries of health sometimes require support in order to advocate intersectoral activities designed to improve health.

Policy-making is often hampered by incomplete data and information on basic questions such as the level and distribution of health expenditures; the effectiveness, costs and implications for equity of different ways of using scarce resources; and the extent of severe financial hardship and impoverishment due to the need to pay for health services. Many countries do not have sufficient skills in budgeting, financial planning and management, a shortcoming that impedes their potential to maximize health gains from available resources. International experience on the impact of different health financing and organizational reforms has not yet been adequately reviewed and consolidated in a way that makes the experience readily available to policy-makers in a form they can use. The challenge is to develop means of obtaining key information, to use this knowledge as an input to the policy debate about ways to improve health systems, and to build capacity to obtain and use this information where necessary.

## STRATEGIC APPROACHES

The approach taken to achieve the objective will follow the broad principles outlined in resolution WHA58.33 and reflects the diversity in income levels and in the nature of health problems, institutional development, capacities, histories and political and social philosophies in the Member States. It includes raising additional funds in and for countries where health needs are high, available revenues are insufficient, and accountability mechanisms can ensure the transparent and effective use of funds. This will generally require a mix of domestic and external sources, including financing for health-related activities from other sectors. Additional domestic financing will be secured through a mix of State and non-State agents and institutions, and will require effective government stewardship. Countries will also work with the international community to improve the predictability of external flows.

Reliance on high out-of-pocket payments could be reduced by improving the effectiveness of prepayment mechanisms; this requires assessing the feasibility, effectiveness and equity of reforms to existing financing arrangements or the introduction of new arrangements.

Efficiency of resource use could be improved by focusing on questions such as the appropriate mix of activities to finance and inputs to purchase. This requires assessing the mix of prevention, promotion, treatment and rehabilitation interventions and intersectoral action; capital, as compared to recurrent, expenditure; and different types of recurrent expenditure, such as human resources and medicines. Consideration could also be given to whether high-cost, low-impact interventions are being financed at the expense of low-cost, high-impact alternatives, and how to change the incentives inherent in the way that services are purchased or

### The Secretariat will focus on:

- advocating more and predictable financing for health globally, regionally and nationally, and participation in partnerships that further this aim;
- providing support for ministries of health to position health higher on the domestic agenda and, as appropriate, to advocate increased financing from ministries of finance and external sources and for health-related activities from other sectors;
- providing support to countries to develop and sustain high levels of accountability and transparency in the use of funds, and to strengthen their stewardship functions relating to financial management;
- generating evidence and options and providing technical support for developing prepayment institutions and mechanisms, in collaboration with partners, in order to reduce reliance on out-of-pocket payments where they deter people from obtaining interventions or result in severe financial hardship;
- providing technical support and evidence for policy-making on ways to improve efficiency, including ensuring adequate financing for key inputs such as medicines and human resources, and for key actions such as prevention, promotion and intersectoral cooperation;
- working to reduce waste and inefficiency and to improve equity in resource use.

provided in order to improve the quality and efficiency of service delivery.

The Member States would also improve social protection by ensuring that the poor and other vulnerable groups have better access to needed services (personal, nonpersonal, and intersectoral) and that paying for care does not result in financial catastrophe or impoverishment; promoting transparency and accountability in health-financing systems; and improving information generation and use. In this regard, many countries do not know the extent of financial catastrophe associated with out-of-pocket payments or the extent to which the burden of financing the health system in its entirety is progressive, proportional, or regressive. Others do not know how much is spent in the private sector, and on what.

### ASSUMPTIONS, RISKS AND OPTIONS

Achieving this strategic objective requires developing and maintaining effective partnerships and involving stakeholders at national, regional and global levels. Of particular importance are international and regional financial institutions, a number of bilateral donors, and ministries of finance.

It is also assumed that countries and development partners will remain committed to the goal of achieving universal coverage, and that sufficient funds are available to undertake an ambitious, expanded workplan to provide support to countries.

Possible risks are:

- that the recent increases in health financing in poor countries will be tied closely to only a few of the key health problems they face;
- increased financing from external sources could bypass rather than strengthen domestic institutions for revenue collection, pooling of funds and purchasing or provision of interventions and services;
- mechanisms intended to improve the predictability of external flows for health will not be supported internationally.

### ORGANIZATION-WIDE EXPECTED RESULTS

14.1 Ethical and evidence-based policy and technical support provided to Member States to improve the performance of health-system financing in terms of financial protection, equity in finance, use of services, and efficiency of resource use.	INDICATORS	
	14.1.1 Number of countries provided with technical and policy support designed to reduce financial barriers to access to needed health interventions; incidence of financial catastrophe and impoverishment linked to health payments; improvement of the efficiency and equity of resource use	14.1.2 Number of key information briefs documenting best practices on revenue raising, pooling and purchasing or provision of interventions and services to guide policy formulation and implementation prepared and disseminated
	BASELINE	
	15 countries	6 technical briefs for policy-makers
	TARGETS TO BE ACHIEVED BY 2009	
	40 countries	12 technical briefs

#### The Secretariat will focus on:

- providing technical support and evidence for policy-making on ways to improve equity in resource use, including identifying groups suffering in financial catastrophe and impoverishment because of health payments, and methods that can be used to protect them;
- sharing of country experience with different types of financing, pooling and purchasing or provision arrangements in different settings, along with the factors of success in sustaining progress on key policy objectives;
- providing and disseminating norms, standards and tools relevant to the above activity;
- providing and disseminating information necessary for the development, operation and monitoring of fair, adequate and sustainable health-financing systems;
- building capacity at country level.

<b>TARGETS TO BE ACHIEVED BY 2013</b>		
90 countries		20 technical briefs
<b>RESOURCES (US\$ THOUSAND)</b>		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
32 605	39 000	41 000
<b>JUSTIFICATION</b>		
<i>There has been a substantial increase in requests for support from Member States on ways to improve the efficiency and/or equity of their health-financing systems, and to extend financial risk protection to vulnerable groups. This 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.</i>		

<b>14.2</b> International, regional and national advocacy, information and technical support designed to mobilize additional and predictable funding for health.	<b>INDICATORS</b>		
	<b>14.2.1</b> WHO presence and leadership in international, regional and national partnerships to increase funding for health in poor countries	<b>14.2.2</b> WHO support to countries in the design and/or monitoring of Poverty Reduction Strategy Papers, sector-wide approaches, medium-term expenditure frameworks and other long-term financing mechanisms	<b>14.2.3</b> Number of technical briefs collating evidence on best practices for coordination of external financial assistance at global, regional and national levels in order to increase extent and to improve predictability of external assistance
	<b>BASELINE</b>		
	WHO participation in 2 global or regional partnerships on financing options	6 countries	1 technical brief for policy-makers disseminated
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	WHO participation in 4 global or regional partnerships on financing options	16 countries	4 technical briefs
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	WHO participation in 8 global or regional partnerships on financing options	40 countries	8 technical briefs
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	7 480	13 000	14 000
	<b>JUSTIFICATION</b>		
	<p><i>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 momentum internationally and to provide active support to countries to build health into country economic plans such as medium-term expenditure frameworks. This requires strengthening capacity of country offices as well as other levels of WHO.</i></p>		

<b>14.3</b> Measurement tools developed to analyse transparency and accountability in health-financing systems, and technical support	<b>INDICATORS</b>		
	<b>14.3.1</b> Number of countries provided with technical support for using WHO tools to track and evaluate the use of funds, to estimate future financial needs, and to manage and monitor available funds		
	<b>BASELINE</b>		
	15 countries		

14.4 Norms and standards developed for tracking resources, and estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe and impoverishment, and their implementation promoted, supported and monitored.	INDICATORS		
	14.4.1 Key tools, norms and standards to guide policy development and implementation developed, disseminated and their use supported, according to expressed need, but including resource tracking, the economic consequences of disease, costs and effects of interventions, financial catastrophe and impoverishment		
	BASELINE		
	Tools available to countries for national health accounts, costing financial catastrophe and impoverishment, and cost effectiveness		
	TARGETS TO BE ACHIEVED BY 2009		
	Additional tools for resource tracking, additionality and economic burden. Revision of existing tools where necessary. Framework on formulation of financing policy		
	TARGETS TO BE ACHIEVED BY 2013		
	Tools and frameworks modified, updated and disseminated as necessary		
	RESOURCES (US\$ THOUSAND)		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
10 639	9 000	9 000	
JUSTIFICATION			
The demand is rising for WHO to provide norms or guidelines on how to estimate the economic impact of illness, or to track expenditures on particular diseases, or to identify and monitor the households suffering financial catastrophe and impoverishment as a result of out-of-pocket payments for health services. Capacity to meet these demands needs to be expanded substantially together with the ability to provide support to policy-makers seeking to use the resulting norms and standards.			

<b>14.5</b> Steps taken to build capacity in framing of health financial policy, and the production, interpretation and use of financial information.	<b>INDICATORS</b>
	<b>14.5.1</b> Number of countries provided with support to build capacity in the formulation of health financing policies and strategies, and in the collection and use of financial information such as health expenditures and costs, financial catastrophe and impoverishment, cost-effectiveness, and budgeting
	<b>BASELINE</b>
	25 countries
	<b>TARGETS TO BE ACHIEVED BY 2009</b>
	55 countries

<b>TARGETS TO BE ACHIEVED BY 2013</b>		
90 countries		
<b>RESOURCES (US\$ THOUSAND)</b>		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
22 474	21 000	23 000
<b>JUSTIFICATION</b>		
<i>In many countries, skills in financial and economic planning and management for health are limited. The demands from Member States for support have increased rapidly, and an increase in the budget for 2008-2009 is required to meet the need to build capacity.</i>		

<b>14.6</b> Steps taken to stimulate the generation, translation and dissemination of knowledge and to shape the research agenda.	<b>INDICATORS</b>		
	<b>14.6.1</b> Key information and knowledge on health expenditures, financing, efficiency and equity to guide policy development and implementation validated and disseminated		
	<b>BASELINE</b>		
	Annual updates of health expenditure for 193 Member States, and information on the extent of catastrophic expenditure and impoverishment for 70 countries where households are most at risk		
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	Annual updates of health expenditure for 193 Member States, and updated or new information on the extent of catastrophic expenditure and impoverishment for 20 countries		
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	Annual updates of health expenditure for 193 Member States, and extent of catastrophic expenditure and impoverishment updated for 20 countries		
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	7 327	10 000	10 000
<b>JUSTIFICATION</b>			
<i>Member States are provided with key information on health expenditures, the effectiveness and costs of major interventions, and the extent of financial catastrophe and impoverishment relating to out-of-pocket payments. Considerable additional work needs to be done to ensure the timely dissemination of this information to policy-makers. Moreover, this work continues to identify many gaps in knowledge and unanswered questions that are crucial to policy-making, but the links between them and the researchers who could provide answers need to be strengthened. This requires an increase in funding throughout the period covered by the medium-term strategic plan.</i>			

**To provide leadership, strengthen governance and foster partnership and collaboration with countries 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.<sup>1</sup> 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. 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 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 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.

<sup>1</sup> 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 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 could be strengthened to allow stakeholders to tackle health issues in a transparent 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 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. 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 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

<b>15.1</b> Effective leadership and direction of the Organization exercised through enhancement of governance, and the coherence, accountability and synergy of WHO's work.	INDICATORS			
	<b>15.1.1</b> Proportion of resolutions adopted that focus on policy and can be implemented at global, regional and national levels	<b>15.1.2</b> Proportion of documents submitted to governing bodies within constitutional deadlines, in all official languages	<b>15.1.3</b> Level of understanding by key stakeholders of WHO's role, priorities and key messages	<b>15.1.4</b> Percentage of oversight projects completed under the annual work plan which seek to evaluate and improve processes for risk management, control and governance
	BASELINE			
	20%	100%	Survey to be carried out	100%
	TARGETS TO BE ACHIEVED BY 2009			
	40%	100%	10% increase over survey baseline	100%

	TARGETS TO BE ACHIEVED BY 2013			
	50%	100%	25% increase over survey baseline	100%
	RESOURCES (US\$ THOUSAND)			
	Costs 2008-2009	Estimates 2010-2011		Estimates 2012-2013
	89 807	97 927		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.			

15.2 Effective WHO country presence <sup>1</sup> 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		
	15.2.1 Number of Member States using country cooperation strategies as a basis for planning WHO’s country work and for harmonizing cooperation with the United Nations country team members and other development partners	15.2.2 Proportion of countries where WHO’s presence reflects the respective Country Cooperation Strategy	15.2.3 Number of countries in which harmonized mechanism to assess the contribution of the Secretariat to national health outcomes is implemented
	BASELINE		
	40	20%	3
	TARGETS TO BE ACHIEVED BY 2009		
	80	40%	25
	TARGETS TO BE ACHIEVED BY 2013		
	135	80%	80
	RESOURCES (US\$ THOUSAND)		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	72 659	79 228	87 481
	JUSTIFICATION		
WHO’s commitment to strengthen operations have greater impact at country level will be maintained and may require further resources in the coming years in order, for example, to increase ability to collaborate more with country-level partners and harmonization mechanisms.			

<sup>1</sup> 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.

<b>15.3</b> 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	<b>INDICATORS</b>			
	<b>15.3.1</b> Proportion of external aid flows to health supplied through flexible and long-term instruments	<b>15.3.2</b> Proportion of health partnerships in which WHO participates and that work according to the Best Practice Principles for Global Health Partnerships	<b>15.3.3</b> Proportion of trade agreements appropriately reflecting public health interests, as outlined in WHO guidance	<b>15.3.4</b> 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
	<b>BASELINE</b>			
	Not yet established	Not yet established	Less than 5%	Less than 20%

TARGETS TO BE ACHIEVED BY 2009			
Mechanism established (in partnership with OECD/Development Assistance Committee and World Bank) for systematically monitoring long-term commitments or aid to health, programmed through government; baseline data gathered; target set for 2013	Set of indicators from the Paris Declaration on Aid Effectiveness adopted by the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Alliance for Vaccines and Immunization, and other global health partnerships; monitoring system established; baseline data gathered; targets set for 2013	10%	Over 50%
TARGETS TO BE ACHIEVED BY 2013			
To be established by 2009	To be established by 2009	20%	
RESOURCES (US\$ THOUSAND)			
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013	
21 643	23 600	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.			

15.4 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			
	15.4.1 Number of countries that have access to relevant health information and advocacy material for the effective delivery of health programmes as reflected in the country cooperation strategies	15.4.2 Average number of page views/visits per month to the WHO web site	15.4.3 Number of multilingual (non-English) pages available on the WHO web site	15.4.4 Number of WHO publications sold per biennium
	BASELINE			
	To be established	28 million/3.5 million	12 733	350 000
	TARGETS TO BE ACHIEVED BY 2009			
	Baseline plus 20%	48 million/5 million	22 000	400 000
	TARGETS TO BE ACHIEVED BY 2013			
	Baseline plus 50%	80 million/7 million	40 000	500 000
	RESOURCES (US\$ THOUSAND)			
	Costs 2008-2009	Estimates 2010-2011		Estimates 2012-2013
	35 991	39 245		43 333
	JUSTIFICATION			
	In line with WHO's work, the activities related to this Organization-wide expected result will slightly increase.			

## **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: about 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.

The global public health architecture, within which WHO plays a key role, is increasingly complex. New actors and partnerships continuously emerge. Moreover, efforts to harmonize activities in the development community and broader reforms within the United Nations system also influence the way global and local actors operate. WHO must not only participate actively in these developments but ensure that its ways of working reflect this changing environment.

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.

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

### **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 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 are communicated, understood and integrated at all levels of the Organization, in particular through learning and development activities.

be done, however, to ensure that the framework builds on lessons learnt, better reflects country needs, and encourages greater collaboration throughout the Organization.

Financial management is a challenge in a situation in which more than 70% of the Organization's resources are voluntary contributions. Regular monitoring of, and reporting on, resources across the Organization has improved. However, more flexibility 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 of 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 create a culture that promotes learning and manages performance. More must be done to facilitate the rotation and mobility of staff within the Organization.

A system is being implemented that allows the Organization to exploit better of its knowledge base and to have access to timely information that provides support to management decision-making. Such a system has to be continuously aligned with, and responsive to, the changing needs of the Organization. Efforts to improve the quality of managerial and administrative service-delivery throughout the Organization must be pursued.

Recognizing the decentralized nature of WHO's work, a key challenge at all levels of the Secretariat is the alignment between responsibility and authority, which is a prerequisite for sound accountability. Critical thinking is required to ensure that decision-making and implementation are being done at the right levels in order to maximize efficiency and effectiveness, in line with the needs and demands of the Organization. Particular emphasis should be placed on strengthening the managerial capacity of WHO country offices.

## STRATEGIC APPROACHES

In order to achieve the strategic objective and respond to the above challenges, broad complementary approaches are required. Over the past two to three 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 next six 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;

### The Secretariat will focus on:

- strengthening a results-based approach in all aspects of WHO's work, an approach that emphasizes the importance of 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 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; 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.

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

A key assumption is that there is support in WHO – both Member States and Secretariat – to continue and further accelerate the reforms under way. Indeed, 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. Clear communication internally and externally will be essential to ensure that efforts to meet this objective remain relevant to the changing needs of the Organization.

It is also assumed that the changes in the external and internal environment that are 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.

Pressures to contain administrative costs are likely to remain. The Secretariat will continue to minimize costs and ensure that all options are considered in this regard, including outsourcing or relocation opportunities. Such changes in ways of working are not without risk and must not be carried out to the detriment of institutional knowledge, quality, appropriate controls and accountability. This 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.

### ORGANIZATION-WIDE EXPECTED RESULTS

16.1 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			
	16.1.1 Proportion of approved workplans that incorporate lessons learnt from the previous biennium as identified in the programme budget performance assessment and have been drawn up in a consultative process involving the three levels of the Organization	16.1.2 Proportion of reports on strategic objectives for the mid-term review and programme budget performance assessment that have been peer reviewed and submitted in a timely fashion	16.1.3 Percentage of evaluations and performance audit projects completed under the annual workplan in the application of the Organization's evaluation guidelines and other oversight policies	16.1.4 Proportion of managers trained and certified on WHO's accountability mechanisms

	<b>BASELINE</b>			
	50%	50%	100%	0% (certification programme not yet in place)
	<b>TARGETS TO BE ACHIEVED BY 2009</b>			
	80%	80%	100%	90%
	<b>TARGETS TO BE ACHIEVED BY 2013</b>			
	90%	90%	100%	95%
	<b>RESOURCES (US\$ THOUSAND)</b>			
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013	
	37 913	40 383	43 805	
	<b>JUSTIFICATION</b>			

*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.*

<b>16.2</b> 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.	<b>INDICATORS</b>		
	<b>16.2.1</b> Degree of compliance of WHO with International Public Sector Accounting Standards	<b>16.2.2</b> Proportion of strategic objectives with expenditure levels meeting programme budget targets	<b>16.2.3</b> Proportion of voluntary contributions that are un-earmarked
	<b>BASELINE</b>		
	Accounting Standards not implemented	70% (areas of work)	15%
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	International Public Sector Accounting Standards implemented	80%	20%
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
		100%	30%
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013

62 780	66 871	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.*

<b>16.3</b> Human resource policies and practices in place to attract and retain top talent, promote learning and professional development, manage	<b>INDICATORS</b>		
	<b>16.3.1</b> Proportion of offices <sup>1</sup> with approved human resources plans for a biennium	<b>16.3.2</b> Number of staff assuming a new position or moving to a new location during a biennium	<b>16.3.3</b> Proportion of staff in compliance with the cycle of the Performance Management Development System, i.e. objectives and development needs have been discussed between staff and supervisor



performance, and foster ethical behaviour.	<b>BASELINE</b>		
	40%	About 100	65%
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	75%	300	75%
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	100%	400	95%
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	30 767	32 772	35 549
	<b>JUSTIFICATION</b>		
	<i>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.</i>		

<sup>1</sup> Offices here refers to country offices (144), regional office divisions (~30) and headquarter departments (~40).

<b>16.4</b> 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.	<b>INDICATORS</b>		
	<b>16.4.1</b> Proportion of known proposals, projects, and applications tracked on a regular basis through global portfolio management processes	<b>16.4.2</b> Number of information technology disciplines <sup>1</sup> implemented Organization-wide according to best-practice benchmarks	<b>16.4.3</b> Proportion of offices using consistent real-time management information
	<b>BASELINE</b>		
	40%	0 (only localized implementation)	0% office-specific management information
	<b>TARGETS TO BE ACHIEVED BY 2009</b>		
	75%	5	75%
	<b>TARGETS TO BE ACHIEVED BY 2013</b>		
	95%	9	90%
	<b>RESOURCES (US\$ THOUSAND)</b>		
	Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
	110 334	117 523	127 483
	<b>JUSTIFICATION</b>		
	<i>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.</i>		

<sup>1</sup> This includes, for example, incidence management, configuration management, release management, service-desk function.

## DRAFT MEDIUM-TERM STRATEGIC PLAN 2008-2013

<b>16.5</b> Managerial and administrative support services <sup>1</sup> necessary for the efficient functioning of the Organization provided in accordance with service-level agreements that emphasize quality and responsiveness.	<b>INDICATORS</b>	
	<b>16.5.1</b> Proportion of services delivered according to criteria in service-level agreements	<b>16.5.2</b> Proportion of procedures delivered according to criteria in emergency standard operating procedures
	<b>BASELINE</b>	
	0% (agreements currently under development)	0% (procedures currently under development)
	<b>TARGETS TO BE ACHIEVED BY 2009</b>	
	75%	75%
	<b>TARGETS TO BE ACHIEVED BY 2013</b>	
	100%	100%
	<b>RESOURCES (US\$ THOUSAND)</b>	
	Costs 2008-2009	Estimates 2010-2011
	155 109	165 216
	Estimates 2012-2013	
	179 217	
	<b>JUSTIFICATION</b>	
	<i>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.</i>	

<sup>1</sup> Includes services in the areas of information technology, human resources, financial resources, logistics, and language services.

<b>16.6</b> Physical working environment conducive to the well-being and safety of staff in all locations.	<b>INDICATORS</b>	
	<b>16.6.1</b> Timeliness of implementation of the capital master plan, within the approved budget	<b>16.6.2</b> Proportion of locations that have implemented policies and plans to improve staff health and safety in the workplace, including compliance with Minimum Operating Safety Standards
	<b>BASELINE</b>	
	Plan being submitted to the Executive Board at its 120th session	65%
	<b>TARGETS TO BE ACHIEVED BY 2009</b>	
	On target	75%
	<b>TARGETS TO BE ACHIEVED BY 2013</b>	
	On target	95%
	<b>RESOURCES (US\$ THOUSAND)</b>	
	Costs 2008-2009	Estimates 2010-2011
	157 006	167 235
	Estimates 2012-2013	
	181 408	
	<b>JUSTIFICATION</b>	
	<i>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.</i>	

**DRAFT PROPOSED PROGRAMME BUDGET 2008-2009**



## CONTENTS

	<b>Page</b>
<b>Strategic objectives</b>	
1. To reduce the health, social and economic burden of communicable diseases .....	118
2. To combat HIV/AIDS, tuberculosis and malaria .....	120
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries .....	122
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals .....	124
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact .....	126
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex .....	128
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches .....	130
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health .....	132
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development. ....	134
10. To improve the organization, management and delivery of health services .....	136
11. To strengthen leadership, governance and the evidence base of health systems .....	138
12. To ensure improved access, quality and use of medical products and technologies...	140
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes .....	142
14. To extend social protection through fair, adequate and sustainable financing. ....	144
15. To provide leadership, strengthen governance and foster partnership and collaboration with countries in order, to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work. ....	146
16. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively .....	148
<b>Financial Tables</b>	
Table 1. Cost by strategic objective and location, 2008-2009 .....	150
Table 2. Cost by strategic objective and office, all levels, 2008-2009 .....	152
Table 3. Cost by strategic objective and office, 2008-2009 .....	153
Table 4. Major WHO partnerships .....	160
Table 5. Links between strategic objectives 2008-2009 and areas of work 2006-2007 .....	161

**STRATEGIC OBJECTIVE 1****To reduce the health, social and economic burden of communicable diseases****Scope**

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

<b>ORGANIZATION-WIDE EXPECTED RESULTS</b>	
<b>1.1</b>	Policy and technical support provided to Member States in order to maximize equitable access of all people to vaccines of assured quality, including new immunization products and technologies, and to integrate other essential child-health interventions with immunization.
<b>1.2</b>	Effective coordination and support provided in order to achieve certification of poliomyelitis eradication, and destruction, or appropriate containment, of polioviruses, leading to a simultaneous cessation of oral poliomyelitis vaccination globally.
<b>1.3</b>	Effective coordination and support provided to Member States in order to provide access for all populations to interventions for the prevention, control, elimination and eradication of neglected tropical diseases, including zoonotic diseases.
<b>1.4</b>	Policy and technical support provided to Member States in order to enhance their capacity to carry out surveillance and monitoring of all communicable diseases of public health importance.
<b>1.5</b>	New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed and validated, with scientists from developing countries increasingly taking the lead in this research.
<b>1.6</b>	Support provided to Member States in order to achieve the minimum core capacities required by the International Health Regulations (2005) for the establishment and strengthening of alert and response systems for use in epidemics and other public health emergencies of international concern.
<b>1.7</b>	Member States and the international community equipped to detect, assess, respond to and cope with major epidemic and pandemic-prone diseases (e.g. influenza, meningitis, yellow fever, haemorrhagic fevers, plague and smallpox) through the development and implementation of tools, methodologies, practices, networks and partnerships for prevention, detection, preparedness and intervention.
<b>1.8</b>	Regional and global capacity coordinated and made rapidly available to Member States for detection, verification, risk assessment and response to epidemics and other public health emergencies of international concern.
<b>TOTAL</b>	

**Links with other strategic objectives**

- Strategic objectives 2, 3, 4, 6 and 9: in relation to integrated disease control, surveillance and harmonized research initiatives.
- Strategic objective 5: in relation to mutual support in field operations and health security.
- Strategic objective 8: in relation to the adoption of adequate solutions for management of health-care waste.
- Strategic objective 9: in relation to water and sanitation aspects of zoonotic diseases.
- Strategic objectives 10, 11, 13 and 14: in relation to the implementation of programmes through financially sustainable health-system approaches.
- Strategic objective 12: in relation to access to safe and effective vaccines, medicines and interventions, as well as quality assurance of diagnostics and laboratory services.

<b>COSTS BY LOCATION (US\$ THOUSAND)</b>							
<b>Africa</b>	<b>The Americas</b>	<b>South-East Asia</b>	<b>Europe</b>	<b>Eastern Mediterranean</b>	<b>Western Pacific</b>	<b>Headquarters</b>	<b>TOTAL</b>
58 450	3 144	26 700	7 700	19 700	8 190	30 610	<b>154 494</b>
135 504	3 128	59 700	3 000	24 725	7 300	30 459	<b>263 816</b>
54 620	7 490	8 700	300	24 200	7 840	29 398	<b>132 548</b>
23 550	3 088	18 300	5 100	8 700	5 400	16 022	<b>80 160</b>
5 000	2 205	3 000	500	4 475	800	57 379	<b>73 359</b>
10 640	6 929	5 100	8 100	9 600	8 640	28 182	<b>77 191</b>
22 300	2 004	8 900	2 000	5 000	7 700	14 025	<b>61 929</b>
7 000	4 812	4 700	3 300	5 000	8 000	23 925	<b>56 737</b>
<b>317 064</b>	<b>32 800</b>	<b>135 100</b>	<b>30 000</b>	<b>101 400</b>	<b>53 870</b>	<b>230 000</b>	<b>900 234</b>

**Resource breakdown for the strategic objective for 2008-2009 (US\$ thousand)**

	<b>Countries</b>	<b>Regions</b>	<b>Headquarters</b>	<b>TOTAL</b>
<b>All financing 2008-2009</b>	<b>393 187</b>	<b>277 047</b>	<b>230 000</b>	<b>900 234</b>
Percentage by level	44	31	25	

**STRATEGIC OBJECTIVE 2****To combat HIV/AIDS, tuberculosis and malaria****Scope**

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

<b>ORGANIZATION-WIDE EXPECTED RESULTS</b>	
<b>2.1</b>	Guidelines, policy, strategy and other tools developed for prevention of, and treatment and care for patients with, HIV/AIDS, tuberculosis and malaria, including innovative approaches for increasing coverage of the interventions among poor people, and hard-to-reach and vulnerable populations.
<b>2.2</b>	Policy and technical support provided to countries towards expanded gender-sensitive delivery of prevention, treatment and care interventions for HIV/AIDS, tuberculosis and malaria, including integrated training and service delivery; wider service-provider networks; and strengthened laboratory capacities and better linkages with other health services, such as those for reproductive health, maternal, newborn and child health, sexually transmitted infections, nutrition, drug-dependence treatment services, respiratory care, neglected diseases and environmental health.
<b>2.3</b>	Global guidance and technical support provided on policies and programmes in order to promote equitable access to essential medicines, diagnostic tools and health technologies of assured quality for the prevention and treatment of HIV/AIDS, tuberculosis and malaria, and their rational use by prescribers and consumers, and, in order to ensure uninterrupted supplies of diagnostics, safe blood and blood products, injections and other essential health technologies and commodities.
<b>2.4</b>	Global, regional and national systems for surveillance, evaluation and monitoring strengthened and expanded to keep track of progress towards targets and allocation of resources for HIV/AIDS, tuberculosis and malaria control and to determine the impact of control efforts and the evolution of drug resistance.
<b>2.5</b>	Political commitment sustained and mobilization of resources ensured through advocacy and nurturing of partnerships on HIV/AIDS, tuberculosis and malaria at country, regional and global levels; support provided to countries as appropriate to develop or strengthen and implement mechanisms for resource mobilization and utilization and increase the absorption capacity of available resources; and engagement of communities and affected persons increased to maximize the reach and performance of HIV/AIDS, tuberculosis and malaria control programmes.
<b>2.6</b>	New knowledge, intervention tools and strategies developed and validated to meet priority needs for the prevention and control of HIV/AIDS, tuberculosis and malaria, with scientists from developing countries increasingly taking the lead in this research.
<b>TOTAL</b>	



**Links with other strategic objectives**

- Strategic objective 1: particularly work related to delivery of interventions; strengthening research capacity and expanding access to new strategies and tools, such as vaccines; and strengthening systems for monitoring and surveillance of communicable diseases.
- Strategic objective 4: particularly efforts related to supporting research and development of new tools and interventions; meeting specific needs of children, adolescents and women of child-bearing age; formulation and implementation of gender-sensitive interventions; and tackling sexually transmitted infections.
- Strategic objective 6: specifically relating to prevention of tobacco use and its relationship with tuberculosis; and prevention of unsafe sex.
- Strategic objective 7: specifically work relating to approaches that enhance equity and are pro-poor, gender-responsive, ethical and human rights based.
- Strategic objective 10: particularly efforts related to organization, management and delivery of health services.
- Strategic objective 12: specifically work related to essential medicines, medical products and technologies for the prevention and treatment of HIV/AIDS, tuberculosis and malaria.
- Strategic objective 13: particularly areas of human resource capacity strengthening, integrated training and widening of service provider networks.
- Strategic objective 14: particularly work related to minimizing the potential of financial catastrophe and impoverishment due to out-of-pocket health expenses.

<b>COSTS BY LOCATION (US\$ THOUSAND)</b>							
<b>Africa</b>	<b>The Americas</b>	<b>South-East Asia</b>	<b>Europe</b>	<b>Eastern Mediterranean</b>	<b>Western Pacific</b>	<b>Headquarters</b>	<b>TOTAL</b>
60 850	8 510	12 400	7 200	8 000	8 702	41 743	<b>147 405</b>
97 360	17 568	39 200	14 400	24 000	17 344	49 569	<b>259 441</b>
23 510	5 840	5 100	3 100	2 000	8 582	10 436	<b>58 568</b>
33 208	8 510	11 000	5 500	11 000	9 894	26 089	<b>105 201</b>
6 472	2 402	5 900	4 300	2 000	8 523	6 523	<b>36 120</b>
22 000	5 970	7 700	1 500	7 000	6 555	53 640	<b>104 365</b>
<b>243 400</b>	<b>48 800</b>	<b>81 300</b>	<b>36 000</b>	<b>54 000</b>	<b>59 600</b>	<b>188 000</b>	<b>711 100</b>

**Resource breakdown for the strategic objective for 2008-2009 (US\$ thousand)**

	<b>Countries</b>	<b>Regions</b>	<b>Headquarters</b>	<b>TOTAL</b>
<b>All financing 2008-2009</b>	<b>353 992</b>	<b>169 108</b>	<b>188 000</b>	<b>711 100</b>
Percentage by level	50	24	26	

**STRATEGIC OBJECTIVE 3****To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries****Scope**

The work under this strategic objective focuses on the following activities: policy development; programme implementation; monitoring and evaluation; strengthening of health and rehabilitation systems and services; implementation of prevention programmes and capacity building in the area of chronic noncommunicable conditions (including cardiovascular diseases, cancer, chronic respiratory diseases, diabetes, hearing and visual impairment – including blindness, and genetic disorders, mental, behavioural and neurological disorders, including those provoked by psychoactive substance use; injuries due to road traffic crashes, drowning, burns, poisoning, falls, violence in the family, the community or between organized groups; and disabilities from all causes).

<b>ORGANIZATION-WIDE EXPECTED RESULTS</b>	
<b>3.1</b>	Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities.
<b>3.2</b>	Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities.
<b>3.3</b>	Improvements made in Member States' capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities.
<b>3.4</b>	Improved evidence compiled by WHO on the cost-effectiveness of interventions to tackle chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities.
<b>3.5</b>	Guidance and support provided to Member States for the preparation and implementation of multisectoral, population-wide programmes to prevent mental and behavioural disorders, violence and injuries, together with hearing and visual impairment, including blindness.
<b>3.6</b>	Guidance and support provided to Member States to improve the ability of their health and social systems to prevent and manage chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities.
<b>TOTAL</b>	

### Links with other strategic objectives

- Strategic objective 6: in relation to population-wide approaches to combating tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity as risk factors; and in relation to approaches directed at individuals at high risk from these risk factors, as well as approaches directed at the prevention of other risk factors.

COSTS BY LOCATION (US\$ THOUSAND)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
2 730	1 539	4 700	2 000	2 000	4 400	8 374	25 743
4 004	1 902	3 600	4 000	5 000	3 300	8 379	30 185
3 276	1 781	2 800	1 000	4 000	2 200	8 721	23 778
2 366	1 514	2 400	2 000	4 000	3 300	8 038	23 618
2 366	1 597	1 800	2 000	2 000	2 200	9 403	21 366
3 458	1 667	2 700	5 000	3 000	6 600	10 085	32 510
18 200	10 000	18 000	16 000	20 000	22 000	53 000	157 200

### Resource breakdown for the strategic objective for 2008-2009 (US\$ thousand)

	Countries	Regions	Headquarters	TOTAL
All financing 2008-2009	67 268	36 932	53 000	157 200
Percentage by level	43	23	34	

**STRATEGIC OBJECTIVE 4**

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

**Scope**

Work under this strategic objective will focus on action towards ensuring universal access to, and coverage with, effective public health interventions to improve maternal, newborn, child, adolescent, and sexual and reproductive health, with emphasis on reducing gender inequality and health inequities; development of evidence-based, gender-sensitive, coordinated and coherent approaches to addressing needs at key stages of life and improving sexual and reproductive health, using a life-course approach; fostering synergies between maternal, newborn, child, adolescent, sexual and reproductive health interventions and other public health programmes, and supporting action to strengthen health systems; and formulation and implementation of policies and programmes that promote healthy and active ageing for all individuals.

<b>ORGANIZATION-WIDE EXPECTED RESULTS</b>	
<b>4.1</b>	Support provided to Member States to formulate a comprehensive policy, plan and strategy for scaling up towards universal access to effective interventions in collaboration with other programmes, paying attention to reducing gender inequality and health inequities, providing a continuum of care throughout the life course, integrating service delivery across different levels of the health system and strengthening coordination with civil society and the private sector.
<b>4.2</b>	National research capacity strengthened as necessary and new evidence, products, technologies, interventions and delivery approaches of global and/or national relevance available to improve maternal, newborn, child and adolescent health, to promote active and healthy ageing, and to improve sexual and reproductive health.
<b>4.3</b>	Guidelines, approaches and tools for improving maternal care applied at the country level, including technical support provided to Member States for intensified action to ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods, particularly for poor and disadvantaged populations, with progress monitored.
<b>4.4</b>	Guidelines, approaches and tools for improving neonatal survival and health applied at country level, with technical support provided to Member States for intensified action towards universal coverage, effective interventions and monitoring of progress.
<b>4.5</b>	Guidelines, approaches and tools for improving child health and development applied at the country level, with technical support provided to Member States for intensified action towards universal coverage of the population with effective interventions and for monitoring progress, taking into consideration international and human-rights norms and standards, notably those stipulated in the Convention on the Rights of the Child.
<b>4.6</b>	Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, and for the scaling up of a package of prevention, treatment and care interventions in accordance with established standards.
<b>4.7</b>	Guidelines, approaches and tools made available, with provision of technical support to Member States for accelerated action towards implementing the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health, with particular emphasis on ensuring equitable access to good-quality sexual and reproductive health services, particularly in areas of unmet need, and with respect for human rights as they relate to sexual and reproductive health.
<b>4.8</b>	Guidelines, approaches, tools, and technical assistance provided to Member States for increased advocacy for consideration of ageing as a public health issue, for the development and implementation of policies and programmes aiming at maintaining maximum functional capacity throughout the life course and for the training of health-care providers in approaches that ensure healthy ageing.
<b>TOTAL</b>	

### Links with other strategic objectives

- Strategic objectives 1 and 2: in relation to ensuring the effective delivery, in an integrated manner, of immunization and other interventions for the control of major infectious diseases through services for maternal, newborn and child and adolescent health and sexual and reproductive health.
- Strategic objectives 6 to 9, especially 6, 7 and 9: sufficient attention needs to be given to (a) social and economic determinants of ill-health that limit progress towards this strategic objective, (b) major risk factors, such as poor nutrition, and (c) human rights-based and gender-responsive approaches to ensure equitable access to key services.
- Strategic objectives 10 to 14: with attention to specific actions required to strengthen health systems so that they can rapidly expand access to effective interventions for maternal, newborn, child, adolescent and sexual and reproductive health, while ensuring a continuum of care across the life course and across different levels of the health system, including the community.

COSTS BY LOCATION (US\$ THOUSAND)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
8 604	2 072	13 400	3 500	6 000	2 000	500	36 076
15 609	3 760	3 800	500	4 000	500	45 000	73 169
30 000	5 370	7 900	1 800	7 000	6 400	7 000	65 470
21 658	5 217	6 200	1 500	7 000	3 300	6 000	50 875
12 107	2 916	7 700	1 800	4 000	6 400	7 000	41 923
11 470	2 763	5 100	1 500	4 000	3 900	6 000	34 733
11 087	4 526	5 900	2 400	6 000	2 900	15 500	48 313
4 465	1 076	1 100	1 000	2 000	0	1 000	10 641
115 000	27 700	51 100	14 000	40 000	25 400	88 000	361 200

### Resource breakdown for the strategic objective for 2008-2009 (US\$ thousand)

	Countries	Regions	Headquarters	TOTAL
All financing 2008-2009	167 556	105 644	88 000	361 200
Percentage by level	47	29	24	

**STRATEGIC OBJECTIVE 5****To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact****Scope**

The joint efforts of the Member States and the Secretariat regarding this strategic objective involve the following: health-sector emergency preparedness; intersectoral action for reducing risk and vulnerability within the framework of the International Strategy for Disaster Reduction; responding to the health needs experienced during emergencies and crises (including nutrition-related needs as well as those concerning water and sanitation); assessing needs of affected populations; health actions during the transition and recovery phases following conflicts and disasters; fulfilling WHO's mandate within the framework of the reform process to enhance the United Nations humanitarian response; the global alert and response system for environmental and food-safety public health emergencies within the framework of the International Health Regulations (2005); risk reduction in respect of specific threats; and preparedness and response programmes for environmental and food-safety public health emergencies. In this way, WHO is making an important contribution to health security that also has critical implications for efforts to promote peace.

<b>ORGANIZATION-WIDE EXPECTED RESULTS</b>	
<b>5.1</b>	Norms and standards developed, capacity built and technical support provided to Member States for the development and strengthening of national emergency preparedness plans and programmes.
<b>5.2</b>	Norms and standards developed, capacity built and technical support provided to Member States for a timely response to disasters associated with natural hazards and to conflict-related crises.
<b>5.3</b>	Norms and standards developed, capacity built and technical support provided to Member States for assessing needs and for planning and implementing interventions during the transition and recovery phases of conflicts and disasters.
<b>5.4</b>	Coordinated technical support provided to Member States for communicable disease control in natural disaster and conflict situations.
<b>5.5</b>	Support provided to Member States for strengthening national preparedness and for establishing alert and response mechanisms for food-safety and environmental health emergencies.
<b>5.6</b>	Effective communications issued, partnerships formed and coordination developed with other organizations in the United Nations system, governments, local and international nongovernmental organizations, academic institutions and professional associations at the country, regional and global levels.
<b>TOTAL</b>	

**Links with other strategic objectives**

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

<b>COSTS BY LOCATION (US\$ THOUSAND)</b>							
<b>Africa</b>	<b>The Americas</b>	<b>South-East Asia</b>	<b>Europe</b>	<b>Eastern Mediterranean</b>	<b>Western Pacific</b>	<b>Headquarters</b>	<b>TOTAL</b>
8 200	4 500	8 100	5 000	12 000	3 528	4 500	<b>45 828</b>
18 600	4 000	5 300	5 000	21 000	5 712	8 500	<b>68 112</b>
14 600	4 000	4 100	3 000	8 000	3 528	9 500	<b>46 728</b>
9 700	2 000	2 200	3 000	0	1 680	4 500	<b>23 080</b>
9 200	2 500	1 700	3 000	0	1 176	1 700	<b>19 276</b>
5 900	3 000	3 100	2 000	0	1 176	1 300	<b>16 476</b>
<b>66 200</b>	<b>20 000</b>	<b>24 500</b>	<b>21 000</b>	<b>41 000</b>	<b>16 800</b>	<b>30 000</b>	<b>219 500</b>

**Resource breakdown for the strategic objective for 2008-2009 (US\$ thousand)**

	<b>Countries</b>	<b>Regions</b>	<b>Headquarters</b>	<b>TOTAL</b>
<b>All financing 2008-2009</b>	<b>147 686</b>	<b>41 814</b>	<b>30 000</b>	<b>219 500</b>
Percentage by level	67	19	14	

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

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

The main activities involve capacity building for health promotion across all relevant programmes, risk-factor surveillance, the development of ethical and evidence-based policies, strategies, interventions, recommendations, standards and guidelines for health promotion, and the prevention or reduction of the occurrence of the major risk factors.

<b>ORGANIZATION-WIDE EXPECTED RESULTS</b>	
<b>6.1</b>	Advice and support provided to Member States to build their capacity for health promotion across all relevant programmes, and to establish effective multisectoral and multidisciplinary collaborations for promoting health and preventing or reducing major risk factors.
<b>6.2</b>	Guidance and support provided in order to strengthen national systems for surveillance of major risk factors through development and validation of frameworks, tools and operating procedures and their dissemination to Member States where a high or increasing burden of death and disability is attributable to these risk factors.
<b>6.3</b>	Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease and death associated with tobacco use, enabling them to strengthen institutions in order to tackle or prevent the public health problems concerned; support also provided to the Conference of the Parties to the WHO Framework Convention on Tobacco Control for implementation of the provisions of the Convention and development and implementation of protocols and guidelines.
<b>6.4</b>	Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease or death associated with alcohol, drugs and other psychoactive substance use, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.
<b>6.5</b>	Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed and technical support provided to Member States with a high or increasing burden of disease or death associated with unhealthy diets and physical inactivity, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.
<b>6.6</b>	Evidence-based and ethical policies, strategies, interventions, recommendations, standards and guidelines developed and technical support provided to Member States to promote safer sex and strengthen institutions in order to tackle and manage the social and individual consequences of unsafe sex.
<b>TOTAL</b>	



**Links with other strategic objectives**

- Strategic objectives 2, 3, 4, 7, 8 and 9: although these seek to deal with the determinants of poor health and strengthen service provision, this strategic objective seeks in particular, to create healthy environments in order to enable individuals to make healthy choices.

<b>COSTS BY LOCATION (US\$ THOUSAND)</b>							
<b>Africa</b>	<b>The Americas</b>	<b>South-East Asia</b>	<b>Europe</b>	<b>Eastern Mediterranean</b>	<b>Western Pacific</b>	<b>Headquarters</b>	<b>TOTAL</b>
6 708	4 000	4 100	1 700	6 000	8 000	9 900	<b>40 408</b>
5 000	2 000	2 100	2 100	5 000	4 000	3 900	<b>24 100</b>
4 000	3 000	2 900	2 200	6 000	7 000	13 900	<b>39 000</b>
3 658	2 000	1 200	1 500	3 000	4 000	5 900	<b>21 258</b>
3 608	2 000	2 800	1 300	3 000	4 000	3 900	<b>20 608</b>
3 026	1 000	1 700	1 200	2 000	5 000	4 900	<b>18 826</b>
<b>26 000</b>	<b>14 000</b>	<b>14 800</b>	<b>10 000</b>	<b>25 000</b>	<b>32 000</b>	<b>42 400</b>	<b>164 200</b>

**Resource breakdown for the strategic objective for 2008-2009 (US\$ thousand)**

	<b>Countries</b>	<b>Regions</b>	<b>Headquarters</b>	<b>TOTAL</b>
<b>All financing 2008-2009</b>	<b>77 760</b>	<b>44 040</b>	<b>42 400</b>	<b>164 200</b>
Percentage by level	47	27	26	

**STRATEGIC OBJECTIVE 7**

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

**Scope**

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

<b>ORGANIZATION-WIDE EXPECTED RESULTS</b>	
<b>7.1</b>	Significance of social and economic determinants of health recognized throughout the Organization and incorporated into normative work and technical collaboration with Member States and other partners.
<b>7.2</b>	Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels in order to address social and economic determinants of health and to encourage poverty-reduction and sustainable development.
<b>7.3</b>	Social and economic data relevant to health collected, collated and analysed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).
<b>7.4</b>	Ethics- and rights-based approaches to health promoted within WHO and at national and global levels.
<b>7.5</b>	Gender analysis and responsive actions incorporated into WHO's normative work and support provided to Member States for formulation of gender-sensitive policies and programmes.
<b>TOTAL</b>	

### Links with other strategic objectives

Issues of health equity, ethical standards, gender, pro-poor approaches and human rights are relevant to all other strategic objectives.

- Strategic objectives 1 to 5: notwithstanding the technical complexities, it is firmly established that health outcomes are powerfully influenced by social and economic determinants, as well as by the availability and quality of clinical services.
- Strategic objectives 6, 8 and 9: the present strategic objective is primarily concerned with the underlying determinants and structural factors (such as labour markets, education system, and gender inequality) defining people's different positions in social hierarchies, which affect intermediate determinants such as the environment, including food (strategic objectives 8 and 9) and individual factors such as behaviours (strategic objective 6).
- Strategic objectives 10 to 14: health policies and systems need to include intersectoral action on health determinants. Coherent action on health inequities also depends on the availability of appropriately disaggregated health data and the capacity to analyse and use such data to develop policies and services that respond to the needs of different social groups and address structural factors.

COSTS BY LOCATION (US\$ THOUSAND)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
1 579	2 224	1 200	1 200	4 500	625	6 701	18 029
1 000	1 563	1 100	2 500	4 100	375	6 047	16 685
3 860	1 102	800	1 700	2 400	375	3 375	13 612
1 270	872	800	0	100	500	4 008	7 550
1 669	1 239	1 000	600	900	625	4 890	10 923
9 378	7 000	4 900	6 000	12 000	2 500	25 021	66 799

### Resource breakdown for the strategic objective for 2008-2009 (US\$ thousand)

	Countries	Regions	Headquarters	TOTAL
All financing 2008-2009	27 331	14 447	25 021	66 799
Percentage by level	41	22	37	

**STRATEGIC OBJECTIVE 8:**

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

**Scope**

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

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

<b>ORGANIZATION-WIDE EXPECTED RESULTS</b>	
<b>8.1</b>	Evidence-based assessments made, and norms and guidance formulated and updated on major environmental hazards to health (e.g., poor air quality, chemical substances, electromagnetic fields, radon, poor-quality drinking-water, and waste-water reuse); technical support provided for the implementation of international environmental agreements and for monitoring progress towards achievement of the Millennium Development Goals.
<b>8.2</b>	Technical support and guidance provided to Member States for the implementation of primary prevention interventions that reduce environmental hazards to health, enhance safety and promote public health, including in specific settings and among vulnerable population groups.
<b>8.3</b>	Technical assistance and support provided to Member States for strengthening occupational and environmental health policy-making, planning of preventive interventions, service delivery and surveillance.
<b>8.4</b>	Guidance, tools and initiatives created in order to support the health sector to influence policies in priority sectors, assess health impacts, determine costs and benefits of policy alternatives in those sectors, and select investments in non-health sectors that improve health, the environment and safety.
<b>8.5</b>	Health-sector leadership enhanced for creating a healthier environment and changing policies in all sectors so as to tackle the root causes of environmental threats to health, through means such as responding to emerging and re-emerging consequences of development on environmental health, climate change, and altered patterns of consumption and production and to the damaging effect of evolving technologies.
<b>TOTAL</b>	

### Links with other strategic objectives

- Strategic objective 5: preparedness and response to environmental health emergencies, crucial to achieving strategic objective 8, are linked with other aspects of emergency response.
- Strategic objectives 2 to 4: given that eliminating environmental hazards to health can prevent up to a quarter of the global burden of disease, work will contribute especially to the reduction in disease burden among children (strategic objective 4), from vector-borne diseases (strategic objective 2) and from noncommunicable diseases (strategic objective 3).
- Strategic objective 10: occupational and environmental health services are a key part of the preventive function of health services.
- Strategic objectives 5, 6, 7, 9 and 15: influencing sectors of the economy to reduce risks and promote health through their investments and policy decisions is essential in terms of work on determinants of health (strategic objectives 5, 6, 7 and 9) and for establishing partnerships to advance the global health agenda (strategic objective 15).

COSTS BY LOCATION (US\$ THOUSAND)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
500	3 338	3 500	2 000	7 500	1 250	15 400	33 488
12 000	2 222	6 200	5 000	700	3 750	5 800	35 672
2 000	2 491	1 900	2 000	2 100	3 750	7 300	21 541
1 000	2 473	1 400	3 000	5 700	2 500	5 200	21 273
3 500	1 776	1 000	6 000	500	1 250	6 300	20 326
19 000	12 300	14 000	18 000	16 500	12 500	40 000	132 300

### Resource breakdown for the strategic objective for 2008-2009 (US\$ thousand)

	Countries	Regions	Headquarters	TOTAL
All financing 2008-2009	57 506	34 794	40 000	132 300
Percentage by level	44	26	30	

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

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

<b>ORGANIZATION-WIDE EXPECTED RESULTS</b>	
<b>9.1</b>	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.
<b>9.2</b>	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.
<b>9.3</b>	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.
<b>9.4</b>	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.
<b>9.5</b>	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.
<b>9.6</b>	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.
<b>TOTAL</b>	

### Links with other strategic objectives

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

- strategic objective 1: in relation to prevention of zoonoses and foodborne diseases
- strategic objective 2: especially in expanding and improving interventions related to HIV/AIDS prevention, treatment, care and support
- strategic objective 4: in relation to public-health interventions for maternal, newborn, child and adolescent health
- strategic objective 5: in relation to minimizing the impact of emergency situations on the nutritional status of populations
- strategic objective 6: in relation to promotion of healthy dietary practices throughout the life-course
- strategic objective 8: in relation to environmental health risks.

COSTS BY LOCATION (US\$ THOUSAND)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
4 000	2 784	1 500	800	2 000	3 880	2 000	16 964
6 000	1 740	2 500	600	1 500	2 910	15 000	30 250
7 000	1 555	2 600	1 300	2 000	1 940	2 000	18 395
7 500	3 469	3 600	1 300	1 500	4 850	2 000	24 219
7 000	2 367	2 100	500	1 000	1 940	2 000	16 907
7 000	2 785	1 800	1 500	1 000	3 880	2 000	19 965
38 500	14 700	14 100	6 000	9 000	19 400	25 000	126 700

### Resource breakdown for the strategic objective for 2008-2009 (US\$ thousand)

	Countries	Regions	Headquarters	TOTAL
All financing 2008-2009	55 907	45 793	25 000	126 700
Percentage by level	44	36	20	

**STRATEGIC OBJECTIVE 10****To improve the organization, management and delivery of health services****Scope**

The work to be undertaken to realize this strategic objective will enhance the way health systems perform in response to populations' needs and demands. It will be underpinned by the principles of primary health care and health for all, and a concern to reduce inequity of access and exclusion from the benefits of health care. It seeks to expand access equitably across the range of services necessary to improving health outcomes, and responding to legitimate demands for care by matching service responses to needs and demand, by increasing organizational and managerial capacities of institutions and provider networks, and by strengthening informed demand. The work will also cover the organization and management of all population-based and personal health services – individual providers, facilities and provider networks, and public, private and voluntary services at all levels, from those within the community to tertiary hospitals and specialized services.

It is concerned with the promotion of all aspects of quality in relation to service delivery: patient- and community-focus, responsiveness, and continuity of care; safety, effectiveness and efficiency; avoidance of the fragmentation that results from the multiplication of disease-specific programmes and initiatives, through actions that are tailored to local and national circumstances and priorities; and anticipating how technological innovation, changing needs and evolving demand will influence service delivery.

<b>ORGANIZATION-WIDE EXPECTED RESULTS</b>	
<b>10.1</b>	Standards, best practices and principles of equity endorsed by, or developed with support from, WHO increasingly reflected in service-delivery policies and their implementation in Member States.
<b>10.2</b>	Organizational and managerial capacities of service-delivery institutions and networks in Member States strengthened.
<b>10.3</b>	Mechanisms and regulatory systems in place in Member States in order to ensure synergy between public and non-public service-delivery systems that lead to better overall service delivery.
<b>10.4</b>	Policy, structural and managerial changes in the health services architecture of Member States implemented in order to ensure that disease-specific programmes are adequately embedded in general health services so as to enhance overall performance of health service delivery.
<b>TOTAL</b>	



### Links with other strategic objectives

- All strategic objectives concerned with the achievement of specific health outcomes, primarily strategic objectives 1 to 4, which deal directly with service delivery through the development and implementation of specific interventions.
- Strategic objective 7: particularly in relation to equity, pro-poor health policies and the progressive realization of the right to health – the work translates achievements in those areas into service delivery.
- Strategic objective 5: complementing the specific circumstances of service delivery in fragile states.
- Strategic objectives 13 and 14 and, particularly, 11: progress in work on the evidence base, information and the governing of the health system underlies work on this strategic objective.
- Strategic objective 15: particularly work on providing leadership, strengthening governance and encouraging partnerships and collaboration in engagement with countries.

COSTS BY LOCATION (US\$ THOUSAND)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
14 375	3 125	7 700	4 800	9 000	5 500	9 000	53 500
10 222	2 222	4 300	2 400	8 000	2 750	6 500	36 394
7 986	1 736	1 100	1 200	3 000	1 650	5 500	22 172
13 417	2 917	1 900	3 600	0	1 100	9 000	31 934
46 000	10 000	15 000	12 000	20 000	11 000	30 000	144 000

### Resource breakdown for the strategic objective for 2008-2009 (US\$ thousand)

	Countries	Regions	Headquarters	TOTAL
All financing 2008-2009	74 358	39 642	30 000	144 000
Percentage by level	52	27	21	

**STRATEGIC OBJECTIVE 11****To strengthen leadership, governance and the evidence base of health systems****Scope**

The work towards attainment of this strategic objective covers the responsibilities and processes of governing health systems, i.e. the leadership, governance and stewardship of these systems. It also covers properties of the system, such as its ability to detect problems, monitor performance and find solutions; the work will contribute to the development of such system intelligence through research, production of information and evidence, and management of knowledge, elements that are crucial for supporting policy-making and implementation.

The responsibilities and processes for governing of health systems relate to: leading and guiding formation and implementation of policies, bridging the gaps between knowledge and practice; optimizing the allocation and use of resources, including financial and other cooperation with external agencies; facilitating collaboration across government and with other actors and stakeholders; ensuring harmonization, alignment and a fit between policies and organizational structure and culture; setting fair rules; regulating the behaviour of actors and stakeholders; and putting in place effective mechanisms to ensure accountability and transparency.

Generation of the system intelligence to underpin the governing of health systems at country and global levels implies monitoring the health situation, assessing health trends and monitoring health-system performance; shaping the research agenda and stimulating the generation, translation and dissemination of knowledge; setting norms and standards for the generation of information, and promoting and monitoring their implementation; and articulating ethical and evidence-based policy options.

<b>ORGANIZATION-WIDE EXPECTED RESULTS</b>	
<b>11.1</b>	Country capacity and practices improved in national and local health-sector policy-making, regulation, strategic planning, implementation of reforms, and intersectoral and interinstitutional coordination.
<b>11.2</b>	Coordination of donor assistance improved at the global and country levels in order to achieve national targets for health-system development and global health goals.
<b>11.3</b>	Member States' health-information systems strengthened to provide and use high-quality and timely information for health planning and monitoring of countries' and major international goals.
<b>11.4</b>	Knowledge and evidence for health decision-making enhanced by consolidation and publication of existing evidence, facilitation of knowledge generation in priority areas, and global leadership in health-research policy and coordination, including steps to ensure ethical conduct.
<b>11.5</b>	National health research for health-systems development strengthened, within the context of regional and international research and engagement of civil society.
<b>11.6</b>	Knowledge management and eHealth policies and strategies developed and implemented in order to strengthen health systems.
<b>TOTAL</b>	

### Links with other strategic objectives

- All strategic objectives concerned with the achievement of specific health outcomes, primarily strategic objectives 1 to 4.
- Strategic objective 5: the work complements that dealing with the specific circumstances of building government and institutional capacity to organize health systems in fragile States.
- All health- and disease-related strategic objectives: the work provides a platform for close collaboration with the evidence component.
- The work supports the equity-related strategic objective 7 and links with the other strategic objectives related to health policies, systems and technologies (10 and 12 to 14).

COSTS BY LOCATION (US\$ THOUSAND)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
4 326	3 024	3 300	9 000	4 600	3 000	4 200	31 450
871	540	600	500	1 000	750	510	4 771
9 866	2 160	2 500	4 000	4 000	4 000	8 460	34 986
5 199	1 620	1 600	3 000	2 000	2 000	17 690	33 109
5 358	1 836	1 900	1 000	3 500	3 260	4 100	20 954
6 410	1 620	6 200	4 500	3 500	750	13 070	36 050
32 030	10 800	16 100	22 000	18 600	13 760	48 030	161 320

### Resource breakdown for the strategic objective for 2008-2009 (US\$ thousand)

	Countries	Regions	Headquarters	TOTAL
All financing 2008-2009	65 787	47 503	48 030	161 320
Percentage by level	41	29	30	

**STRATEGIC OBJECTIVE 12****To ensure improved access, quality and use of medical products and technologies****Scope**

Medical products include chemical and biological medicines; vaccines; blood and blood products; cells and tissues mostly of human origin; biotechnology products; traditional medicines and medical devices. Technologies include, among others, those for diagnostic testing, imaging, and laboratory testing. The work undertaken under this strategic objective will focus on making access more equitable (as measured by availability, price and affordability) to essential medical products and technologies of assured quality, safety, efficacy and cost-effectiveness, and on their sound and cost-effective use. For the sound use of products and technologies, work will focus on building appropriate regulatory systems; evidence-based selection; information for prescribers and patients; appropriate diagnostic, clinical and surgical procedures; vaccination policies; supply systems, dispensing and injection safety; and blood transfusion. Information includes clinical guidelines, independent product information and ethical promotion.

<b>ORGANIZATION-WIDE EXPECTED RESULTS</b>	
<b>12.1</b>	Formulation and monitoring of comprehensive national policies on access, quality and use of essential medical products and technologies advocated and supported.
<b>12.2</b>	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.
<b>12.3</b>	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.
<b>TOTAL</b>	

### Links with other strategic objectives

- Strategic objectives 1 to 5 (health outcomes): none of these objectives can be achieved without essential medical products, medicines and health technologies. With regard to access, work under this strategic objective will focus on “horizontal” issues such as comprehensive supply systems, pricing surveys and national pricing policies. On quality assurance and regulatory support, all WHO’s work is covered by this strategic objective. Work on rational use will focus on general aspects such as evidence-based selection of essential medical products and technologies, development of clinical guidelines, patient safety, compliance with long-term treatment regimens and containing antimicrobial resistance.
- Strategic objective 10: work also contributes to health service delivery.
- Strategic objective 7: good governance.
- Strategic objective 15: global public policy.
- Strategic objective 14: sustainable financing of products and technologies, on which access also depends.

COSTS BY LOCATION (US\$ THOUSAND)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
6 458	2 497	5 800	3 000	3 500	5 050	12 184	38 489
11 478	4 659	7 100	2 000	11 000	2 020	28 733	66 990
4 931	1 844	1 600	2 000	2 400	3 030	9 091	24 896
22 867	9 000	14 500	7 000	16 900	10 100	50 008	130 375

### Resource breakdown for the strategic objective for 2008-2009 (US\$ thousand)

	Countries	Regions	Headquarters	TOTAL
All financing 2008-2009	54 673	25 694	50 008	130 375
Percentage by level	42	20	38	

**STRATEGIC OBJECTIVE 13****To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes****Scope**

The work under this strategic objective will involve workforce development across the continuum of entry, working life and exit, with a focus on the following: developing national workforce plans and strategies; enabling effective regulation of the educational system and job market in order to encourage an equitable distribution of health workers; achieving an appropriate mix of health workers responsive to population needs; and improving the management of the health workforce and of the environment in which it works, including through provision of financial and non-financial incentives, particularly for remote and underserved areas.

<b>ORGANIZATION-WIDE EXPECTED RESULTS</b>	
<b>13.1</b>	Capacity of Member States strengthened for leading in health-workforce development.
<b>13.2</b>	Information and knowledge base for developing the health workforce strengthened at national, regional and global levels.
<b>13.3</b>	Technical support provided to Member States in crisis to reduce their shortages by improving the production, distribution and skill mix of their health workforce.
<b>13.4</b>	Networking and partnerships strengthened at global, regional, and country levels, in order to improve the institutional infrastructure in Member States experiencing a crisis in human resources for health.
<b>TOTAL</b>	

**Links with other strategic objectives**

- Strategic objective 2: in relation to the integration of human resources for health across priority health programmes, including providing technical collaboration for human-resources planning and combating the impact of diseases such as HIV/AIDS on the health workforce.
- Strategic objective 4: in relation to the development of skills and competencies of health workers for maternal, child and adolescent health.
- Strategic objectives 10, 11, 12, and 14: in relation to both the reduction of disparities in access to health services and the improvement of health-systems performance.

<b>COSTS BY LOCATION (US\$ THOUSAND)</b>							
<b>Africa</b>	<b>The Americas</b>	<b>South-East Asia</b>	<b>Europe</b>	<b>Eastern Mediterranean</b>	<b>Western Pacific</b>	<b>Headquarters</b>	<b>TOTAL</b>
7 856	4 000	6 900	2 500	2 800	3 100	4 495	<b>31 651</b>
5 987	1 700	2 500	1 500	1 800	1 200	3 426	<b>18 113</b>
16 783	3 000	4 800	1 500	1 500	7 800	9 603	<b>44 986</b>
4 326	1 300	4 800	500	10 200	1 400	2 476	<b>25 002</b>
<b>34 952</b>	<b>10 000</b>	<b>19 000</b>	<b>6 000</b>	<b>16 300</b>	<b>13 500</b>	<b>20 000</b>	<b>119 752</b>

**Resource breakdown for the strategic objective for 2008-2009 (US\$ thousand)**

	<b>Countries</b>	<b>Regions</b>	<b>Headquarters</b>	<b>TOTAL</b>
<b>All financing 2008-2009</b>	<b>66 353</b>	<b>33 399</b>	<b>20 000</b>	<b>119 752</b>
Percentage by level	55	28	17	

**STRATEGIC OBJECTIVE 14****To extend social protection through fair, adequate and sustainable financing****Scope**

This strategic objective reflects the guiding principles set out in resolution WHA58.33. Work will focus on increasing financing for health in poor countries from domestic and external sources; improving the predictability of funding; ensuring contribution of new external resources to the development of sustainable domestic financial institutions; developing financial-risk pooling mechanisms to reduce the extent of financial catastrophe and impoverishment; reducing financial barriers to prevention, promotion, treatment and rehabilitation interventions and intersectoral health actions; ensuring efficient and equitable use of available health resources, including the appropriate mix of public and non-State providers and funding sources, and of inputs, including medicines; improving availability and use of key information on inputs, processes, outputs and outcomes of health-financing systems; development of tools for monitoring and evaluating the performance of financing systems and ensuring transparency in revenue generation and use.

<b>ORGANIZATION-WIDE EXPECTED RESULTS</b>	
<b>14.1</b>	Ethical and evidence-based policy and technical support provided to Member States to improve the performance of health-system financing in terms of financial protection, equity in finance, use of services, and efficiency of resource use.
<b>14.2</b>	International, regional and national advocacy, information and technical support designed to mobilize additional and predictable funding for health.
<b>14.3</b>	Measurement tools developed to analyse transparency and accountability in health-financing systems, and technical support provided for their use, where needed.
<b>14.4</b>	Norms and standards developed for tracking resources, and estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe and impoverishment, and their implementation promoted, supported and monitored.
<b>14.5</b>	Steps taken to build capacity in framing of health financial policy, and the production, interpretation and use of financial information.
<b>14.6</b>	Steps taken to stimulate the generation, translation and dissemination of knowledge and to shape the research agenda.
<b>TOTAL</b>	



### Links with other strategic objectives

Work will be linked with that under all other strategic objectives, through efforts to assure adequate funds for improving health in Member States, minimize financial barriers to the use of needed services, and encourage use of the most efficient and equitable interventions in order to provide the best level of health with the available resources.

COSTS BY LOCATION (US\$ THOUSAND)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
10 000	3 774	2 500	4 000	5 000	3 156	4 175	32 605
1 000	962	1 200	200	600	1 048	2 470	7 480
2 000	296	3 000	800	2 200	1 554	3 995	13 845
5 000	296	400	200	1 500	708	2 535	10 639
10 000	1 776	1 000	2 000	2 200	1 748	3 750	22 474
1 100	296	600	800	700	786	3 045	7 327
29 100	7 400	8 700	8 000	12 200	9 000	19 970	94 370

### Resource breakdown for the strategic objective for 2008-2009 (US\$ thousand)

	Countries	Regions	Headquarters	TOTAL
All financing 2008-2009	44 832	29 568	19 970	94 370
Percentage by level	48	31	21	

**STRATEGIC OBJECTIVE 15**

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

**Scope**

This strategic objective facilitates the work of WHO to achieve all other strategic objectives. Responding to priorities in the Eleventh General Programme of Work, it recognizes that the context for international health has changed significantly. The scope of this objective covers three broad, complementary areas: leadership and governance of the Organization; WHO's support for, presence in, and engagement with individual Member States; and the Organization's role in bringing the collective energy and experience of Member States and other actors to bear on health issues of global and regional importance.

The main innovation implicit in this objective is that it seeks to harness the depth and breadth of WHO's country experience in order to influence global and regional debates, thereby to influence positively the environment in which national policy-makers work, and contribute to the attainment of the health-related Millennium Development goals and other internationally agreed health-related goals.

<b>ORGANIZATION-WIDE EXPECTED RESULTS</b>	
<b>15.1</b>	Effective leadership and direction of the Organization exercised through enhancement of governance, and the coherence, accountability and synergy of WHO's work.
<b>15.2</b>	Effective WHO country presence <sup>1</sup> 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.
<b>15.3</b>	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.
<b>15.4</b>	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.
<b>TOTAL</b>	

<sup>1</sup> 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.

### Links with other strategic objectives

This strategic objective is intrinsically linked to all the other objectives, as it builds on and supports the entire work of the Organization. As such it is closely related and complementary to strategic objective 16, to develop and sustain WHO as a flexible, learning Organization, enabling it to carry out its mandate more effectively and efficiently. The latter objective is more inward-looking, geared towards managerial and administrative issues, whereas strategic objective 15 is more outward-looking, focusing on issues of WHO leadership and governance, on work in Member States, and collaboration with partners at global, regional and country levels.

COSTS BY LOCATION (US\$ THOUSAND)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
15 012	6 087	5 300	11 500	4 100	3 538	44 270	89 807
22 281	7 501	5 400	10 000	11 300	11 061	5 116	72 659
6 434	1 132	2 600	1 000	3 400	637	6 440	21 643
6 773	2 280	1 300	2 500	8 200	764	14 174	35 991
<b>50 500</b>	<b>17 000</b>	<b>14 600</b>	<b>25 000</b>	<b>27 000</b>	<b>16 000</b>	<b>70 000</b>	<b>220 100</b>

### Resource breakdown for the strategic objective for 2008-2009 (US\$ thousand)

	Countries	Regions	Headquarters	TOTAL
<b>All financing 2008-2009</b>	<b>96 884</b>	<b>53 216</b>	<b>70 000</b>	<b>220 100</b>
Percentage by level	44	24	32	

**STRATEGIC OBJECTIVE 16****To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively****Scope**

The scope of this objective covers the functions that support the work of the Secretariat in country and regional offices and at headquarters. Work is organized according to entire results-based management framework and processes, from strategic and operational planning and budgeting to performance monitoring and evaluation; management of financial resources through monitoring, mobilization and coordination Organization-wide, ensuring an efficient flow of available resources throughout the Organization; management of human resources, including human resource planning, recruitment, staff development and learning, performance management, and conditions of service and entitlements; provision of operational support, ranging from the management of infrastructure and logistics, language services, staff and premises security, and staff medical services to the management of information technology; and appropriate accountability and governance mechanisms across all areas.

The strategic objective also covers broad institutional reform that will ensure that the above functions are continuously strengthened and provide better, more efficient and cost-effective support to the Organization. It is closely linked to broader reforms within the United Nations system at both country and global levels.

<b>ORGANIZATION-WIDE EXPECTED RESULTS</b>	
<b>16.1</b>	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.
<b>16.2</b>	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.
<b>16.3</b>	Human resource policies and practices in place to attract and retain top talent, promote learning and professional development, manage performance, and foster ethical behaviour.
<b>16.4</b>	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.
<b>16.5</b>	Managerial and administrative support services <sup>1</sup> necessary for the efficient functioning of the Organization provided in accordance with service-level agreements that emphasize quality and responsiveness.
<b>16.6</b>	Physical working environment conducive to the well-being and safety of staff in all locations.
<b>TOTAL</b>	

<sup>1</sup> Includes services in the areas of information technology, human resources, financial resources, logistics, and language services.

### Links with other strategic objectives

This objective should not be considered in isolation from the other strategic objectives, as its scope reflects and is responsive to the needs of the Organization as a whole. In particular, it should be read in conjunction with strategic objective 15, to provide leadership, strengthen governance and foster partnership and collaboration with countries and to fulfil the mandate of WHO in advancing the global health agenda. Strategic objective 16 is more inward-looking, geared towards managerial and administrative issues, whereas strategic objective 15 is more outward-looking, focusing on issues of WHO leadership and governance and on collaboration with Member States and partners at global, regional and country levels.

COSTS BY LOCATION (US\$ THOUSAND)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
7 550	1 800	7 400	1 300	4 000	7 863	8 000	37 913
10 246	5 300	8 800	3 000	2 000	3 434	30 000	62 780
7 120	3 300	3 200	5 000	2 000	147	10 000	30 767
21 571	8 000	5 500	11 700	9 000	4 563	50 000	110 334
36 239	6 300	7 000	13 000	15 000	11 570	66 000	155 109
37 534	5 800	18 400	6 000	7 000	6 272	76 000	157 006
120 260	30 500	50 300	40 000	39 000	33 849	240 000	553 909

### Resource breakdown for the strategic objective for 2008-2009 (US\$ thousand)

	Countries	Regions	Headquarters	TOTAL
All financing 2008-2009	74 183	239 726	240 000	553 909
Percentage by level	14	43	43	

Table 1. Cost by strategic objective

Strategic objective	Africa	The Americas	South-East Asia
1. To reduce the health, social and economic burden of communicable diseases	317 064	32 800	135 100
2. To combat HIV/AIDS, malaria and tuberculosis	243 400	48 800	81 300
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries	18 200	10 000	18 000
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals	115 000	27 700	51 100
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	66 200	20 000	24 500
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex	26 000	14 000	14 800
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	9 378	7 000	4 900
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	19 000	12 300	14 000
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development	38 500	14 700	14 100
10. To improve the organization, management and delivery of health services	46 000	10 000	15 000
11. To strengthen leadership, governance and the evidence base of health systems	32 030	10 800	16 100
12. To ensure improved access, quality and use of medical products and technologies	22 867	9 000	14 500
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes	34 952	10 000	19 000
14. To extend social protection through fair, adequate and sustainable financing	29 100	7 400	8 700
15. To provide leadership, strengthen governance and foster partnership and collaboration with countries in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	50 500	17 000	14 600
16. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	120 260	30 500	50 300
<b>TOTAL</b>	<b>1 188 451</b>	<b>282 000</b>	<b>496 000</b>

and location, 2008-2009 (US\$ thousand)

Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
30 000	101 400	53 870	230 000	<b>900 234</b>
36 000	54 000	59 600	188 000	<b>711 100</b>
16 000	20 000	22 000	53 000	<b>157 200</b>
14 000	40 000	25 400	88 000	<b>361 200</b>
21 000	41 000	16 800	30 000	<b>219 500</b>
10 000	25 000	32 000	42 400	<b>164 200</b>
6 000	12 000	2 500	25 021	<b>66 799</b>
18 000	16 500	12 500	40 000	<b>132 300</b>
6 000	9 000	19 400	25 000	<b>126 700</b>
12 000	20 000	11 000	30 000	<b>144 000</b>
22 000	18 600	13 760	48 030	<b>161 320</b>
7 000	16 900	10 100	50 008	<b>130 375</b>
6 000	16 300	13 500	20 000	<b>119 752</b>
8 000	12 200	9 000	19 970	<b>94 370</b>
25 000	27 000	16 000	70 000	<b>220 100</b>
40 000	39 000	33 849	240 000	<b>553 909</b>
<b>277 000</b>	<b>468 900</b>	<b>351 279</b>	<b>1 199 429</b>	<b>4 263 059</b>

**Table 2. Cost by strategic objective and office, all levels, 2008-2009 (US\$ thousand)**

Strategic objective	GRAND TOTAL			Regions		Headquarters
				Country	Regional	
	Assessed contribution <sup>a</sup>	Voluntary contribution	All financing	All financing	All financing	All financing
1. To reduce the health, social and economic burden of communicable diseases	81 799	818 435	900 234	393 187	277 047	230 000
2. To combat HIV/AIDS, malaria and tuberculosis	46 882	664 218	711 100	353 992	169 108	188 000
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries	46 826	110 374	157 200	67 268	36 932	53 000
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals	80 068	281 132	361 200	167 556	105 644	88 000
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	17 254	202 246	219 500	147 686	41 814	30 000
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex	44 558	119 642	164 200	77 760	44 040	42 400
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	12 374	54 425	66 799	27 331	14 447	25 021
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	38 003	94 297	132 300	57 506	34 794	40 000
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development	35 664	91 036	126 700	55 907	45 793	25 000
10. To improve the organization, management and delivery of health services	40 507	103 493	144 000	74 358	39 642	30 000
11. To strengthen leadership, governance and the evidence base of health systems	46 846	114 474	161 320	65 787	47 503	48 030
12. To ensure improved access, quality and use of medical products and technologies	32 850	97 525	130 375	54 673	25 694	50 008
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes	41 380	78 372	119 752	66 353	33 399	20 000
14. To extend social protection through fair, adequate and sustainable financing	19 698	74 672	94 370	44 832	29 568	19 970
15. To provide leadership, strengthen governance and foster partnership and collaboration with countries, to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	137 360	82 740	220 100	96 884	53 216	70 000
16. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	277 931	275 978	553 909	74 183	239 726	240 000
<b>TOTAL</b>	<b>1 000 000</b>	<b>3 263 059</b>	<b>4 263 059</b>	<b>1 825 263</b>	<b>1 238 367</b>	<b>1 199 429</b>

<sup>a</sup> Includes miscellaneous income.



**Table 3. Cost by strategic objective and office, 2008-2009 (US\$ thousand)**

Strategic objective	Africa				
	Total			Country	Regional
	Assessed contribution <sup>a</sup>	Voluntary contribution	All financing	All financing	All financing
1. To reduce the health, social and economic burden of communicable diseases	13 676	303 388	317 064	144 110	172 954
2. To combat HIV/AIDS, malaria and tuberculosis	7 635	235 765	243 400	152 734	90 666
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries	9 963	8 237	18 200	10 249	7 951
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals	41 812	73 188	115 000	57 398	57 602
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	3 217	62 983	66 200	57 012	9 188
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex	14 356	11 644	26 000	16 309	9 691
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	3 718	5 660	9 378	5 926	3 452
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	9 970	9 030	19 000	9 778	9 222
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development	17 003	21 497	38 500	18 865	19 635
10. To improve the organization, management and delivery of health services	8 350	37 650	46 000	25 613	20 387
11. To strengthen leadership, governance and the evidence base of health systems	5 577	26 453	32 030	15 403	16 627
12. To ensure improved access, quality and use of medical products and technologies	6 950	15 917	22 867	14 849	8 018
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes	10 601	24 351	34 952	22 420	12 532
14. To extend social protection through fair, adequate and sustainable financing	3 229	25 871	29 100	15 006	14 094
15. To provide leadership, strengthen governance and foster partnership and collaboration with countries in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work.	30 163	20 337	50 500	43 352	7 148
16. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	36 280	83 980	120 260	1 372	118 888
<b>TOTAL</b>	<b>222 500</b>	<b>965 951</b>	<b>1 188 451</b>	<b>610 396</b>	<b>578 055</b>

<sup>a</sup> Includes miscellaneous income.

**Table 3. Cost by strategic objective and office, 2008-2009 (US\$ thousand)**

Strategic objective	The Americas				
	Total			Country	Regional
	Assessed contribution <sup>a</sup>	Voluntary contribution	All financing	All financing	All financing
1. To reduce the health, social and economic burden of communicable diseases	10 044	22 756	32 800	11 968	20 832
2. To combat HIV/AIDS, malaria and tuberculosis	3 082	45 718	48 800	31 695	17 105
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries	3 701	6 299	10 000	6 361	3 639
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals	6 948	20 752	27 700	17 014	10 686
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	1 668	18 332	20 000	16 169	3 831
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex	3 349	10 651	14 000	9 209	4 791
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	1 531	5 469	7 000	5 427	1 573
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	5 899	6 401	12 300	8 928	3 372
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development	2 245	12 455	14 700	6 043	8 657
10. To improve the organization, management and delivery of health services	3 437	6 563	10 000	7 313	2 687
11. To strengthen leadership, governance and the evidence base of health systems	7 839	2 961	10 800	5 449	5 351
12. To ensure improved access, quality and use of medical products and technologies	1 453	7 547	9 000	6 037	2 963
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes	3 650	6 350	10 000	5 566	4 434
14. To extend social protection through fair, adequate and sustainable financing	2 994	4 406	7 400	4 229	3 171
15. To provide leadership, strengthen governance and foster partnership and collaboration with countries in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	10 717	6 283	17 000	9 701	7 299
16. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	16 443	14 057	30 500	10 633	19 867
<b>TOTAL</b>	<b>85 000</b>	<b>197 000</b>	<b>282 000</b>	<b>161 742</b>	<b>120 258</b>

<sup>a</sup> Includes miscellaneous income.

**Table 3. Cost by strategic objective and office, 2008-2009 (US\$ thousand)**

Strategic objective	South-East Asia				
	Total			Country	Regional
	Assessed contribution <sup>a</sup>	Voluntary contribution	All financing	All financing	All financing
1. To reduce the health, social and economic burden of communicable diseases	8 700	126 400	135 100	105 400	29 700
2. To combat HIV/AIDS, malaria and tuberculosis	7 800	73 500	81 300	66 200	15 100
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries	7 800	10 200	18 000	14 000	4 000
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals	11 800	39 300	51 100	38 000	13 100
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	3 500	21 000	24 500	18 300	6 200
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex	5 100	9 700	14 800	9 500	5 300
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	1 500	3 400	4 900	3 500	1 400
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	4 200	9 800	14 000	11 500	2 500
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development	3 900	10 200	14 100	9 800	4 300
10. To improve the organization, management and delivery of health services	6 800	8 200	15 000	13 300	1 700
11. To strengthen leadership, governance and the evidence base of health systems	4 600	11 500	16 100	11 500	4 600
12. To ensure improved access, quality and use of medical products and technologies	5 100	9 400	14 500	11 100	3 400
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes	9 600	9 400	19 000	14 100	4 900
14. To extend social protection through fair, adequate and sustainable financing	2 600	6 100	8 700	7 000	1 700
15. To provide leadership, strengthen governance and foster partnership and collaboration with countries in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	7 200	7 400	14 600	7 700	6 900
16. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	18 200	32 100	50 300	20 000	30 300
<b>TOTAL</b>	<b>108 400</b>	<b>387 600</b>	<b>496 000</b>	<b>360 900</b>	<b>135 100</b>

<sup>a</sup> Includes miscellaneous income.

**Table 3. Cost by strategic objective and office, 2008-2009 (US\$ thousand)**

Strategic objective	Europe				
	Total			Country	Regional
	Assessed contribution <sup>a</sup>	Voluntary contribution	All financing	All financing	All financing
1. To reduce the health, social and economic burden of communicable diseases	1 800	28 200	30 000	18 000	12 000
2. To combat HIV/AIDS, malaria and tuberculosis	1 800	34 200	36 000	21 600	14 400
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries	2 200	13 800	16 000	10 000	6 000
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals	1 500	12 500	14 000	9 000	5 000
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	2 100	18 900	21 000	13 000	8 000
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex	1 000	9 000	10 000	5 000	5 000
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	600	5 400	6 000	2 500	3 500
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	1 200	16 800	18 000	10 500	7 500
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development	600	5 400	6 000	2 900	3 100
10. To improve the organization, management and delivery of health services	2 300	9 700	12 000	7 200	4 800
11. To strengthen leadership, governance and the evidence base of health systems	2 400	19 600	22 000	13 200	8 800
12. To ensure improved access, quality and use of medical products and technologies	700	6 300	7 000	4 500	2 500
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes	1 200	4 800	6 000	3 500	2 500
14. To extend social protection through fair, adequate and sustainable financing	1 300	6 700	8 000	4 800	3 200
15. To provide leadership, strengthen governance and foster partnership and collaboration with countries in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	15 000	10 000	25 000	10 000	15 000
16. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	27 900	12 100	40 000	13 500	26 500
<b>TOTAL</b>	<b>63 600</b>	<b>213 400</b>	<b>277 000</b>	<b>149 200</b>	<b>127 800</b>

<sup>a</sup> Includes miscellaneous income.

**Table 3. Cost by strategic objective and office, 2008-2009 (US\$ thousand)**

Strategic objective	Eastern Mediterranean				
	Total			Country	Regional
	Assessed contribution <sup>a</sup>	Voluntary contribution	All financing	All financing	All financing
1. To reduce the health, social and economic burden of communicable diseases	7 412	93 988	101 400	80 050	21 350
2. To combat HIV/AIDS, malaria and tuberculosis	5 614	48 386	54 000	44 290	9 710
3. Prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries	4 668	15 332	20 000	12 872	7 128
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals	4 490	35 510	40 000	30 135	9 865
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	2 138	38 862	41 000	33 225	7 775
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex	4 642	20 358	25 000	17 624	7 376
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	604	11 396	12 000	8 395	3 605
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	3 450	13 050	16 500	9 100	7 400
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development	1 513	7 487	9 000	6 063	2 937
10. To improve the organization, management and delivery of health services	10 794	9 206	20 000	13 405	6 595
11. To strengthen leadership, governance and the evidence base of health systems	4 663	13 937	18 600	11 674	6 926
12. To ensure improved access, quality and use of medical products and technologies	3 329	13 571	16 900	12 272	4 628
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes	3 468	12 832	16 300	11 851	4 449
14. To extend social protection through fair, adequate and sustainable financing	2 800	9 400	12 200	8 487	3 713
15. To provide leadership, strengthen governance and foster partnership and collaboration with countries to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work.	12 588	14 412	27 000	17 380	9 620
16. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	23 327	15 673	39 000	17 130	21 870
<b>TOTAL</b>	<b>95 500</b>	<b>373 400</b>	<b>468 900</b>	<b>333 953</b>	<b>134 947</b>

<sup>a</sup> Includes miscellaneous income.

**Table 3. Cost by strategic objective and office, 2008-2009 (US\$ thousand)**

Strategic objective	Western Pacific				
	Total			Country	Regional
	Assessed contribution <sup>a</sup>	Voluntary contribution	All financing	All financing	All financing
1. To reduce the health, social and economic burden of communicable diseases	8 384	45 486	53 870	33 659	20 211
2. To combat HIV/AIDS, malaria and tuberculosis	6 509	53 091	59 600	37 473	22 127
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries	6 450	15 550	22 000	13 786	8 214
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.	4 479	20 921	25 400	16 009	9 391
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	1 891	14 909	16 800	9 980	6 820
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex	6 594	25 406	32 000	20 118	11 882
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	105	2 395	2 500	1 583	917
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	3 297	9 203	12 500	7 700	4 800
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development	3 074	16 326	19 400	12 236	7 164
10. To improve the organization, management and delivery of health services	4 050	6 950	11 000	7 527	3 473
11. To strengthen leadership, governance and the evidence base of health systems	3 863	9 897	13 760	8 561	5 199
12. To ensure improved access, quality and use of medical products and technologies	2 685	7 415	10 100	5 915	4 185
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes	6 552	6 948	13 500	8 916	4 584
14. To extend social protection through fair, adequate and sustainable financing	1 410	7 590	9 000	5 310	3 690
15. To provide leadership, strengthen governance and foster partnership and collaboration with countries in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	8 832	7 168	16 000	8 751	7 249
16. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	15 425	18 424	33 849	11 548	22 301
<b>TOTAL</b>	<b>83 600</b>	<b>267 679</b>	<b>351 279</b>	<b>209 072</b>	<b>142 207</b>

<sup>a</sup> Includes miscellaneous income.

**Table 3. Cost by strategic objective and office, 2008-2009 (US\$ thousand)**

Strategic objective	Headquarters		
	Total		
	Assessed contribution <sup>a</sup>	Voluntary contribution	All financing
1. To reduce the health, social and economic burden of communicable diseases	31 783	198 217	230 000
2. To combat HIV/AIDS, malaria and tuberculosis	14 442	173 558	188 000
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries	12 044	40 956	53 000
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals	9 039	78 961	88 000
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	2 740	27 260	30 000
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex	9 517	32 883	42 400
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	4 316	20 705	25 021
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	9 987	30 013	40 000
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development	7 329	17 671	25 000
10. To improve the organization, management and delivery of health services	4 776	25 224	30 000
11. To strengthen leadership, governance and the evidence base of health systems	17 904	30 126	48 030
12. To ensure improved access, quality and use of medical products and technologies	12 633	37 375	50 008
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes	6 309	13 691	20 000
14. To extend social protection through fair, adequate and sustainable financing	5 365	14 605	19 970
15. To provide leadership, strengthen governance and foster partnership and collaboration with countries in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	52 860	17 140	70 000
16. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	140 356	99 644	240 000
<b>TOTAL</b>	<b>341 400</b>	<b>858 029</b>	<b>1 199 429</b>

<sup>a</sup> Includes miscellaneous income.

**Table 4. Major WHO partnerships<sup>1</sup>**

<b>Partners</b>	<b>TOTAL (US\$ thousand)</b>
Alliance for Health Policy and Systems Research	8 000
Secretariat of WHO's Framework Convention on Tobacco Control	8 010
Global Alliance for Vaccines and Immunization (GAVI)	67 933
Global Alliance against Chronic Respiratory Diseases	1 500
Global Health Workforce Alliance	7 490
Global Polio Eradication Initiative	381 306
Health Metrics Network	25 000
Intergovernmental Forum on Chemical Safety	1 000
Partnership for Maternal, Newborn and Child Health	41 400
Roll Back Malaria Partnership	18 700
UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases	98 000
Stop TB Partnership Global Drug Facility	100 000
International Food Safety Authorities Network	500
United Nations System Standing Committee on Nutrition	200
United Nations Road Safety Collaboration	400
UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction	39 000
Initiative for Vaccine Research	1 600
Violence Prevention Alliance	400
Vision 2020: The Right to Sight	1 500
WHO alliance for the global elimination of trachoma	1 350
<b>TOTAL</b>	<b>803 289</b>

<sup>1</sup> Partnerships that contribute to delivering the proposed programme 2008-2009 within the budget of US\$ 4 263 million.



**Table 5. Links between strategic objectives 2008-2009 and areas of work 2006-2007**

<b>Strategic objectives 2008-2009</b>	<b>Areas of work 2006-2007</b>	<b>Activities %</b>
<b>1. To reduce the health, social and economic burden of communicable diseases</b>	Child and adolescent health	5
	Communicable disease prevention and control	96
	Communicable disease research	50
	Epidemic alert and response	100
	Immunization and vaccine development	91
<b>2. To combat HIV/AIDS, malaria and tuberculosis</b>	Essential health technologies	3
	Child and adolescent health	5
	Communicable disease research	50
	HIV/AIDS	100
	Immunization and vaccine development	2
	Malaria	100
	Making pregnancy safer	5
	Nutrition	5
	Reproductive health	13
	Tobacco	1
	Tuberculosis	100
<b>3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries</b>	Health promotion	50
	Violence, injuries and disabilities	100
	Mental health and substance abuse	65
	Surveillance, prevention and management of chronic, noncommunicable diseases	50
	Tobacco	20
<b>4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals</b>	Child and adolescent health	83
	Making pregnancy safer	85
	Nutrition	10
	Reproductive health	87
<b>5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact</b>	Essential health technologies	3
	Communicable disease prevention and control	1
	Emergency preparedness and response	100
	Food safety	10
	Mental health and substance abuse	10
	Making pregnancy safer	5
	Nutrition	5
	Health and environment	10
<b>6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex</b>	Child and adolescent health	2
	Health promotion	50
	Mental health and substance abuse	25
	Surveillance, prevention and management of chronic, noncommunicable diseases	50
	Tobacco	79
<b>7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches</b>	Policy-making for health in development	33
	Gender, women and health	100

## DRAFT PROPOSED PROGRAMME BUDGET 2008-2009

## FINANCIAL TABLES

Strategic objectives 2008-2009	Areas of work 2006-2007	Activities %
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	Health and environment	90
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development	Child and adolescent health	5
	Communicable disease prevention and control	3
	Food safety	90
	Nutrition	80
10. To improve the organization, management and delivery of health services	Policy making for health in development	12
	Health systems policies and service delivery	80
	Making pregnancy safer	5
11. To strengthen leadership, governance and the evidence base of health systems	Policy-making for health in development	25
	Hhealth information, evidence and research policy	100
	Knowledge management and information technology	30
12. To ensure improved access, quality and use of medical products and technologies	Essential health technologies	95
	Essential medicines	100
	Immunization and vaccine development	6
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes	Human resources for health	100
	Health systems policies and service delivery	10
14. To extend social protection through fair, adequate and sustainable financing	Health financing and social protection	100
	Policy-making for health and development	18
	Health systems policies and service delivery	10
	Immunization and vaccine development	1
15. To provide leadership, strengthen governance and foster partnership and collaboration with countries in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	Policy-making for health and development	12
	Planning, resource coordination and oversight	18
	Direction	100
	Governing bodies	44
	Knowledge management and information technology	20
	External relations	70
	WHO's core presence in countries	50
16. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	Planning, resource coordination and oversight	82
	Budget and financial management	100
	Governing bodies	56
	Human resources management in WHO	100
	Infrastructure and logistics	100
	Knowledge management and information technology	50
	External relations	30
	WHO's core presence in countries	50
	Information technology fund	100
	Exchange rate hedging	100
	Security fund	100
	Real estate fund	100