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Proposed programme budget 2010–2011

The attached draft of WHO's proposed programme budget for 2010–2011 (RC/2008/2) is submitted to the Regional Committee for its review and comments before it is presented to the Executive Board at its 124th session in January 2009 and subsequently to the Sixty-second World Health Assembly (WHA62) in May 2009. It should be read in conjunction with the document on the European Region's perspective (EUR/RC58/8 Add.1).

In accordance with resolution WHA60.11 calling on the Director-General "to recommend to the Health Assembly through the Executive Board, in conjunction with the proposed programme budgets 2010–2011 and 2012–2013, revisions to the Medium-term strategic plan as may be necessary", the Regional Committee may wish to comment on the draft amendments to the Medium-term strategic plan 2008–2013 (MTSP) to be presented to the Executive Board in January 2009 and the World Health Assembly in May 2009. The draft amended MSTP is also attached (RC/2008/1).

RC/2008/2

DRAFT PROPOSED PROGRAMME BUDGET 2010–2011

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INTRODUCTION

WHO's Draft Proposed programme budget 2010–2011 presents the expected results and budget requirements for the biennium 2010–2011 within the broader context of the Organization's Medium-term strategic plan, which covers the six-year period 2008–2013. The strategic plan defines the strategic objectives for WHO, and details the Organization-wide expected results for the Secretariat for the period. The overarching priorities for health are described in the Eleventh General Programme of Work 2006–2015, which also reflects WHO's comparative advantages, its core functions, the main challenges it faces and its opportunities for the future.

Since the Medium-term strategic plan lays out the strategic direction of WHO for 2008–2013, the Organization-wide expected results for 2010–2011 remain largely the same as those for the biennium 2008–2009. However, the Programme budget 2010–2011 includes some shifts in emphasis, reflecting the evolving global health situation and the corresponding changes needed in WHO's work. The changes in emphasis of some strategic objectives are described in the amended Medium-term strategic plan.

The result of an external review of the indicators of the Medium-term strategic plan has also shown that there is a need for improvement in the effort to make the indicators more measurable and meaningful.¹ The revised indicators are shown for the individual strategic objectives.

Budgetary implications of partnerships and outbreak and crises response

Partnerships

Recent discussions at meetings of WHO's governing bodies have highlighted the importance, and also the complexity, of the global health architecture, including partnerships and the need to consider coordination and harmonization among the various parties. In the Programme budget 2008–2009 a number of partnerships were noted but this was not an exclusive list and their contribution to the delivery of the Organization-wide expected results was not defined. As the major partnerships usually have independent governance mechanisms, it was also unclear how changes in the budget levels of these partnerships affected the overall WHO programme budget.

With a view to increasing the transparency of partnerships within the global governance of WHO, including their budget management, an analysis was undertaken of all the Organization's partnerships and collaborative arrangements – 97 in total. The results indicated that the group was highly heterogeneous, ranging from large partnerships with a considerable degree of independence but administratively hosted by WHO, to other entities having the characteristics of internal expert groups or advocacy arrangements.

Within the full grouping there is an identifiable subset involving major partnerships and collaborative arrangements that can be broadly divided in two groups: (i) those partnerships that contribute directly to the achievement of the Organization-wide expected results and follow the results hierarchy of the WHO programme budget, and which are therefore considered entirely inside the programme budget envelope; and (ii) those partnerships that do not contribute to the results hierarchy but which nonetheless have a strong link with WHO. Although the importance of these latter partnerships is recognized for the achievement of the strategic objectives of the Medium-term strategic plan, their budgets are outside the WHO programme budget envelope for the biennium 2010–2011.

¹ The improvement of indicators will be incremental and there may be further refinement in subsequent versions of the Draft Proposed programme budget 2010–2011.

Eleven such partnerships and collaborative arrangements outside the programme budget envelope are listed in Annex 1. The annex provides an explanation of their strategic approaches as well as the scope of their work and their synergy and coordination with WHO for the biennium 2010–2011.¹

The partnerships and collaborative arrangements that are considered within the WHO programme budget envelope have increased their share of the total budget and it is recognized that a separate approach to budget management needs to be taken in their case. Over the last bienniums the budget growth of these partnerships has been difficult to predict and their total contribution to the overall WHO budget has not been clear.

Outbreak and crisis response

WHO has been playing an increasingly important role in outbreak and crisis response, and the activities concerned and their budgetary implications are by their very nature unpredictable. This has again led to budgetary increases that have not been fully distinguished from other types of increases.

In recognition of the budgetary considerations mentioned above, the Draft Proposed programme budget 2010–2011 is presented in three segments. This segmentation applies both to the initial budget presentation and to budget management during the biennium. The three segments are:

- WHO programmes
- Partnerships and collaborative arrangements
- Outbreak and crisis response

In order to provide greater transparency and improve WHO's monitoring, management and implementation of the programme budget, outbreak and crises response and partnerships and collaborative arrangements will be tracked and reported on separately. This will begin in the biennium 2008–2009, and will take full effect from the biennium 2010–2011.

This segmentation has implications of varying complexity for the different technical strategic objectives. Four strategic objectives (numbers 3, 7, 9 and 11) are composed only of WHO programmes and have no components involving partnerships and collaborative arrangements; nor are these strategic objectives affected by crisis response. Conversely, strategic objectives 1 and 5 contain all three budget segments.

Level of the Draft Proposed programme budget 2010–2011

The budgets of WHO have been increasing consistently over the past four bienniums, rising from US\$ 1800 million in the biennium 2002–2003 to US\$ 4200 million in the biennium 2008–2009. There is a growing recognition that the Organization needs to consolidate its growth and strengthen its implementation capacity, while at the same time ensuring there is a continuing focus on priorities. With that in mind, the Draft Proposed programme budget 2010–2011 has initially been established at the same **nominal value** as the baseline of the **WHO programme segment** of the revised programme budget for the biennium 2008–2009.

In December 2007 the operational plans for the biennium 2008–2009 reflected the developments that had taken place and the increased demand registered since the approval by the Sixtieth World Health Assembly of the Programme budget 2008–2009. This was particularly evident in the partnership segment; however, it was also the case, albeit to a lesser extent, for the WHO programme segment.

¹ The question of which partnerships should be included in the WHO programme budget envelope and which should remain outside is still under discussion.

On the basis of this analysis, the **WHO programme segment** of the Draft Proposed programme budget 2010–2011 is initially set at US\$ 3888 million, showing no increase as compared with operational plans for the biennium 2008–2009. The relative distribution between headquarters and the regions is unchanged within this budgetary provision. This strategic decision is in line with the Director General’s commitment to maintain budgetary discipline and exercise restraint in line with the Organization’s capacity to scale up implementation.

Within this overall budget envelope the Organization, (countries, regions and headquarters) has developed budget proposals across the 13 strategic objectives. The **partnership and collaborative arrangement segment** within the programme budget stands at US\$ 747 million in the biennium 2008–2009; it has grown to US\$ 1050 million for the biennium 2010–2011.

The **outbreak and crisis response segment** is also estimated to increase against the level for the biennium 2008–2009. However, the budget for that segment has not been included at this point in view of the unpredictability of the needs concerned. These will be estimated nearer in time to the implementation of the Programme budget 2010–2011 and reported back to the governing bodies. More generally, the governing bodies will, at regular intervals, be kept abreast of developments concerning the budget of the outbreak and crisis response segment.

Table 1. illustrates the problems with predicting the Organization’s response to outbreaks and crisis well in advance, and shows the steady increase in the budget value of partnerships and collaborative agreements. The lack of clarity on the full budgetary contribution of partnerships within the programme budget envelope has hitherto been a constraint in the overall budgetary process. It has become difficult to compare partnerships’ budgets across bienniums since in the past these were not delineated and because there are budgetary movements as new partnerships are created and others become less important.

Table 1. Expenditure for the Programme budgets 2006–2007, 2008–2009 and for the Proposed programme budget 2010–2011 in budget segments.

Budget segments	2006–2007	2008–2009		2010–2011
	Actual	Approved budget	Revised budget	(before currency adjustments)
WHO programmes	2103.2	3741.7	3888.4	3888.0
Partnerships and collaborative arrangements within the budget envelope	705.0	369.9	747.0	1049.9
Outbreak and crisis response	290.0	115.9	316.2	0.0
Grand total	3098.2	4227.5	4951.6	4937.9

Partnerships and collaborative arrangements contribute more significantly to the achievement of some strategic objectives. Within strategic objective 1 the largest single component concerns the Global Polio Eradication Initiative, representing US\$ 389 million. Details on the individual partnerships can be found in Summary Tables 4 and 5.

Table 2. Proposed programme budget 2010–2011 by strategic objective (broken down by budget segment and compared with the approved Programme budget 2008–2009).

Strategic objectives	Programme budget 2008–2009 (WHO programmes)		Proposed programme budget 2010–2011 (before currency adjustments)				
	Approved WHO programmes 2008–2009	Revised WHO programmes 2008–2009	Proposed WHO programmes 2010–2011	Change over approved Programme budget 2008–2009 %	Partnerships and collaborative arrangements	Outbreak and crisis response	Total Programme budget 2010–2011
1	625.2	677.2	664.3	6.3	878.7	Note	1543.0
2	634.6	658.0	653.7	3.0	78.0	n.a	731.7
3	158.1	157.1	161.8	2.3	-	n.a	161.8
4	319.2	314.1	313.7	-1.7	40.5	n.a	354.2
5	134.0	134.1	123.7	-7.7	3.0	Note	126.7
6	162.1	167.9	164.1	1.2	13.0	n.a	177.1
7	65.9	66.6	71.9	9.1	-	n.a	71.9
8	130.5	136.6	145.5	11.5	1.2	n.a	146.7
9	126.7	121.4	118.9	-6.2	-	n.a	118.9
10	494.6	506.8	510.2	3.2	35.5	n.a	545.7
11	134.0	161.9	160.7	19.9	-	n.a	160.7
12	214.3	244.3	253.9	18.5	-	n.a	253.9
13	542.4	542.4	545.6	0.6	-	n.a	545.6
Total	3741.6	3888.4	3888.0	3.9	1049.9	Note ¹	4937.9

Although the WHO programme segment is unchanged in nominal terms between the biennium 2008–2009 and the biennium 2010–2011, Table 2 illustrates that some adjustments have been made between the strategic objectives in order to reflect increased emphases on the following:

- Strategic objectives 3 and 6 as a result of the endorsement by the Sixty-first World Health Assembly of the action plan for the global strategy for the prevention and control of noncommunicable diseases²
- Strategic objective 7 in response to the recommendations of the Commission on Social Determinants of Health
- Strategic objective 8 in order to accommodate the additional emphasis on climate change
- Strategic objective 10 in support of WHO's effort to revitalize primary health care, which is the focus of the *World health report 2008*
- Strategic objective 11 in order to support prequalification and quality control of medicines
- Strategic objective 12 in order to accommodate the increased number of meetings of the governing bodies and increased country presence.

¹ The outbreak and crisis budget will be determined nearer the time of implementation. It will start at a low level and is likely to increase throughout the biennium 2010–2011.

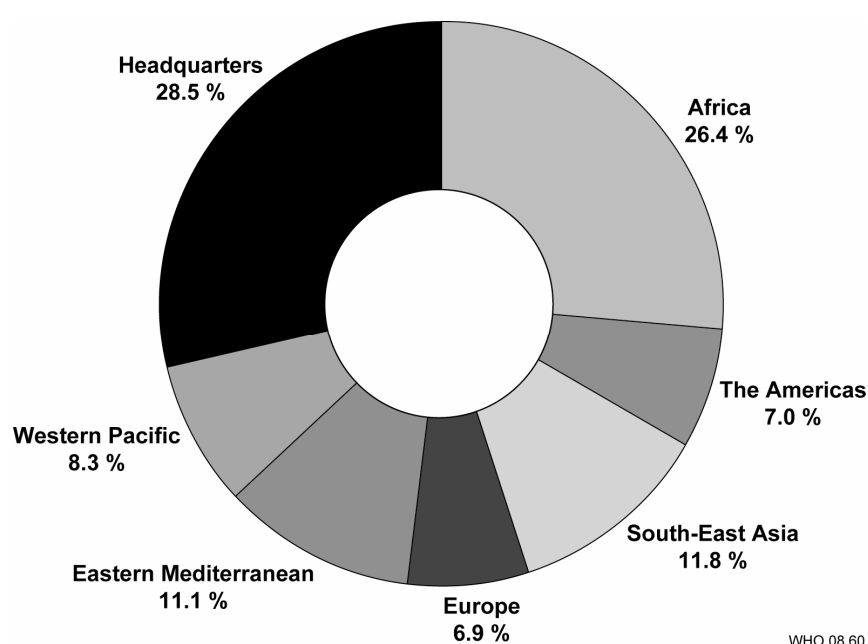
² Resolution WHA61.14.

In pursuance of the Organization's strategy to strengthen the first-line support provided to countries with adequate back-up at regional and global levels, the major part of the programme budget will be spent in regions and countries while maintaining headquarters functions. The "70%–30%" principle continues to guide the overall distribution of resources between regions/countries and headquarters, with the understanding that there will be variations between the strategic objectives and their underlying programmes depending on the nature of the programmes concerned. The budget distribution between the individual regions is unchanged for the WHO programme segment and reflects regional needs in line with the ranges from the validation mechanism for strategic resource allocation reviewed by the Executive Board¹ (see Figure 1).

Table 3. Proposed programme budget 2010–2011 by major office broken down by budget segment.

Location (major office)	Total approved Programme budget 2008–2009 <i>US\$ million</i>	Proposed programme budget 2010–2011 (before currency adjustments)		
		Total programme budget	WHO programmes	Partnerships and collaborative arrangements
		<i>US\$ million</i>		
Africa	1193.9	1451.0	1026.0	425.0
The Americas	278.5	277.0	272.0	5.0
South-East Asia	491.5	568.0	459.0	109.0
Europe	274.8	278.1	268.0	10.1
Eastern Mediterranean	465.0	485.4	433.0	52.4
Western Pacific	347.9	348.4	322.0	26.4
Headquarters	1175.9	1530.0	1108.0	422.0
Total	4227.5	4937.9	3888.0	1049.9

Figure 1. Distribution between regions and headquarters of the budget segment for WHO programmes for the biennium 2010–2011 (excluding partnerships and collaborative arrangements and outbreak and crisis response)



¹ See document EBSS-EB118/2006/REC/1, summary record of the fourth meeting, section 4.

Mechanisms of financing the Programme budget 2010–2011

Strategic objectives 1 to 11 are financed from both assessed and voluntary contributions, although voluntary contributions account for an increasing share of the total funding.

Voluntary contributions received by the Organization vary greatly in the degree to which they are earmarked for specific activities, in their predictability and in the time of their receipt. The voluntary contributions with both the least earmarking and a high level of predictability are obviously the easiest for WHO to align to its priorities and financing needs. The greater the earmarking of voluntary contributions, the more difficult it is for the Organization to fully finance all aspects of its work.

It is encouraging that the number of donors contributing core voluntary contributions has increased since 2006. It is hoped that this trend will continue as the management of these funds becomes more refined and as donor confidence in WHO's results-based management approach increases.

Core voluntary contributions

An important financing and management mechanism has been established, namely, the **core voluntary contributions account**. This account will manage those core voluntary contributions that are either fully flexible or flexible at strategic objective level. The account will help to ensure that funds are available to implement the programme budget so that the integrity of the strategic objectives and Organization-wide expected results is maintained, and so that there is a better programmatic delivery of the totality of the Medium-term strategic plan. The oversight of the core voluntary contributions account lies with the advisory group on financial resources. Discussions with major donors and partners have indicated growing support for this mechanism and the aim is to ensure approximately US\$ 300 million of such highly flexible funds for the biennium 2010–2011.

Core voluntary contributions that are specified to the level of Organization-wide expected results are referred to as “**designated core voluntary contributions**”. Such funds are managed through the Organization-wide technical programmes and networks in order to ensure efficient and timely delivery of the expected results. Designated core voluntary contributions are estimated at about US\$ 400 million for the biennium 2010–2011.

Oversight of the core voluntary contributions is exercised by the advisory group on financial resources. This group of senior WHO staff is in charge of monitoring financial and technical implementation of the programme budget and makes recommendations to the Director-General on corporate resource allocation.

Other voluntary contributions

In addition to the total of US\$ 700 million of core voluntary contributions, about US\$ 3500 million is expected to be raised in the form of specified contributions (Table 5). The expectation that the Organization will be able to mobilize the proposed level of voluntary contributions is considered justified on the basis of current trends.

Strategic objectives 12 and 13

Successful implementation of WHO's programme budget requires adequate financial, programmatic, infrastructure, monitoring, and accountability mechanisms. A proportion of the operating costs of these mechanisms is directly attributable to the programmes and their expected results, and is therefore part of the respective strategic objective budgets. However, other administrative and managerial functions are fixed and cannot be directly attributed to technical programmes. These include, within strategic objective 12, the governance mechanisms of the Organization including the various meetings of the governing bodies. The latter involve both statutory meetings and those arising from new emerging issues, such as the Intergovernmental Working Group on Public Health, Innovation and

Intellectual Property. Functions such as legal services, the Ombudsman and the office of the Internal Auditor are also budgeted in this strategic objective.

Strategic objective 12 also includes the work of the senior officers of the Secretariat throughout the Organization and associated costs. This includes country representatives, Regional Directors, Directors of Programme Management, Assistant Directors-General and the Office of the Director General.

Strategic objective 13 includes costs for financial management, information technology, human resources, procurement, planning and performance management, building management and infrastructure, staff development and learning, and security.

The growth in the Organization and its budget in recent years has placed increased demands on management and administrative support functions. In order to meet these demands some cost efficiencies have been made and further efforts are planned for the biennium 2010–2011. However, it is clear that any additional reduction in the resources available for administrative functions will affect the Organization's ability to achieve its technical objectives.

A proportion of voluntary contributions, referred to as “**programme support costs**”, is used to cover the costs incurred in implementation and in financing the administrative support services that underpin effective achievement of the expected results in all strategic objectives. In keeping with the authority given to the Director-General in both the Financial Regulations and Health Assembly resolutions, programme support costs of 13% are levied in order to help to meet the budgetary requirements of strategic objectives 12 and 13, together with these indirect costs. However, in practice, it has proven impossible to reach the 13% target. This is explained by the large number of exceptions, including a standard reduced cost for emergencies and crises and for the programme against poliomyelitis, as well as the general pressure on the United Nations system to reduce its charges for programme support costs. The current average collection rate amounts to only 7% of the overall voluntary contributions. This insufficient rate has led to a financing gap for strategic objectives 12 and 13.

The cost of delivering the administrative services has been increasing as a result of the growth in WHO's level of operations. This increase has been exacerbated by the falling value of the dollar and has been particularly critical to the financing of support functions, given the high preponderance of costs at headquarters in Switzerland, which are denominated in Swiss francs. Similar situations exist in several of the regional offices but to varying extents. In view of this, during the biennium 2010–2011, the two instruments described below will be employed in order to close the financing gap.

- An increased proportion of the assessed contributions will be applied to strategic objectives 12 and 13. At all locations, a minimum of 60% of the budget of these two strategic objectives should be financed from assessed contributions.
- A mechanism for common administration costs, set initially at 2.5%, will be established. This income source is within the budgets of strategic objectives 1 to 11 and will be used for financing the following corporate management and administrative functions: United Nations common charges including security; real estate, exchange rate hedging; the global service centre; insurance costs and global information technology.

Adjustments for currency fluctuations

If expenditure financed by dollar income is to remain unchanged, such income will have to be adjusted upwards. In this way, the same amount of local currencies can continue to be purchased. WHO incurs expenditures in many currencies, and to the extent that these expenditures are financed by United States dollar income sources (assessed contributions and voluntary contributions in United States dollars), the dollar cost of these expenditures in the biennium 2010–2011 will be higher than in the biennium 2008–2009. This is the continuation of a trend that has been visible over the last three bienniums.

Table 4. Estimated impact of exchange rate change on Programme budget 2010–2011 compared with exchange rate used for preparing Programme budget 2008–2009

	Exchange rate at May 2006	Impact of exchange rate change (US\$ million)	Exchange rate at June 2008
US\$ financed component of total budget			
Assessed contributions	929		
Voluntary contributions	1077		
Subtotal US\$ financed	2006	301	2307 ¹
Financed in other currencies	2932		2932
Total Programme budget	4938		5239

US\$ currency fall as weighted average of WHO cash flows 15%²

In Table 4 calculations are presented showing:

- (i) The total component of United States dollar-based income, within the overall programme budget, based on the proposed level of assessed contributions, and expectations of donor agreements concluded in United States dollars.
- (ii) The weighted average fall in the value of the United States dollar against the currency of expenditure in each major office location within WHO. The exchange rates used for this purpose are those that prevailed at the time of preparation of the Programme budget 2008–2009 and those of June 2008. This assumes that June 2008 exchange rates will approximate to those during the biennium 2010–2011; however, given that there will be further exchange rate movement, and that it is impossible to forecast accurately future exchange rates, it is proposed that these calculations be subject to further review, in the event that there are further significant exchange rate movements before the Programme budget 2010–2011 has been finalized.
- (iii) Location-specific exchange rate movements have been weighted in accordance with the planned overall budget percentage distribution between offices.

Table 4. indicates that an amount of US\$ 301 million is required to ensure that the same absolute (nominal) values of local currency expenditures as those budgeted for the biennium 2008–2009 can be met across the Organization. This is **before** taking into consideration any inflation affecting activity cost increases or salary increases. Given that global inflation is on a sharply upward trend (current global inflation is running at 5.7% according to the World Bank), even this figure of US\$ 301 million therefore falls significantly short of the amount required for zero real-terms maintenance in the value of WHO's budget for the biennium 2010–2011, compared with the current biennium.

¹ Exchange rate impact is assumed uniquely on that component of the total income in United States dollars and for which expenditures are incurred in the currencies of each of the major offices, in proportion to the overall budget distribution. For example, the United States dollar-denominated share of the budget allocation to headquarters is 28.5%, or US\$ 572 million of the total US\$ 2006 million. This financing is used to pay expenses denominated in Swiss francs, or that are correlated to the Swiss franc (e.g. salaries of staff members in the professional category).

² Currency fall calculated between May 2006, being exchange rates at the time of preparation of the Programme budget 2008–2009, and exchange rates at June 2008. This analysis excludes further potential exchange rate costs associated with the fall in value of other significant income currencies versus currencies of expenditure, most notably the United Kingdom pound.

Income projections for the Programme budget 2010–2011

Translating this US\$ 301 million to the level of the overall approved Programme budget 2008–2009 so as to maintain the same nominal value requires an additional 7.1% increase. It is proposed that this increase be applied in the same proportion to both assessed and voluntary contributions so as to maintain the same proportionality between these different sources of financing. For assessed contributions this translates into an additional US\$ 56.6 million.

Thus the nominal level of assessed contributions amounting to US\$ 985.4 million is proposed for the biennium 2010–2011, and an amount of US\$ 4253.5 million will need to be raised from voluntary contributions. This will give a total budget of US\$ 5238.9 million.

Miscellaneous income, which is derived mainly from interest earnings on assessed contributions, collection of arrears of assessed contributions, and unspent assessed contributions at the end of a biennium, will no longer be included in the programme budget, but will instead be subject to separate appropriation by Member States, based on the actual income available in the year following recognition of income. Miscellaneous income is traditionally difficult to estimate, owing to the multiple, unpredictable sources involved, and it is therefore difficult to include on a forward-looking basis in the budget.

Table 5. Proposed programme budget 2010–2011: financing compared with actual expenditures in the biennium 2006–2007 and the approved Programme budget 2008–2009

Source of income	Actual expenditures 2006–2007		Approved Programme budget 2008–2009		Proposed programme budget 2010–2011		Proposed programme budget 2010–2011 (currency adjusted)	
	US\$ million	%	US\$ million	%	US\$ million	%	US\$ million	%
Assessed contributions	863.3		928.8		928.8		985.4	
Miscellaneous income	35.3		30.0		0.0		0.0	
Total assessed contributions	898.6	29.0	958.8	22.7	928.8	18.8	985.4	18.8
Flexible core voluntary contributions	150.0		300.0		300.0		300.0	
Designated core voluntary contributions	220.0		300.0		400.0		400.0	
Specified voluntary contributions	1829.6		2668.7		3309.1		3553.5	
Total voluntary contributions	2199.6	71.0	3268.7	77.3	4009.1	81.2	4253.5	81.2
Total financing	3098.2	100.0	4227.5	100.0	4937.9	100.0	5238.9	100.0

The distribution of the overall currency adjustment with respect to headquarters and the regions will be determined nearer the date of implementation depending on the effect of the currency fluctuation at the location in question.

Included in the total financing needs is the budgeted US\$ 1049.9 million for partnerships and collaborative arrangements that are expected to be financed from specified voluntary contributions (see Table 1).

Monitoring the programme budget

Performance monitoring and assessment are essential for the proper implementation of the programme budget and for informing the revision of policies and strategies. Monitoring and assessment of the programme budget are Organization-wide processes conducted at the 12-month, mid-term period (the mid-term review) and upon completion of the biennium (the programme budget performance assessment). The documents resulting from the review and the assessment are both submitted to the governing bodies for their consideration.

The mid-term review serves to track and appraise progress towards achievement of the expected results. It facilitates corrective action, and the reprogramming and reallocation of resources during implementation. For each strategic objective, colour ratings are assigned (red, yellow or green) in order to indicate progress in achieving the expected results at the mid-term. The review also describes the impediments, problems and risks encountered, together with the actions required to ensure that the expected results are achieved.

The end-of-biennium programme budget performance assessment is a comprehensive appraisal of the performance of each organizational level and of the Organization as a whole, including the achievement of the targets set for the expected result indicators. The assessment focuses on achievements as compared with planned results, and on lessons learnt, in order to inform planning for the next biennium. The relevant findings provide essential information for subsequent programme budgets and for possible revisions to the Medium-term strategic plan. The performance assessment for the biennium 2006–2007 has noted the lessons learnt and these have informed the formulation of the Draft Proposed programme budget 2010–2011.

The set of indicators for all Organization-wide expected results in the Medium-term strategic plan 2008–2013 has been carefully and systematically reviewed with the aim of improving clarity and facilitating measurement and reporting. Most of the indicators have been refined; some have been replaced when it was considered that they were unable to provide an adequate measurement of the stated result. The refinement and tracking of indicators across all levels of the Organization represents an incremental process and work undertaken in the current biennium will also lead to improvements in processes and tools for the biennium 2010–2011.

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.

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 objective 10: in relation to the implementation of programmes through financially sustainable health-system approaches.
- Strategic objective 11: in relation to access to safe and effective vaccines, medicines and interventions, as well as quality assurance of diagnostics and laboratory services.

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

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

Total budget by location for the strategic objective for 2010–2011 (US\$ thousand)

Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
605.0	34.4	209.0	38.7	155.7	84.4	415.8	1543.0

Resource breakdown for the strategic objective for 2010–2011 (US\$ thousand)

	Countries	Regions	Headquarters	TOTAL
All financing 2010–2011				
Percentage by level				

Budget by organization-wide expected result and location

<p>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.</p>	INDICATORS																	
	<p>1.1.1 <u>Number of Member States with at least 90% national vaccination coverage (DTP3)</u></p>	<p>1.1.2 <u>Number of Member States that have introduced <i>Haemophilus influenzae</i> type b vaccine in their national immunization schedule</u></p>																
	BASELINE 2010																	
	130	135																
	TARGETS TO BE ACHIEVED BY 2011																	
140	150																	
<p align="center">Budget (US\$ thousand)</p> <table border="1"> <thead> <tr> <th>Africa</th> <th>The Americas</th> <th>South-East Asia</th> <th>Europe</th> <th>Eastern Mediterranean</th> <th>Western Pacific</th> <th>Headquarters</th> <th>TOTAL</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>345.1</td> </tr> </tbody> </table>			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL								345.1
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL											
							345.1											

<p>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.</p>	INDICATORS																	
	<p>1.2.1 <u>Percentage of final country reports demonstrating interruption of wild poliovirus transmission and containment of wild poliovirus stocks accepted by the relevant regional commission for the certification of poliomyelitis eradication</u></p>	<p>1.2.2 <u>Percentage of Member States using trivalent oral poliovirus vaccine that have a timeline and strategy for eventually stopping its use in routine immunization programmes</u></p>																
	BASELINE 2010																	
	75%	0%																
	TARGETS TO BE ACHIEVED BY 2011																	
98%	75%																	
<p align="center">Budget (US\$ thousand)</p> <table border="1"> <thead> <tr> <th>Africa</th> <th>The Americas</th> <th>South-East Asia</th> <th>Europe</th> <th>Eastern Mediterranean</th> <th>Western Pacific</th> <th>Headquarters</th> <th>TOTAL</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>478.1</td> </tr> </tbody> </table>			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL								478.1
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL											
							478.1											

1.8 Regional and global capacity coordinated and made rapidly available to Member States for detection, verification, risk assessment and response to epidemics and other public health emergencies of international concern.	INDICATORS						
	1.8.1 <u>Number of WHO locations with the global event-management system in place to support coordination of risk assessment, communications and field operations for headquarters, regional and country offices</u>				1.8.2 <u>Proportion of requests for assistance from Member States for which WHO mobilizes coordinated international support for disease investigation and containment efforts, characterization of events, and sustained containment of outbreaks</u>		
	BASELINE 2010						
	60				100%		
	TARGETS TO BE ACHIEVED BY 2011						
90				100%			
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							60.3

1.9 <u>Effective operations and response by Member States and the international community to declared emergencies situations due to epidemic and pandemic prone diseases.</u>	INDICATORS						
	1.9.1 <u>Proportion of declared emergency situations due to epidemic and pandemic prone diseases where operations have been implemented in a timely fashion</u>						
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							-

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.

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 3: particularly work relating to HIV and mental health
- Strategic objective 4: particularly efforts related to supporting research and development of new tools and interventions; meeting specific needs of children, adolescents and women of child-bearing age; formulation and implementation of gender-sensitive interventions; and tackling sexually transmitted infections.
- Strategic objective 6: specifically relating to prevention of tobacco use and its 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 8: particularly relating to environmental health and its relationship with malaria
- Strategic objective 9: particularly work in the area of nutrition and its relationship to HIV/AIDS
- Strategic objective 10: particularly efforts related to organization, management and delivery of health services; areas of human resource capacity strengthening, integrated training and widening of service provider networks; work related to minimizing the potential of financial catastrophe and impoverishment due to out-of-pocket health expenses.
- Strategic objective 11: specifically work related to essential medicines, medical products and technologies for the prevention and treatment of HIV/AIDS, tuberculosis and malaria.
- Strategic objective 12: specifically work related to health knowledge and advocacy material made accessible to member states.

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

- HIV Vaccine Initiative (including AAVP)
- Special Programme for Research, Development and Research Training in Human Reproduction
- Special Programme for Research and Training in Tropical Diseases

Total budget by location for the strategic objective for 2010–2011 (US\$ thousand)

Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
242.0	48.2	105.0	30.5	52.0	53.0	201.0	731.7

Resource breakdown for the strategic objective for 2010–2011 (US\$ thousand)

	Countries	Regions	Headquarters	TOTAL
All financing 2010–2011				
Percentage by level				

Budget by organization-wide expected result and location

<p>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.</p>	INDICATORS						
	<p>2.1.1 Number of <u>low- and middle-income</u> countries that have achieved <u>80% coverage for antiretroviral therapy and the prevention of mother-to-child transmission services</u></p>	<p>2.1.2 Proportion of <u>endemic countries that have achieved their national intervention targets for malaria</u></p>	<p>2.1.3 Number of <u>Member States</u> that have achieved the targets of <u>at least 70% case detection and 85% treatment success rate for tuberculosis</u></p>	<p>2.1.4 Proportion of <u>high burden Member States that have achieved the target of 70% of persons with sexually transmitted infections diagnosed, treated and counselled at primary point-of-care sites</u></p>			
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							146.8

<p>2.2 Policy and technical support provided to countries towards expanded gender-sensitive delivery of prevention, treatment and care interventions for HIV/AIDS, tuberculosis and malaria, including integrated training and service delivery; wider service-provider networks; and strengthened laboratory capacities and better linkages with other health services, such as those for sexual</p>	INDICATORS						
	<p>2.2.1 Number of <u>targeted Member States with comprehensive policies and medium-term plans in response to HIV, tuberculosis and malaria</u></p>	<p>2.2.2 Proportion of <u>high burden countries monitoring provider initiated HIV testing and counselling in sexually transmitted infection and family planning services</u></p>					
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						

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and reproductive health, maternal, newborn and child health, sexually transmitted infections, nutrition, drug-dependence treatment services, respiratory care, neglected diseases and environmental health.							
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							235.3

<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.</p>	INDICATORS							
	<p>2.3.1 Number of new or updated global norms and quality standards for medicines and diagnostic tools for HIV/AIDS, tuberculosis and malaria</p>	<p>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</p>	<p>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)</p>	<p>2.3.4 <u>Number of Member States implementing quality-assured HIV/AIDS screening of all donated blood</u></p>	<p>2.3.5 <u>Number of Member States administering all medical injections using sterile single use syringes</u></p>			
	BASELINE 2010							
	TARGETS TO BE ACHIEVED BY 2011							
Budget (US\$ thousand)								
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL	
							73.3	

<p>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.</p>	INDICATORS						
	<p>2.6.1 Number of new and improved tools (e.g. medicines, vaccines and diagnostic tools) receiving internationally recognized approval for use in HIV/AIDS, tuberculosis or malaria</p>		<p>2.6.2 Number of new and improved interventions and implementation strategies for HIV/AIDS, tuberculosis and malaria, whose effectiveness has been determined and evidence made available to appropriate institutions for policy decisions</p>			<p>2.6.3 Proportion of peer-reviewed publications arising from WHO-supported research on HIV/AIDS, tuberculosis or malaria and for which the main author's institution is based in a developing country</p>	
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							113.1

STRATEGIC OBJECTIVE 3

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

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).

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.

<p>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 <u>neurological</u> disorders, violence, injuries and disabilities together with visual impairment, including blindness.</p>	INDICATORS									
	<p>3.3.1 <u>Number of Member States that have submitted a complete assessment of their national road traffic injury prevention status to WHO during the biennium</u></p>		<p>3.3.2 Number of Member States that have a published document containing <u>national data on the prevalence and incidence of disabilities</u></p>		<p>3.3.3 <u>Number of low- and middle-income Member States with basic mental health indicators</u> annually reported</p>		<p>3.3.4 <u>Number of Member States with a national health reporting system and annual reports that include indicators for the four major noncommunicable conditions</u></p>		<p>3.3.5 <u>Number of Member States documenting, according to population-based surveys, the burden of hearing or visual impairment</u></p>	
	BASELINE 2010									
	TARGETS TO BE ACHIEVED BY 2011									
Budget (US\$ thousand)										
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL			
							22.0			

<p>3.4 Improved evidence compiled by WHO on the cost-effectiveness of interventions to tackle chronic noncommunicable conditions, mental and <u>neurological</u> and <u>substance-use</u> disorders, violence, injuries and disabilities together with visual impairment, including blindness.</p>	INDICATORS						
	<p>3.4.1 <u>Availability of evidence-based guidance on the effectiveness of interventions for the management of selected mental, behavioural or neurological disorders including those due to use of psychoactive substances</u></p>				<p>3.4.2 <u>Availability of evidence-based guidance or guidelines on the effectiveness or cost-effectiveness of interventions for the prevention and management of chronic noncommunicable conditions</u></p>		
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							21.7

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3.5 Guidance and support provided to Member States for the preparation and implementation of multisectoral, population-wide programmes to promote mental health and to prevent mental and behavioural disorders, violence and injuries, together with hearing and visual impairment, including blindness.	INDICATORS						
	3.5.1 Number of guidelines published and widely disseminated on multisectoral interventions to prevent violence and unintentional injuries	3.5.2 <u>Number of Member States that have initiated community-based projects during the biennium to reduce suicides</u>			3.5.3 <u>Number of Member States implementing strategies recommended by WHO for the prevention of hearing or visual impairment</u>		
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							21.6

3.6 Guidance and support provided to Member States to improve the ability of their health and social systems to prevent and manage chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities together with visual impairment, including blindness.	INDICATORS						
	3.6.1 <u>Number of Member States that have incorporated trauma-care services for victims of injuries or violence into their health-care systems using WHO trauma-care guidelines</u>	3.6.2 <u>Number of Member States implementing community-based rehabilitation programmes</u>	3.6.3 <u>Number of low- and middle-income Member States that have completed an assessment of their mental health systems using the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS)</u>	3.6.4 <u>Number of low- and middle-income Member States implementing primary health-care strategies for screening and managing cardiovascular risk</u>	3.6.5 <u>Number of Member States with tobacco cessation support incorporated into primary health care, as defined in the WHO Report on the Global Tobacco Epidemic, 2008: the MPOWER package</u>		
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							29.2

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.

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 and 11: 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.

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

- Special Programme of Research, Development and Research Training in Human Reproduction

<p>4.2 National research capacity strengthened as necessary and new evidence, products, technologies, interventions and delivery approaches of global and/or national relevance available to improve maternal, newborn, child and adolescent health, to promote active and healthy ageing, and to improve sexual and reproductive health.</p>	INDICATORS						
	<p>4.2.1 Number of research centres <u>that have received an initial grant for comprehensive institutional development and support</u></p>		<p>4.2.2 Number of completed studies on priority issues that <u>have been supported by WHO</u></p>			<p>4.2.3 Number of new or updated systematic reviews on best practices, policies and standards of care <u>for improving maternal, newborn, child and adolescent health, promoting active and healthy ageing or improving sexual and reproductive health</u></p>	
	BASELINE 2010						
	8		16			20	
	TARGETS TO BE ACHIEVED BY 2011						
16		32			40		
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							68.3

<p>4.3 Guidelines, approaches and tools for improving maternal care applied at the country level, including technical support provided to Member States for intensified action to ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods, particularly for poor and disadvantaged populations, with progress monitored.</p>	INDICATORS						
	<p>4.3.1 Number of Member States implementing strategies for increasing coverage with skilled care <u>for childbirth</u></p>						
	BASELINE 2010						
	25						
	TARGETS TO BE ACHIEVED BY 2011						
50							
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							70.8

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4.4 Guidelines, approaches and tools for improving neonatal survival and health applied at country level, with technical support provided to Member States for intensified action towards universal coverage, effective interventions and monitoring of progress.	INDICATORS						
	4.4.1 Number of <u>Member States</u> implementing strategies for increasing coverage <u>with interventions for neonatal survival and health</u>						
	BASELINE 2010						
	40						
TARGETS TO BE ACHIEVED BY 2011							
55							
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							31.3

4.5 Guidelines, approaches and tools for improving child health and development applied at the country level, with technical support provided to Member States for intensified action towards universal coverage of the population with effective interventions and for monitoring progress, taking into consideration international and human-rights norms and standards, notably those stipulated in the Convention on the Rights of the Child.	INDICATORS						
	4.5.1 Number of <u>Member States</u> implementing strategies for increasing coverage with child health and development interventions			4.5.2 Number of <u>Member States</u> that have expanded coverage of the integrated management of childhood illness to more than 75% of target districts			
	BASELINE 2010						
	40			30			
TARGETS TO BE ACHIEVED BY 2011							
60			45				
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							58.4

<p>4.6 Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, and for the scaling up of a package of prevention, treatment and care interventions in accordance with established standards.</p>	INDICATORS						
	4.6.1 Number of <u>Member States</u> with a functioning adolescent health and development programme ¹						
	BASELINE 2010						
	50						
TARGETS TO BE ACHIEVED BY 2011							
75							
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							31.2

<p>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.</p>	INDICATORS						
	4.7.1 Number of <u>Member States</u> implementing the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health <u>agreed at the 1994 International Conference on Population and Development (ICPD), its five-year review (ICPD+5), the Millennium Summit and the United Nations General Assembly in 2007</u>	4.7.2 Number of targeted <u>Member States</u> having reviewed their existing national laws, regulations or policies relating to sexual and reproductive health					
	BASELINE 2010						
	30						
TARGETS TO BE ACHIEVED BY 2011							
40							
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							48.3

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

4.8 Guidelines, approaches, tools, and technical assistance provided to Member States for increased advocacy for consideration of ageing as a public health issue, for the development and implementation of policies and programmes aiming at maintaining maximum functional capacity throughout the life course and for the training of health-care providers in approaches that ensure healthy ageing.	INDICATORS						
	4.8.1 Number of Member States with a functioning active healthy ageing programme consistent with WHA58.16 “Strengthening active and healthy ageing”						
	BASELINE 2010						
	<u>15</u>						
TARGETS TO BE ACHIEVED BY 2011							
<u>20</u>							
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							7.8

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; health of migrants; 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 and responding to the Mandates of Member States contained in three relevant resolutions of recent World Health Assemblies (WHA 58.1; WHA 59.22 and WHA 61.17).

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.
- Strategic objective 10: in relation to health of migrants, safe hospitals and health sector risk reduction measures

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

– Health and Nutrition Tracking Service

Total budget by location for the strategic objective for 2010–2011 (US\$ thousand)

Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
34.0	15.9	14.0	8.8	8.0	5.0	41.0	126.7

Resource breakdown for the strategic objective for 2010–2011 (US\$ thousand)

	Countries	Regions	Headquarters	TOTAL
All financing 2010–2011				
Percentage by level				

Budget by organization-wide expected result and location

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 <u>Member States</u> with national emergency preparedness plans that cover multiple hazards	5.1.2 Number of <u>Member States</u> implementing programmes for reducing the vulnerability of <u>health facilities</u> to the effects of natural disasters																								
	BASELINE 2010																									
	60%	40																								
	TARGETS TO BE ACHIEVED BY 2011																									
<table border="1"> <thead> <tr> <th colspan="8">Budget (US\$ thousand)</th> </tr> <tr> <th>Africa</th> <th>The Americas</th> <th>South-East Asia</th> <th>Europe</th> <th>Eastern Mediterranean</th> <th>Western Pacific</th> <th>Headquarters</th> <th>TOTAL</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>49.9</td> </tr> </tbody> </table>			Budget (US\$ thousand)								Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL								49.9
Budget (US\$ thousand)																										
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL																			
							49.9																			

5.2 Norms and standards developed and capacity built to enable Member States to provide timely response to disasters associated with natural hazards and conflict-related crises.	INDICATORS																									
	5.2.1 <u>Operational platforms for surge capacity in place in regions and headquarters ready to be activated in acute-onset emergencies</u>	5.2.2 Number of global and regional training programmes on <u>public health operations</u> in emergency response																								
	BASELINE 2010																									
	100%	16																								
	TARGETS TO BE ACHIEVED BY 2011																									
<table border="1"> <thead> <tr> <th colspan="8">Budget (US\$ thousand)</th> </tr> <tr> <th>Africa</th> <th>The Americas</th> <th>South-East Asia</th> <th>Europe</th> <th>Eastern Mediterranean</th> <th>Western Pacific</th> <th>Headquarters</th> <th>TOTAL</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>18.5</td> </tr> </tbody> </table>			Budget (US\$ thousand)								Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL								18.5
Budget (US\$ thousand)																										
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL																			
							18.5																			

5.3 Norms and standards developed and capacity built to enable Member States to assess needs and for planning interventions during the transition and recovery phases of conflicts and disasters.	INDICATORS																									
	5.3.1 Number of humanitarian action plans with a health component <u>formulated</u> for <u>ongoing emergencies</u>	5.3.2 Number of countries in transition <u>that have formulated a recovery strategy for health</u>																								
	BASELINE 2010																									
	12	25																								
	TARGETS TO BE ACHIEVED BY 2011																									
<table border="1"> <thead> <tr> <th colspan="8">Budget (US\$ thousand)</th> </tr> <tr> <th>Africa</th> <th>The Americas</th> <th>South-East Asia</th> <th>Europe</th> <th>Eastern Mediterranean</th> <th>Western Pacific</th> <th>Headquarters</th> <th>TOTAL</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>19.9</td> </tr> </tbody> </table>			Budget (US\$ thousand)								Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL								19.9
Budget (US\$ thousand)																										
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL																			
							19.9																			

5.4 Coordinated technical support provided to Member States for communicable disease control in natural disaster and conflict situations.	INDICATORS						
	5.4.1 Proportion of acute natural disasters or conflicts where communicable disease-control interventions have been implemented, <u>including activation of early-warning systems and diseases-surveillance for emergencies</u>						
	BASELINE 2010						
	100%						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							13.2

5.5 Support provided to Member States for strengthening national preparedness and for establishing alert and response mechanisms for food-safety and environmental health emergencies.	INDICATORS						
	5.5.1 Proportion of Member States with national plans for preparedness, and alert and response activities in respect of chemical, radiological and environmental health emergencies				5.5.2 Number of Member States with focal points for the International Food Safety Authorities Network and for <u>the environmental health emergencies network</u>		
	BASELINE 2010						
	60%				75		
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							11.5

5.6 Effective communications issued, partnerships formed and coordination developed with other organizations in the United Nations system, governments, local and international nongovernmental organizations, academic institutions and professional associations at the country, regional and global levels	INDICATORS						
	5.6.1 Proportion of Member States affected by <u>acute-onset emergencies and those with ongoing emergencies and a humanitarian coordinator in which the Inter-Agency Standing Committee Humanitarian Health Cluster is operational in line with IASC cluster standards in line with IASC cluster standards</u>				5.6.2 Proportion of Member States with <u>ongoing emergencies and a humanitarian coordinator having a sustainable WHO technical presence covering emergency preparedness, response and recovery</u>		
	BASELINE 2010						
	60%				60%		
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							13.7

5.7 Acute, ongoing and recovery operations implemented in a timely and effective manner.	INDICATORS						
	5.7.1 Proportion of acute-onset emergencies for which WHO mobilizes coordinated national and international action	5.7.2 Proportion of interventions for chronic emergencies implemented in accordance with humanitarian action plans' health components					
	BASELINE 2010						
	80%	100%					
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							-

STRATEGIC OBJECTIVE 6

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

Scope

The work under this strategic objective focuses on integrated, comprehensive, multisectoral and multidisciplinary health-promotion and prevention 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, prevention and reduction of the occurrence of the major risk factors.

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.

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

- Special Programme of Research, Development and Research Training in Human Reproduction
- WHO Centre for Health Development (KOBHE)

<p>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.</p>	INDICATORS							
	<p>6.3.1 <u>Number of Member States having comparable adult tobacco prevalence data available from recent national representative surveys, such as the Global Adult Tobacco Survey (GATS) or STEPS</u></p>			<p>6.3.2 <u>Number of Member States with smoke-free legislation covering all legislative elements, types of places and institutions as defined in the WHO Report on the Global Tobacco Epidemic, 2008</u></p>		<p>6.3.3 <u>Number of Member States with bans on tobacco advertising, promotion and sponsorship as defined in the WHO Report on the Global Tobacco Epidemic, 2008</u></p>		
	BASELINE 2010							
	TARGETS TO BE ACHIEVED BY 2011							
	56		22			30		
Budget (US\$ thousand)								
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL	
							55.2	

<p>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.</p>	INDICATORS							
	<p>6.4.1 <u>Number of Member States that have developed, with WHO support, strategies, plans and programmes for combating or preventing public health problems caused by alcohol, drugs and other psychoactive substance use</u></p>			<p>6.4.2 <u>Number of WHO strategies, guidelines, standards and technical tools developed in order to provide support to Member States in preventing and reducing public health problems caused by alcohol, drugs and other psychoactive substance use</u></p>				
	BASELINE 2010							
	TARGETS TO BE ACHIEVED BY 2011							
	50			10				
Budget (US\$ thousand)								
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL	
							17.1	

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, poverty and various social and economic factors (labour, housing and educational circumstances; trade and macroeconomic factors; and the social status of various groups such as women, children, elderly people, displaced people and ethnic minorities); formulation of policies and programmes that are ethically sound, responsive to gender inequalities, sustainable, effective in meeting the needs of poor people and other vulnerable groups, and consistent with human-rights norms.

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 and 11: 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.

Total budget by location for the strategic objective for 2010–2011 (US\$ thousand)

Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
9.0	6.9	5.0	6.0	13.0	2.0	30.0	71.9

Resource breakdown for the strategic objective for 2010–2011 (US\$ thousand)

	Countries	Regions	Headquarters	TOTAL
All financing 2010–2011				
Percentage by level				

Budget by organization-wide expected result and location

<p>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.</p>	INDICATORS																						
	<p>7.1.1 Number of WHO regions with a regional strategy for addressing social and economic determinants of health as identified in the Report of the Commission on the Social Determinants of Health endorsed by the Director-General</p>																						
	BASELINE 2010																						
	TARGETS TO BE ACHIEVED BY 2011																						
<p align="center">Budget (US\$ thousand)</p> <table border="1"> <thead> <tr> <th>Africa</th> <th>The Americas</th> <th>South-East Asia</th> <th>Europe</th> <th>Eastern Mediterranean</th> <th>Western Pacific</th> <th>Headquarters</th> <th>TOTAL</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td align="center">17.5</td> </tr> </tbody> </table>								Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL								17.5
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL																
							17.5																

<p>7.2 Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels to address social and economic determinants of health, including understanding and acting upon the public health implications of trade and trade agreements, and to encourage poverty-reduction and sustainable development.</p>	INDICATORS																						
	<p>7.2.1 Number of published country experiences on tackling social determinants for health equity</p>			<p>7.2.2 Number of tools to support countries in analysing the implications of trade and trade agreements for health.</p>																			
	BASELINE 2010																						
	TARGETS TO BE ACHIEVED BY 2011																						
<p align="center">Budget (US\$ thousand)</p> <table border="1"> <thead> <tr> <th>Africa</th> <th>The Americas</th> <th>South-East Asia</th> <th>Europe</th> <th>Eastern Mediterranean</th> <th>Western Pacific</th> <th>Headquarters</th> <th>TOTAL</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td align="center">21.9</td> </tr> </tbody> </table>								Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL								21.9
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL																
							21.9																

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 <u>Number of country reports published during the biennium incorporating disaggregated data and analysis of health equity</u>						
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							11.8

7.4 Ethics- and rights-based approaches to health promoted within WHO and at national and global levels.	INDICATORS						
	7.4.1 <u>Number of tools produced for Member States or the Secretariat giving guidance on using a human rights-based approach to advance health</u>			7.4.2 <u>Number of tools produced for Member States or the Secretariat giving guidance on use of ethical analysis to improve health policies</u>			
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							8.8

7.5 Gender analysis and responsive actions incorporated into WHO's normative work and support provided to Member States for formulation of gender-responsive policies and programmes.	INDICATORS						
	7.5.1 <u>Number of WHO norms and standards developed or updated that are gender responsive</u>			7.5.2 <u>Number of Member States supported by WHO that have conducted one or more gender-mainstreaming activities in health programmes</u>			
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							11.9

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).

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

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

- Intergovernmental Forum on Chemical Safety

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8.3 Technical assistance and support provided to Member States for strengthening national occupational and environmental health risk management systems, functions and services	INDICATORS						
	8.3.1 <u>Number of Member States that have implemented national action plans or policies for the management of occupational health risks, such as in relation to WHO's global plan of action on workers' health 2008–2017, with support from the Secretariat</u>						
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							19.8

8.4 Guidance, tools and initiatives created in order to support the health sector in influencing policies in other sectors to allow policies that improve health, the environment and safety to be identified and adopted	INDICATORS						
	8.4.1 <u>Number of Member States that have expressed interest in adopting healthy policies or frameworks proposed by WHO in other sectors than health</u>						
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							14.9

8.5 Health-sector leadership enhanced for creating a healthier environment and changing policies in all sectors so as to tackle the root causes of environmental threats to health, through means such as responding to emerging and re-emerging consequences of development on environmental health and altered patterns of consumption and production and to the damaging effect of evolving technologies	INDICATORS						
	8.5.1 <u>Number of studies or reports on new and re-emerging occupational and environmental health issues published or co-published by WHO</u>		8.5.2 <u>Number of reports published or jointly published by WHO on progress made in achieving water and sanitation objectives of major international development frameworks, such as the Millennium Development Goals</u>			8.5.3 <u>Number of high-level regional forums on environment and health issues organized or technically supported by WHO biennially</u>	
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							19.0

8.6 Evidence-based policies, strategies and recommendations developed, and technical support provided to Member States for identifying, preventing and tackling public health problems resulting from climate change	INDICATORS						
	8.6.1 <u>Number of studies or reports on the public health effects of climate change published or co-published by WHO</u>				8.6.2 <u>Number of countries that have implemented plans to enable the health sector to adapt to the adverse effects on health of climate change</u>		
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							24.1

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.

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.

Total budget by location for the strategic objective for 2010–2011 (US\$ thousand)

Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
40.0	12.6	12.0	5.3	9.0	14.0	26.0	118.9

Resource breakdown for the strategic objective for 2010–2011 (US\$ thousand)

	Countries	Regions	Headquarters	TOTAL
All financing 2010–2011				
Percentage by level				

Budget by organization-wide expected result and location

<p>9.1 Partnerships and alliances formed, leadership built and coordination and networking developed with all stakeholders at country, regional and global levels, in order to promote advocacy and communication, stimulate intersectoral actions, increase investment in nutrition, food-safety and food-security interventions, and develop and support a research agenda.</p>	INDICATORS						
	<p>9.1.1 <u>Number of Member States that have functional institutionalized coordination mechanisms to promote intersectoral approaches and actions in the area of food safety, food security or nutrition</u></p>	<p>9.1.2 Number of <u>Member States</u> that have included nutrition, food-safety and food-security activities <u>and a mechanism for their financing</u> in their sector-wide approaches <u>or</u> Poverty Reduction Strategy Papers</p>					
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							20.9

<p>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.</p>	INDICATORS	
	<p>9.2.1 Number of new nutrition and food-safety standards, guidelines <u>or</u> training manuals produced and disseminated to <u>Member States</u> and the international community</p>	<p>9.2.2 Number of new norms, standards, guidelines, tools and training materials for prevention and management of zoonotic and non-zoonotic foodborne diseases</p>
	BASELINE 2010	
	TARGETS TO BE ACHIEVED BY 2011	

<p>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</p>	INDICATORS						
	<p>9.5.1 Number of <u>Member States</u> that have established or strengthened intersectoral collaboration for the prevention, control and surveillance of foodborne zoonotic diseases</p>	<p>9.5.2 Number of <u>Member States</u> that have initiated a <u>plan for the reduction in the incidence</u> of at least one major foodborne zoonotic disease</p>					
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							14.8

<p>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</p>	INDICATORS						
	<p>9.6.1 Number of selected <u>Member States</u> receiving support to participate in international standard-setting activities related to food, such as those of the Codex Alimentarius Commission</p>	<p>9.6.2 Number of selected <u>Member States</u> that have built national systems for food safety with international links to emergency systems</p>					
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							16.2

STRATEGIC OBJECTIVE 10**To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research****Scope**

The work under this objectives aims to improve management and organization of health service delivery, reflecting the principles of integrated primary health care, so as to scale up coverage, equity and quality of health services and improve health outcomes. The work will improve national capacities for governance and leadership, improve the various mechanisms for coordination (including donor assistance) that support member states in their efforts to achieve national targets. Work will contribute to strengthened country health-information systems, and will contribute to better knowledge and evidence for health decision-making. This will include global and regional work on generation, comparative analysis and synthesis of health statistics and evidence from research. Work will strengthen national health research knowledge management and e-health policies for health-systems development. The health workforce information and knowledge base will be strengthened and technical support to Member States will be provided to improve the production, distribution, skill mix and retention of their health workforce. Health systems financing will be improved through evidence-based policy, norms, standards and related measurement tools, and technical support, resulting in higher availability of funds, social and financial risk protection, equity, and better access to services and efficiency of resource use. Steps will also be taken to advocate for additional funds for health where necessary.

Links with other strategic objectives

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

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

- Special Programme of Research, Development and Research Training in Human Reproduction
- World Alliance for Patient Safety

Total budget by location for the strategic objective for 2010–2011 (US\$ thousand)

Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
142.0	38.5	55.0	49.9	71.8	46.0	142.5	545.7

Resource breakdown for the strategic objective for 2010–2011 (US\$ thousand)

	Countries	Regions	Headquarters	TOTAL
All financing 2010–2011				
Percentage by level				

Budget by organization-wide expected result and location

<p>10.1 Management and organization of integrated, population-based health-service delivery through public and non-public providers and networks improved, reflecting <u>the primary health care strategy</u>, scaling up coverage, equity, <u>quality and safety of personal and population-based health services</u>, and enhancing health outcomes.</p>	INDICATORS																	
	<p>10.1.1 Proportion of <u>Member states</u> that show <u>increased coverage, access and quality of personal (preventive, diagnostic, treatment and rehabilitation) and population-based services</u></p>	<p>10.1.2 Number of <u>Member states</u> that show progress in embedding disease-specific programmes in general health services</p>																
	BASELINE 2010																	
	15% increase	20% increase																
	TARGETS TO BE ACHIEVED BY 2011																	
<p align="center">Budget (US\$ thousand)</p> <table border="1"> <thead> <tr> <th>Africa</th> <th>The Americas</th> <th>South-East Asia</th> <th>Europe</th> <th>Eastern Mediterranean</th> <th>Western Pacific</th> <th>Headquarters</th> <th>TOTAL</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td align="right">130.4</td> </tr> </tbody> </table>			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL								130.4
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL											
							130.4											

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<p>10.2 National capacities for governance and leadership improved through evidence-based policy dialogue, institutional capacity-building for policy analysis and development, strategy-based health system performance assessment, greater transparency and accountability for performance, and more effective intersectoral collaboration.</p>	INDICATORS							
	<p>10.2.1 Proportion of <u>Member states</u> that, against regionally agreed benchmarks, show evidence of improving institutional <u>processes, structures and capacities</u> for policy analysis, policy formulation, strategic planning, regulation, interinstitutional coordination and implementation of reform</p>		<p>10.2.2 Proportion of <u>Member states</u> that, against regionally agreed benchmarks, show evidence of improved accountability for performance and greater participation of civil society, community, consumers and professional organizations in shaping, <u>implementing and reporting on policies</u></p>		<p>10.2.3 Proportion of <u>Member states</u> that, against regionally agreed benchmarks, show evidence of improved performance <u>in law development and enforcement, policy formulation, policy implementation and regulation</u></p>		<p>10.2.4 Proportion of <u>Member states</u> that, against regionally agreed benchmarks, establish effective intersectoral cooperation mechanisms to improve health-systems' performance for better health outcomes</p>	
	BASELINE 2010							
	TARGETS TO BE ACHIEVED BY 2011							
Budget (US\$ thousand)								
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL	
							55.1	

<p>10.3 Coordination of the various mechanisms (including donor assistance) that provide support to Member States in their efforts to achieve national targets for health-system development and global health goals improved.</p>	INDICATORS						
	<p>10.3.1 Number of <u>Member states</u> where the inputs of major stakeholders are harmonized with national policies, measured in line with the Paris Declaration on Aid Effectiveness</p>						
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							14.7

<p>10.4 Country health-information systems that provide and use high-quality and timely information for health planning and for monitoring progress towards national and major international goals strengthened.</p>	INDICATORS						
	10.4.1 Proportion of low- and middle-income countries with adequate health statistics <u>and monitoring of health-related Millennium Development Goals</u> that meet agreed standards						
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							34.5

<p>10.5. Better knowledge and evidence for health decision-making assured through consolidation and publication of existing evidence, facilitation of knowledge generation in priority areas, and global leadership in health research policy and coordination, including with regard to ethical conduct.</p>	INDICATORS						
	<p>10.5.1 Proportion of countries for which high quality profiles with core health statistics are available from its open-access databases</p>		<p>10.5.2 Number of countries in which WHO plays a key role in supporting the generation and use of information and knowledge, including primary data collection through surveys, civil registration or improvement or analysis and synthesis of health facility data for policies and planning</p>			<p>10.5.3 Effective research for health coordination and leadership mechanisms established and maintained at global and regional levels</p>	
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							44.4

<p>10.6 National health research for development of health systems strengthened in the context of regional and international research and engagement of civil society.</p>	INDICATORS						
	<p>10.6.1 Proportion of low- and middle-income countries in which national health-research systems meet internationally agreed <u>minimum standards</u>;</p>				<p>10.6.2 Number of <u>Member states</u> complying with the recommendation to dedicate at least 2% of their health budget to research (Commission on Health Research for Development, 1990)</p>		
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							20.0

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10.7 Knowledge management and eHealth policies and strategies developed and implemented in order to strengthen health systems.	INDICATORS						
	10.7.1 Number of <u>Member states</u> adopting knowledge management <u>policies</u> in order to bridge the “ <u>know-how</u> ” gap particularly aimed to decrease <u>the digital divide</u>			10.7.2 Number of <u>Member states</u> with access to <u>electronic international scientific journals</u> and knowledge <u>archives in health sciences</u> as assessed by the <u>WHO Global Observatory for eHealth biannual survey</u>		10.7.3 Proportion of <u>Member states</u> with <u>eHealth policies, strategies and regulatory frameworks</u> as assessed by the <u>WHO Global Observatory for eHealth biannual survey</u>	
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							27.4

10.8 Health-workforce information and knowledge base strengthened, and country capacities for policy analysis, planning, implementation, information-sharing and research built up	INDICATORS						
	10.8.1 <u>Number of countries reporting two or more national data points on human resources for health within the past five years, reported in the Global Atlas of the Health Workforce</u>			10.8.2 <u>Number of Member states with an national policy and planning unit for human resources for health</u>			
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							46.4

10.9 Technical support provided to Member States, with a focus on those facing severe health-workforce difficulties in order to improve the production, distribution, skill mix and retention of the health workforce.	INDICATORS						
	10.9.1 <u>Proportion of 57 countries with critical shortage of health workforce, as identified in The world health report 2006 with a multi-year HRH plan</u>			10.9.2 <u>Proportion of 57 countries with critical shortage of health workforce, as identified in The world health report 2006 which have an investment plan for scaling up training and education of health workers</u>			
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							66.5

<p>10.10 Evidence-based policy and technical support provided to Member States in order to improve health-system financing in terms of the availability of funds, social and financial-risk protection, equity, access to services and efficiency of resource use.</p>	INDICATORS						
	<p>10.10.1 Number of <u>Member states</u> provided with technical and policy support to raise additional funds for health; to reduce financial barriers to access, incidence of financial catastrophe, and impoverishment linked to health payments; <u>or</u> to improve social protection and the efficiency and equity of resource use</p>				<p>10.10.2 Number of key policy briefs prepared, disseminated and their use supported, which document best practices on revenue-raising, pooling and purchasing, including contracting, provision of interventions and services, and handling of fragmentation in systems associated with vertical programmes and inflow of international funds</p>		
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							33.2

<p>10.11 Norms, standards and measurement tools developed for tracking resources, estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe, impoverishment, and social exclusion, and their use supported and monitored.</p>	INDICATORS						
	<p>10.11.1 Key tools, norms and standards to guide policy development and implementation developed, disseminated and their use supported, according to expressed need, that comprise resource tracking and allocation, budgeting, financial management, economic consequences of disease and social exclusion, organization and efficiency of service delivery, including contracting, <u>or</u> the incidence of financial catastrophe and impoverishment</p>				<p>10.11.2 Number of <u>Member states</u> provided with technical support for using WHO tools to track and evaluate the adequacy and use of funds, to estimate future financial needs, to manage and monitor available funds, <u>or</u> to track the impact of financing policy on households</p>		
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							18.5

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<p>10.12 Steps taken to advocate additional funds for health where necessary; to build capacity in framing of health-financing policy and interpretation and use of financial information; and to stimulate the generation and translation of knowledge to support policy development.</p>	INDICATORS						
	<p>10.12.1 WHO presence and leadership in international, regional and national partnerships and use of its evidence in order to increase financing for health in low-income countries, <u>or</u> provide support to countries in design and monitoring of Poverty Reduction Strategy Papers, sector-wide approaches, medium-term expenditure frameworks, and other long-term financing mechanisms <u>capable of providing social health protect consistent with primary health care</u></p>	<p>10.12.2 Number of <u>Member states</u> provided with support to build capacity in the formulation of health financing policies and strategies and the interpretation of financial data, <u>or</u> with key information on health expenditures, financing, efficiency and equity to guide the process</p>					
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							20.1

<p>10.13 Evidence based norms, standards and measurement tools developed to support member states to quantify and decrease the level of unsafe health care provided.</p>	INDICATORS						
	<p>10.13.1 Key tools, norms and standards to guide policy development, measurement and <u>implementation disseminated and their use supported</u></p>	<p>10.13.2 Number of <u>Member states</u> participating in global patient safety challenges and other <u>global safety initiatives, including research and measurement</u></p>					
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							34.5

STRATEGIC OBJECTIVE 11

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

Scope

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

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, pharmacovigilance and patient safety, compliance with long-term treatment regimens and containing antimicrobial resistance.
- Strategic objective 10: work also contributes to health service delivery; sustainable financing of products and technologies, on which access also depends. An integrated approach to health systems in support of primary health care will be promoted.
- Strategic objective 7: good governance.
- Strategic objective 12: global public policy.

11.3 Evidence-based policy guidance on promoting scientifically sound and cost-effective use of medical products and technologies by health workers and consumers developed and supported within the Secretariat and regional and national programmes.	INDICATORS						
	11.3.1 Number of national or regional programmes receiving support for promoting sound and cost-effective use of medical products <u>or</u> technologies	11.3.2 Number of <u>Member States</u> using national lists, updated within the past five years, of essential medicines, vaccines <u>or</u> technologies for public procurement <u>or</u> reimbursement					
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							23.3

STRATEGIC OBJECTIVE 12

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

Scope

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.

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 13, 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 12 is more outward-looking, focusing on issues of WHO leadership and governance, on work in Member States, and collaboration with partners including the United Nations System, at global, regional and country levels.

Total budget by location for the strategic objective for 2010–2011 (US\$ thousand)

Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
49.0	16.6	17.0	34.2	28.1	15.0	94.0	253.9

Resource breakdown for the strategic objective for 2010–2011 (US\$ thousand)

	Countries	Regions	Headquarters	TOTAL
All financing 2010–2011				
Percentage by level				

Budget by organization-wide expected result and location

<p>12.1 Effective leadership and direction of the Organization exercised through enhancement of governance, and the coherence, accountability and synergy of WHO's work.</p>	INDICATORS						
	<u>12.1.1</u> Proportion of documents submitted to governing bodies within constitutional deadlines in the six WHO official languages	<u>12.1.2</u> Level of understanding by key stakeholders of WHO's role, priorities and key messages as provided by a stakeholder survey					
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							156.9

<p>12.2 Effective WHO country presence¹ 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.</p>	INDICATORS						
	<u>12.2.1</u> Number of Member States where WHO is aligning its country cooperation strategy with the country's priorities and development cycle and harmonizing its work with the United Nations and other development partners within relevant frameworks, such as the United Nations Development Assistance Framework, Poverty Reduction Strategy Papers and Sector-Wide Approaches	<u>12.2.2</u> Proportion of WHO country offices which have reviewed and adjusted their core capacity in accordance with their country cooperation strategy	<u>12.2.3</u> Proportion of country workplans that are consistent with their country cooperation strategy				
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							30.8

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

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12.3 Global health and development mechanisms established to provide more sustained and predictable technical and financial resources for health on the basis of a common health agenda which responds to the health needs and priorities of Member States.	INDICATORS						
	12.3.1 <u>Number of health partnerships in which WHO participates that work according to the best practice principles for Global Health Partnerships</u>			12.3.2 <u>Proportion of health partnerships managed by WHO that comply with WHO partnership policy guidance</u>		12.3.3 <u>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</u>	
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							33.8

12.4 Essential multilingual health knowledge and advocacy material made accessible to Member States, health partners and other stakeholders through the effective exchange and sharing of knowledge.	INDICATORS						
	12.4.1 <u>Average number of page views/visits per month to the WHO headquarters' web site</u>			12.4.2 <u>Number of pages in languages other than English available on WHO country and regional offices' and headquarters' web sites</u>			
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							32.4

STRATEGIC OBJECTIVE 13

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

Scope

The scope of this 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.

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 12, 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 13 is more inward-looking, geared towards managerial and administrative issues, whereas strategic objective 12 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.

Total budget by location for the strategic objective for 2010–2011 (US\$ thousand)

Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
126.0	29.8	45.0	45.3	36.5	34.0	229.0	545.6

Resource breakdown for the strategic objective for 2010–2011 (US\$ thousand)

	Countries	Regions	Headquarters	TOTAL
All financing 2010–2011				
Percentage by level				

Budget by organization-wide expected result and location

13.1 Work of the Organization guided by strategic and operational plans that build on lessons learnt, reflect country needs, are elaborated across the Organization, and used to monitor performance and evaluate results.	INDICATORS						
	13.1.1 Proportion of country workplans that <u>have been peer reviewed with respect to their technical quality, that they incorporate lessons learnt and reflect country needs</u>	13.1.2 Office Specific Expected Results (OSERs) <u>for which progress status has been updated within the established timeframes for periodic reporting</u>					
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							40.8

13.2 Sound financial practices and efficient management of financial resources achieved through continuous monitoring and mobilization of resources to ensure the alignment of resources with the programme budgets.	INDICATORS						
	13.2.1 Degree of compliance of WHO with International Public Sector Accounting Standards	13.2.2 Proportion of <u>voluntary contributions that are classified as “core voluntary contribution “</u>					
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							67.8

13.3 Human resource policies and practices in place to attract and retain top talent, promote learning and professional development, manage performance, and foster ethical behaviour.	INDICATORS						
	13.3.1 Proportion of offices ¹ with approved human resources plans for a biennium			13.3.2 Number of staff assuming a new position or moving to a new location during a biennium (<u>delayed until 2010–2011 biennium</u>)		13.3.3 <u>Proportion of staff in compliance with the cycle of the Performance Management Development System</u>	
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							37.0

13.4 Management strategies, policies and practices in place for information systems, that ensure reliable, secure and cost-effective solutions while meeting the changing needs of the Organization.	INDICATORS						
	13.4.1 Number of information technology disciplines ² implemented Organization-wide according to <u>industry-best-practices benchmarks</u>				13.4.2 Proportion of offices using consistent real-time management information		
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							120.3

13.5 Managerial and administrative support services ³ necessary for the efficient functioning of the Organization provided in accordance with service-level agreements that emphasize quality and responsiveness.	INDICATORS						
	13.5.1 Proportion of services delivered <u>by the global service centre</u> according to criteria in service-level agreements						
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							130.1

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

² This includes, for example, incidence management, configuration management, release management, service-desk function.

³ Includes services in the areas of information technology, human resources, financial resources, logistics, and language services.

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13.6 Working environment conducive to the well-being and safety of staff in all locations.	INDICATORS						
	13.6.1 Proportion of planned projects included in the Capital master plan completed for a given biennium				13.6.2 Proportion of locations that are compliant with Minimum Operating Safety Standards (MOSS)		
	BASELINE 2010						
	TARGETS TO BE ACHIEVED BY 2011						
Budget (US\$ thousand)							
Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
							149.6

Summary table 1. Proposed programme budget by strategic objective

Strategic objective	US\$ million		
	Africa	The Americas	South-East Asia
1. To reduce the health, social and economic burden of communicable diseases	605.0	34.4	209.0
2. To combat HIV/AIDS, malaria and tuberculosis	242.0	48.2	105.0
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries and visual impairment	21.0	11.8	16.0
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	115.0	27.4	46.0
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	34.0	15.9	14.0
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	26.0	13.9	16.0
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	9.0	6.9	5.0
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	19.0	12.1	14.0
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development	40.0	12.6	12.0
10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research	142.0	38.5	55.0
11. To ensure improved access, quality and use of medical products and technologies	23.0	8.9	14.0
12. To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	49.0	16.6	17.0
13. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	126.0	29.8	45.0
TOTAL	1 451.0	277.0	568.0

and major office, 2010–2011 (US\$ million)

<i>(before currency adjustment)</i>				
Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
38.7	155.7	84.4	415.8	1 543.0
30.5	52.0	53.0	201.0	731.7
13.5	19.0	17.0	63.5	161.8
11.2	35.1	25.0	94.5	354.2
8.8	8.0	5.0	41.0	126.7
9.7	21.0	25.0	65.5	177.1
6.0	13.0	2.0	30.0	71.9
19.4	19.0	13.0	50.2	146.7
5.3	9.0	14.0	26.0	118.9
49.9	71.8	46.0	142.5	545.7
5.6	17.2	15.0	77.0	160.7
34.2	28.1	15.0	94.0	253.9
45.3	36.5	34.0	229.0	545.6
278.1	485.4	348.4	1 530.0	4 937.9

Summary table 2. Proposed programme budget by strategic objective, organizational level and source of financing, 2010–2011 (US\$ million)

Strategic objective	GRAND TOTAL			Regions		Headquarters
	Assessed contribution ^a	Voluntary contribution	All financing	Country	Regional	All financing
				All financing	All financing	
1. To reduce the health, social and economic burden of communicable diseases			1 543.0			
2. To combat HIV/AIDS, malaria and tuberculosis			731.7			
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries and visual impairment			161.8			
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			354.2			
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact			126.7			
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex			177.1			
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			71.9			
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			146.7			
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development			118.9			
10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research			545.7			
11. To ensure improved access, quality and use of medical products and technologies			160.7			
12. To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work			253.9			
13. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively			545.6			
TOTAL			4 937.9			

^a Includes miscellaneous income.

Summary table 3. Proposed programme budget by strategic objective, major office and source of financing, 2010–2011 (US\$ million)

Strategic objective	Africa				
	Total			Country	Regional
	Assessed contribution ^a	Voluntary contribution	All financing	All financing	All financing
1. To reduce the health, social and economic burden of communicable diseases			605.0		
2. To combat HIV/AIDS, malaria and tuberculosis			242.0		
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries and visual impairment			21.0		
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			115.0		
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact			34.0		
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			26.0		
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches			9.0		
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			19.0		
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development			40.0		
10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research			142.0		
11. To ensure improved access, quality and use of medical products and technologies			23.0		
12. To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work.			49.0		
13. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively			126.0		
TOTAL			1 451.0		

^a Includes miscellaneous income.

Summary table 3. Proposed programme budget by strategic objective, major office and source of financing, 2010–2011 (US\$ million)

Strategic objective	The Americas				
	Total			Country	Regional
	Assessed contribution ^a	Voluntary contribution	All financing	All financing	All financing
1. To reduce the health, social and economic burden of communicable diseases			34.4		
2. To combat HIV/AIDS, malaria and tuberculosis			48.2		
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries and visual impairment			11.8		
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			27.4		
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact			15.9		
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			13.9		
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			6.9		
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health			12.1		
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development			12.6		
10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research			38.5		
11. To ensure improved access, quality and use of medical products and technologies			8.9		
12. To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work			16.6		
13. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively			29.8		
TOTAL			277.0		

^a Includes miscellaneous income.

Summary table 3. Proposed programme budget by strategic objective, major office and source of financing, 2010–2011 (US\$ million)

Strategic objective	South-East Asia				
	Total			Country	Regional
	Assessed contribution ^a	Voluntary contribution	All financing	All financing	All financing
1. To reduce the health, social and economic burden of communicable diseases			209.0		
2. To combat HIV/AIDS, malaria and tuberculosis			105.0		
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries and visual impairment			16.0		
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			46.0		
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact			14.0		
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			16.0		
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches			5.0		
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			14.0		
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development			12.0		
10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research			55.0		
11. To ensure improved access, quality and use of medical products and technologies			14.0		
12. To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work			17.0		
13. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively			45.0		
TOTAL			568.0		

^a Includes miscellaneous income.

Summary table 3. Proposed programme budget by strategic objective, major office and source of financing, 2010–2011 (US\$ million)

Strategic objective	Europe				
	Total			Country	Regional
	Assessed contribution ^a	Voluntary contribution	All financing	All financing	All financing
1. To reduce the health, social and economic burden of communicable diseases			38.7		
2. To combat HIV/AIDS, malaria and tuberculosis			30.5		
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries and visual impairment			13.5		
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals			11.2		
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact			8.8		
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			9.7		
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			6.0		
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			19.4		
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development			5.3		
10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research			49.9		
11. To ensure improved access, quality and use of medical products and technologies			5.6		
12. To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work			34.2		
13. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively			45.3		
TOTAL			278.1		

^a Includes miscellaneous income.

Summary table 3. Proposed programme budget by strategic objective, major office and source of financing, 2010–2011 (US\$ million)

Strategic objective	Eastern Mediterranean				
	Total			Country	Regional
	Assessed contribution ^a	Voluntary contribution	All financing	All financing	All financing
1. To reduce the health, social and economic burden of communicable diseases			155.7		
2. To combat HIV/AIDS, malaria and tuberculosis			52.0		
3. Prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries and visual impairment			19.0		
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			35.1		
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact			8.0		
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			21.0		
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches			13.0		
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			19.0		
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development			9.0		
10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research			71.8		
11. To ensure improved access, quality and use of medical products and technologies			17.2		
12. To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work.			28.1		
13. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively			36.5		
TOTAL			485.4		

^a Includes miscellaneous income.

Summary table 3. Proposed programme budget by strategic objective, major office and source of financing, 2010–2011 (US\$ million)

Strategic objective	Western Pacific				
	Total			Country	Regional
	Assessed contribution ^a	Voluntary contribution	All financing	All financing	All financing
1. To reduce the health, social and economic burden of communicable diseases			84.4		
2. To combat HIV/AIDS, malaria and tuberculosis			53.0		
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries and visual impairment			17.0		
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.			25.0		
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact			5.0		
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			25.0		
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches			2.0		
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			13.0		
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development			14.0		
10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research			46.0		
11. To ensure improved access, quality and use of medical products and technologies			15.0		
12. To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work			15.0		
13. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively			34.0		
TOTAL			348.4		

^a Includes miscellaneous income.

Summary table 3. Proposed programme budget by strategic objective, major office and source of financing, 2010–2011 (US\$ million)

Strategic objective	Headquarters		
	Total		
	Assessed contribution ^a	Voluntary contribution	All financing
1. To reduce the health, social and economic burden of communicable diseases			415.8
2. To combat HIV/AIDS, malaria and tuberculosis			201.0
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries and visual impairment			63.5
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals			94.5
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact			41.0
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			65.5
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			30.0
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			50.2
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development			26.0
10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research			142.5
11. To ensure improved access, quality and use of medical products and technologies			77.0
12. To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work			94.0
13. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively			229.0
TOTAL			1 530.0

^a Includes miscellaneous income.

**Summary table 4. Individual partnerships and collaborative arrangements
included in the Proposed programme budget by strategic objective,
2010–2011 (US\$ million)**

Strategic objectives/partnerships and collaborative arrangements	Total US\$ million (before currency adjustments)
<i>Strategic objective 1</i>	
Effective collaboration with partners in the GAVI Alliance in support of the accelerated introduction of vaccines against childhood diseases	238.1
Global Polio Eradication Initiative	388.8
Partnership for the control of neglected tropical diseases	50.0
Effective collaboration with partners in the GAVI Alliance in support of integrated surveillance	22.0
UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases	73.8
Vaccine research partnerships	3.0
Effective collaboration with partners in the GAVI Alliance in support of the accelerated introduction of vaccines against epidemic prone diseases	73.0
WHO/FAO/OIE agreement on the management of avian influenza and other emerging diseases	30.0
Total	878.7
<i>Strategic objective 2</i>	
WHO/UNAIDS HIV Vaccine Initiative (including the African AIDS Vaccine Programme)	3.0
UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction	2.0
UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases	73.0
Total	78.0
<i>Strategic objective 4</i>	
UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction	40.5
Total	40.5
<i>Strategic objective 5</i>	
Health and Nutrition Tracking Service	3.0
Total	3.0
<i>Strategic objective 6</i>	
UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction	2.0
WHO Centre for Health Development (Kobe)	11.0
Total	13.0
<i>Strategic objective 8</i>	
Intergovernmental Forum on Chemical Safety	1.2
Total	1.2
<i>Strategic objective 10</i>	
UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction	1.0
World Alliance for Patient Safety	34.5
Total	35.5
Grand total	1 049.9

**Summary table 5. Partnership and collaborative arrangements – movements
between 2008–2009 and 2010–2011**

Name	Partnerships and collaborative arrangements (US\$ million)			
	Approved Programme budget 2008–2009	Revised Programme budget 2008–2009	Revised Programme budget 2008–2009 net of partnerships and collaborative arrangements moved out for biennium 2010–2011	Proposed programme budget for partnerships and collaborative arrangements 2010–2011 (before currency adjustments)
Alliance for Health Policy and Systems Research	-	7.7	-	-
Global Health Workforce Alliance	7.5	11.8	-	-
Health and Nutrition Tracking Service	-	3.0	3.0	3.0
Health Metrics Network	5.0	27.2	-	-
Intergovernmental Forum on Chemical Safety	-	1.2	1.2	1.2
Partnership for Maternal, Newborn and Child Health	-	13.1	-	-
Roll Back Malaria Partnership	13.6	18.7	-	-
UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases	79.3	100.9	100.9	146.8
UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction	40.5	42.8	42.8	45.5
Stop TB Partnership	18.7	27.5	-	-
United Nations Standing Committee on Nutrition	0.2	7.3	-	-
Water Supply and Sanitation Collaborative Council	-	35.8	-	-
HIV Vaccine Initiative (including African AIDS Vaccine Programme)	1.3	1.3	1.3	3.0
Global Polio Eradication Initiative	196.5	399.6	399.6	388.8
World Alliance for Patient Safety	7.0	34.7	34.7	34.5
Vaccine-Research Partnerships	0.3	0.3	0.3	3.0
WHO/FAO/OIE agreement on the management of avian influenza and other emerging diseases	-	14.0	14.0	30.0
WHO Centre for Health Development	-	-	-	11.0
Effective collaboration with GAVI partners	-	-	-	333.1
Partnership for the control of neglected tropical diseases	-	-	-	50.0
Total	369.9	746.9	597.8	1 049.9

PARTNERSHIPS OUTSIDE THE PROGRAMME BUDGET 2010-2011 ENVELOPE

As the demand for international public health assistance has grown, so too has the donor community. Now, in addition to Member States financing international public health, national overseas development assistance programmes are playing a greater role, and contributions from other multilateral organizations, development institutions and private foundations are growing.

As a result, the international health and development community increasingly works through partnerships. Often WHO has a key role in these partnerships, yet they have their own governance structure and WHO has no managerial control of their budgets or workplans.

The relationship established between these partnerships and WHO reflects the synergies and coordination that are necessary to the achievement of the strategic objectives in the Medium-term strategic plan and the Proposed programme budget 2010–2011.

**BIENNIAL BUDGETS OF PARTNERSHIPS
OUTSIDE THE PROGRAMME BUDGET 2010–2011**

Partnership	Strategic objective principally supported	Budget (in US\$ thousand)
Alliance for Health Policy and Systems Research	10	10 000
Global Health Workforce Alliance	10	30 000
Health Metrics Network	10	22 400
Partnership for Maternal, Newborn and Child Health	4	30 000
Roll Back Malaria Partnership	2	50 000
Secretariat of the Framework Convention on Tobacco Control	6	7000
Stop TB Partnership	2	32 500
Global Drug Facility	2	86 250
United Nations Standing Committee on Nutrition	9	7301
International Drug Purchase Facility, UNITAID	2	To be added in the version for EB124
Water Supply and Sanitation Collaborative Council	8	61 410
TOTAL		

ALLIANCE FOR HEALTH POLICY AND SYSTEMS RESEARCH

Strategic objective to which the work of the partnership contributes

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

Strategic approaches the partnership will focus on

The Alliance for Health Policy and Systems Research focuses on the following strategic approaches, to support the achievement of strategic objective 10:

- (i) stimulating the generation and synthesis of policy-relevant health systems knowledge, encompassing evidence, tools and methods,
- (ii) promoting the dissemination and use of health policy and systems knowledge in order to improve the performance of health systems, and
- (iii) facilitating the development of capacity for the generation, dissemination and use of health policy and systems research knowledge among researchers, policy-makers and other stakeholders.

Scope of the partnership's work during the biennium 2010–2011

During the biennium 2010–2011, the Alliance will identify, and build consensus around, high-priority research questions in the health policy and systems field, and support both strategic, multicountry studies and the synthesis of existing knowledge. The Alliance will continue to invest in mechanisms at country and regional levels that promote the use of evidence in policy, and will evaluate the effectiveness of different innovative knowledge translation mechanisms. The Alliance will support the teaching of health policy and systems research as part of post-graduate courses, the strengthening and dissemination of health policy and systems research methodologies, and will implement and evaluate strategies to enhance policy-makers' capacity to use evidence in policy-making. The strategies will be implemented primarily through calls for proposals and the competitive award of grants to developing country institutions.

Coordinating with WHO

The Alliance's programme of work both benefits from WHO's work on health systems and services (for example in terms of identifying research priorities) and contributes to that work (for example in terms of summarizing and synthesizing available evidence on health systems). The Alliance's programme of work clearly links with WHO's strategic objectives, yet the Alliance works primarily through developing country research institutions, thereby engaging a set of actors complementary to WHO's member states.

Partnership's projected budget for contributing to the achievement of the strategic objective during the biennium 2010–2011

US\$ 10 000 thousands

GLOBAL HEALTH WORKFORCE ALLIANCE

Strategic objective to which the work of the partnership contributes

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

Strategic approaches the partnership will focus on

The Alliance will, through the coordinated actions of its members, support the development of evidence-based, comprehensive and coherent country-level approaches and significant scaling up of country, regional and global actions necessary to ensure universal access to motivated and skilled health workers.

Scope of the partnership's work during the biennium 2010–2011

The Alliance operates as a global focal point for workforce development, enhancing access to information, knowledge, best practices, and institution resources for all stakeholders.

Its work will focus on the following three priorities:

- accelerating country work and capacity development through promoting and facilitating partnerships within countries
- harmonizing actors for workforce alignment to strengthen priority programmes and broader health systems
- building knowledge and stimulating learning as a global public good.

Coordinating with WHO

The Alliance aims to stimulate work that brings extra value beyond the activities and productivity of current institutions, including WHO. Work that is prioritized must be catalytic, ensuring complete systems for health workforce development globally.

The Alliance will collaborate with existing institutions and bodies, avoiding duplication or competition, supporting work that is consistent with the partners' mandates, compatible with their capabilities, and linked to the transparency and accountability of their actions.

Partnership's projected budget for contributing to the achievement of the strategic objective during the biennium 2010–2011

US\$ 30 000 thousands

HEALTH METRICS NETWORK

Strategic objective to which the work of the partnership contributes

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

Strategic approaches the partnership will focus on

The Health Metrics Network has a single strategic goal: to increase the availability and use of timely and accurate health information by catalysing the joint funding and development of core country health information systems.

Scope of the partnership's work during the biennium 2010–2011

In support of strategic objective 10, the partnership will pursue its three interrelated objectives:

- to create a harmonized framework for country health information systems, that describes standards for health information systems;
- to strengthen country health information systems by providing technical and catalytic financial support to apply the framework; and
- to ensure access to, and use of, information by local, regional and global constituencies.

Coordinating with WHO

The Health Metrics Network will continue to work closely with the WHO Secretariat in the area of health statistics and informatics in an effort to accelerate the work on standards development that will be crucial to the next version of the framework. The Network will continue to work with WHO regional offices and focal points at the country level to advance country activities to strengthen health information systems.

Partnership's projected budget for contributing to the achievement of the strategic objective during the biennium 2010–2011

US\$ 22 400 thousands

PARTNERSHIP FOR MATERNAL, NEWBORN AND CHILD HEALTH

Strategic objective to which the work of the Partnership contributes

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

Strategic approaches the partnership will focus on

The Partnership for Maternal, Newborn and Child Health focuses on the following work areas: global, regional and country-level political advocacy for maternal, newborn and child health; accelerating and facilitating country action; harmonizing relations with partners and increasing aid effectiveness; tracking progress both towards achieving Millennium Development Goals 4 and 5 and with regard to feeding. Core functions are also included in the annual work plan. These include regular Board meetings, supporting working groups and the WHO Secretariat.

Scope of the Partnership's work during the biennium 2010–2011

The Partnership will continue its advocacy work through the following activities: mapping advocacy messages and tools; developing common messaging platforms; implementing advocacy drives; increasing the Partnership's media visibility; and tracking political commitments and media coverage. In support of countries the Partnership will: provide technical support for national planning and budgeting processes; improve access to useful models for integrated components for maternal, newborn and child health in national health plans; publish best practices; and develop in-country capacity. The Partnership will also exercise leadership in incorporating maternal, newborn and child health into new global health initiatives and in catalyzing effective national coordination mechanisms, as well as in building platforms for strengthening existing measurement mechanisms. The Partnership will also be active in assessing progress by holding stakeholders at all levels accountable in meeting their financial and policy commitments.

Coordinating with WHO

The Partnership for Maternal, Newborn and Child Health will coordinate its identification and analysis of specific countries' constraints in order to avoid duplicating efforts that may be undertaken by WHO. Recognizing the additional resources the Partnership can bring to bear, it will supplement WHO's work in the area of maternal, newborn and child health.

Partnership's projected budget for contributing to the achievement of the strategic objective during the biennium 2010–2011

US\$ 30 000 thousands

ROLL BACK MALARIA PARTNERSHIP

Strategic objective to which the work of the partnership contributes

2: To combat HIV/AIDS, tuberculosis and malaria

Strategic approaches the partnership will focus on

The Roll Back Malaria Partnership's Global Malaria Business Plan and the annual Partnership-wide harmonized workplans serve to coordinate global actions for malaria control by all partners. The strategic objective is well aligned with both the Business Plan and the workplans. The following activities will also be critical to success: promoting universal access to essential interventions for prevention, treatment, care and support in order to halt disease transmission and reduce morbidity and mortality; ensuring sustained political commitment and more effective partnerships, including coherence and harmonization of operations with partners at all levels; and advocating for concerted efforts.

Scope of the partnership's work during the biennium 2010–2011

The work of the Roll Back Malaria Partnership focuses on supporting countries to (i) scale up rapidly in order to reach targets for rolling back malaria by the year 2010; (ii) sustain disease control through scaling up; and (iii) move towards transmission reduction and regional elimination.

Coordinating with WHO

The Partnership coordinates its activities through the Partnership-wide workplans, in which the WHO Secretariat is operationally involved across departments and at multiple levels. Accountability is ensured through the Roll Back Malaria Partnership Board.

Partnership's projected budget for contributing to the achievement of the strategic objective during the biennium 2010-2011

US\$ 50 000 thousands

(Proportion of estimated budget in direct support of the strategic objective is currently unknown. This figure is based on the 2008 harmonized workplan)

SECRETARIAT OF THE FRAMEWORK CONVENTION ON TOBACCO CONTROL

Strategic objective to which the work of the partnership contributes

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.

Strategic approaches that the partnership 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;
- 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; and
- providing direct technical assistance for the implementation of the WHO Framework Convention on Tobacco Control, including provision of support to strengthen the tobacco-control policies outlined in the MPOWER package.

Scope of the partnership's work during the biennium 2010–2011

Based on the provisions of the WHO Framework Convention on Tobacco Control and the priorities and strategies identified by the Conference of the Parties, the work of the Conference and the Convention Secretariat will promote the development of internationally agreed instruments for the implementation of different articles of the Convention. The Convention Secretariat will also focus on raising awareness of and disseminating the different instruments, and on helping Parties in their use in the process of implementing the Convention. The work of the Convention Secretariat will include the provision of support to Parties in complying with their reporting obligations, as well as the preparation of annual summary reviews on progress made in implementing the Convention internationally. Coordination with relevant international and regional intergovernmental organizations, particularly those accredited as observers to the Conference of the Parties, engaging their expertise in support of the implementation of the Convention, will constitute another important area of work.

Coordinating with WHO

Ensuring synergy and complementarity with the work of WHO, particularly the Tobacco Free Initiative, is an important strategy of the Conference of the Parties and the Convention Secretariat. This work will focus on the following: treaty-specific issues; further development of treaty instruments; intergovernmental negotiations and processes; utilizing the legally binding character of the treaty for promoting whole-government commitment and action in the implementation of the treaty; and utilizing the opportunities provided by international obligations of the Parties to promote global and regional coordination and action. At the country level the principal activities will involve promoting access to internationally available resources; providing assistance in treaty-specific and legal matters; profiling and utilizing the political and intergovernmental dimension and potential of the treaty in supporting global and national action against tobacco; supporting Parties in their engagement in the work of the Conference of the Parties and its subsidiary bodies; and supporting the use of and utilizing the information provided through the reporting instrument for promoting the exchange of experiences and the use of best practices available in Parties. Every effort will be made to avoid duplication with the work of the Tobacco Free Initiative and other departments of the WHO Secretariat, which will continue to lead the technical work, advocacy, surveillance and capacity building in countries, and

which will contribute to the work of the Conference of the Parties and the Convention Secretariat through the provision of their considerable technical expertise and knowledge.

Partnership's projected budget for contributing to the achievement of the strategic objective during the biennium 2010–2011.

The budget for the biennium 2010-2011 has not yet been drafted and discussed. However, the Convention Secretariat envisages that workplan components corresponding to nearly US\$ 5000 thousands from voluntary assessed contributions and nearly US\$ 2000 thousands from extrabudgetary contributions will directly contribute to the achievement of the strategic objective.

STOP TB PARTNERSHIP

Strategic objective to which the work of the partnership contributes

2: To combat HIV/AIDS, tuberculosis and malaria

Strategic approaches the partnership will focus on

The Stop TB Partnership will focus on the following approaches to realize its objectives:

- expanding and strengthening the coalition of organizations involved in tuberculosis control and research by, for example, increasing community and private sector involvement;
- broadening the agenda for tuberculosis control and research, increasing consensus thereon by means, inter alia, of the Global Plan to Stop TB 2006–2015, and the strengthening of guidance, for example, through the activities of the relevant working groups (the DOTS Expansion Working Group, the Multidrug-resistant Tuberculosis Working Group and the Green Light Committee);
- expanding the reach and increasing the impact of global advocacy by, for example, conducting high-level missions to countries;
- coordinating and supporting partner activities in key areas including technical assistance to countries, some of which have already benefited other functions and disease programmes in countries' health systems;
- improving tuberculosis control in countries, both directly, via, for example, the Global Drug Facility and the Green Light Committee, and indirectly through the Partnership's other activities, such as advocacy.

Scope of the partnership's work during the biennium 2010–2011

During this period work will focus on:

- expanding the network of partners further and directing their energy towards better tuberculosis control;
- enhancing global communications;
- targeted advocacy, communication and social mobilization efforts in order to build support for tuberculosis control at various levels;
- building national partnerships;
- supporting the work of civil society in generating support at the grass roots level for tuberculosis control;
- monitoring the Global Plan to Stop TB 2006-2015; and
- Stop TB Partnership's Technical Assistance Mechanism in order to relieve bottlenecks in the implementation of grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Coordinating with WHO

The Stop TB Partnership will align its activities closely with the WHO Secretariat and will supplement the latter's work. The Partnership will actively support WHO's six-pronged Stop TB strategy, and will support the work of the three implementation working groups mentioned above, which are hosted in the WHO Secretariat. In this way, the duplication of efforts can be avoided, and the impact of different

initiatives optimized. In undertaking its work the Partnership will follow all the rules and regulations of WHO.

Partnership's projected budget for contributing to the achievement of the strategic objective during the biennium 2010-2011

US\$ 32 500 thousands

GLOBAL DRUG FACILITY

Strategic objective to which the work of the partnership contributes:

2: To Combat HIV/AIDS, tuberculosis and malaria

Strategic approaches the partnership will focus on:

- a grant service whereby first-line antituberculosis drugs are granted to eligible and approved countries that require donor support to meet their drug needs;
- a direct procurement service for governments, donors and nongovernmental organizations to purchase drugs for use in programmes in countries that have sufficient finances but which lack adequate procurement capacity, including a robust quality assurance system; and
- a technical support service whereby the grant and direct procurement services are combined with technical assistance for in-country drug management and monitoring. The Global Drug Facility supports global efforts to improve antituberculosis drug quality assurance, primarily through the WHO-managed prequalification programme for priority essential medicines. The Facility combines these core services with in-country monitoring of the management of the drugs it supplies. Monitoring teams, composed of tuberculosis and drug management experts, work with programmes to identify strategies that will strengthen drug management, and ensure rational drug use and effective distribution. The Global Drug Facility provides a comprehensive catalogue of the antituberculosis drugs and supplies needed to diagnose and treat adults and children, covering both patients infected with drug-sensitive tuberculosis and those with the drug-resistant form of the disease.

Scope of the Global Drug Facility's work during the biennium 2010 - 2011

During this period the Facility will:

- maintain an effective grant service for tuberculosis drugs, including a transparent and rigorous applications review process;
- ensure growth of the direct procurement service for countries or donors wishing to use their own resources to purchase tuberculosis drugs via the Facility;
- supply approximately two million patient treatments via the grant and direct procurement services;
- increase supply of diagnostic kits for smear microscopy via the direct procurement service;
- maintain and improve the electronic order management system to (1) allow the Facility to electronically place order requests for countries, (2) enable countries to track and trace their tuberculosis drug consignments, and (3) permit the Facility to generate performance reports related to supply chain efficiency;
- ensure that the Facility's operations continue to be supported by a comprehensive unified internal quality management and information system that is ISO 9001:2000 certified;
- maintain strategic rotating stockpiles of first- and second-line tuberculosis drugs;
- provide the WHO-managed prequalification programme with technical and financial support in order to increase the number of tuberculosis drugs achieving prequalification;
- provide, facilitate and broker technical assistance to all countries using the Facility (supported via both the grant and direct procurement services) in order to improve drug management;
- maintain timely delivery of the drugs it grants, including rapid lead times for emergency procurements; and

- contain average drug cost per additional patient cure and reduce prices for certain categories of product by pooling procurement to maintain optimal economies of scale for supply partners, and by coordinating effective forecasting initiatives and keeping abreast of market dynamics to successfully engage industry with respect to product price optimization, assured product quality and sufficient capacity.

Coordinating with WHO

The Global Drug Facility will coordinate its activities relating to procurement and management of the aforementioned products with WHO country programmes, the DOTS Expansion Working Group, the Multidrug-resistant Tuberculosis Working Group, the Stop TB Partnership's Technical Assistance Mechanism, the Green Light Committee and other key WHO partners such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the International Drug Purchase Facility (UNITAID) in order to avoid duplicating efforts and optimize investments in initiatives for drug (and diagnostics) management.

Partnership's projected budget for contributing to the achievement of the strategic objective during the biennium 2010–2011

The projected biennial budget is US\$ 86 250 thousands. The bulk of this figure is for expenditures on procurement of drugs and diagnostics, with the remainder for operational costs including technical assistance, monitoring and evaluation and salaries.

UNITED NATIONS SYSTEM STANDING COMMITTEE ON NUTRITION

Strategic objective to which the work of the partnership contributes

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

Strategic approaches the partnership will focus on

The Standing Committee will focus on the following strategic approaches to support the achievement of the strategic objective: promoting, disseminating and monitoring coordinated international activities in food and nutrition.

Scope of the partnership's work during the biennium 2010–2011

The work of the Standing Committee in support of this strategic objective will focus on.

- communication, advocacy and partnership-building campaigns aimed at reducing hunger and the double burden of malnutrition;
- promoting coherent national food and nutrition policy and programme frameworks that are agreed to, integrated into national poverty reduction programmes, and scaled up; and
- promoting monitoring and evaluation frameworks for reducing hunger and malnutrition.

Coordinating with WHO

The Standing Committee will coordinate its activities with WHO through the United Nations Standing Committee on Nutrition Steering Committee, of which several United Nations agencies are members (including FAO, WHO, UNICEF and WFP), as well as representatives of bilateral agencies and civil society. The work of the Steering Committee is to promote coordination across agencies and avoid the duplication of effort.

Partnership's projected budget for contributing to the achievement of the strategic objective during the biennium 2010–2011

US\$ 7 301 thousands

INTERNATIONAL DRUG PURCHASE FACILITY, UNITAID

Information to be added in the version for EB124

WATER SUPPLY AND SANITATION COLLABORATIVE COUNCIL

Strategic objectives to which the work of the partnership contributes

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.

The Council's work has implications for other strategic objectives since improved sanitation and hygiene reduce diarrhoeal diseases – major killers, especially of children. Sanitation services reduce the burden of communicable diseases (strategic objective 1), reduce morbidity and mortality of children (strategic objective 4) and improve nutrition (strategic objective 9). Advocacy and policy work on sanitation tackle the underlying social and economic determinants of health (strategic objective 7).

Strategic approaches the partnership will focus on

The Council's organizational objective is to accelerate the provision of sustainable water, sanitation and waste management services to all people. During this planning period, the Council will continue to concentrate its energy on sanitation and hygiene, rather than on water. It will also pursue its three-part strategic approach, comprising:

- networking and knowledge management
- advocacy and communications
- grants management (the Global Sanitation Fund)

Scope of the partnership's work during the biennium 2010–2011

The Council's national coalitions (which are not hosted by WHO) will be active in approximately 40 countries, and the Council's secretariat (which is hosted by WHO) will coordinate networking and knowledge management at the global level. The Council will carry out advocacy and communications work at national and global levels, and the Global Sanitation Fund will provide grants to organizations to carry out sanitation and hygiene services in approximately 20 countries.

Coordinating with WHO

Although planning and implementing their work independently, WHO and the Water Supply and Sanitation Collaborative Council intend their activities to be complementary and will pursue cooperation when the benefits achievable are significant. Collaborative work is expected to include joint publications, joint meetings, the exchange of professional views and knowledge, and committee work. WHO's mainly normative, technical, evidence-based work and the Council's mainly practical, outgoing, people-centred activities are mutually complementary.

There is no duplication between the Council's work and that of WHO.

Partnership's projected budget for contributing to the achievement of the strategic objective during the biennium 2010–2011

US\$ 61 410 thousands

RC/2008/1

Original: English

MEDIUM-TERM STRATEGIC PLAN 2008–2013

AMENDED (DRAFT)

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

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

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

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, June 2008

MEDIUM-TERM STRATEGIC PLAN 2008–2013

AMENDED (DRAFT)

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INTRODUCTION

Challenges, gaps and future needs

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

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

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

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

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

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

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

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

Lessons learnt

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Strategic direction for 2008–2013

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. To reduce the health, social and economic burden of communicable diseases
2. To combat HIV/AIDS, tuberculosis and malaria
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries and visual impairment
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals

5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health
9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development
10. To improve health services through better governance, financing, staffing and management informed by reliable and accessible evidence and research
11. To ensure improved access, quality and use of medical products and technologies
12. To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work
13. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively.

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

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

WHO's framework for results-based management

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

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

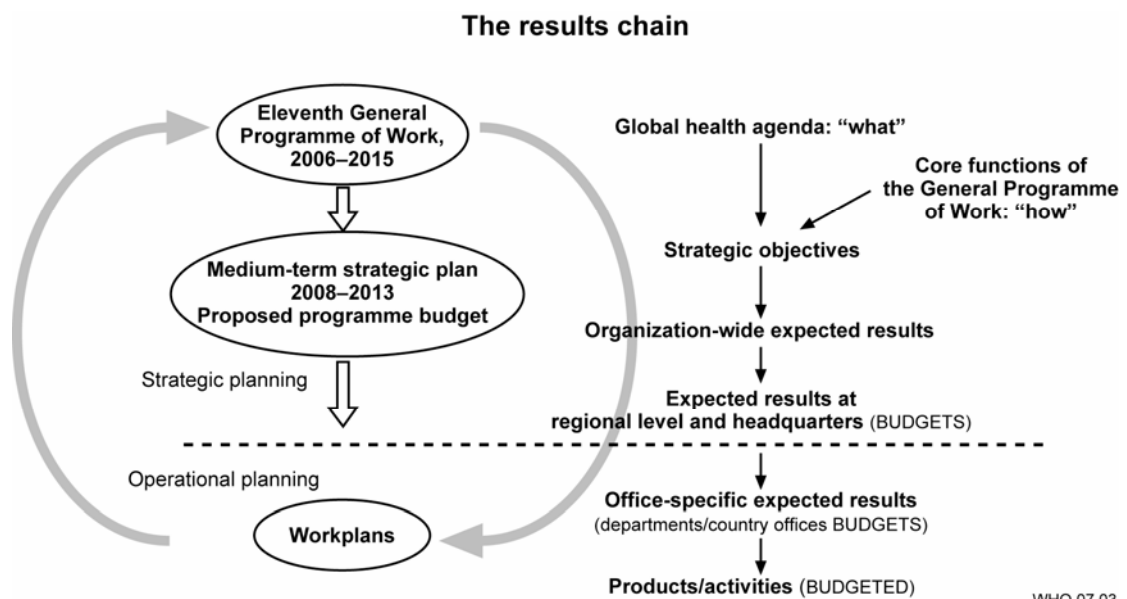
¹ Document A59/25.

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

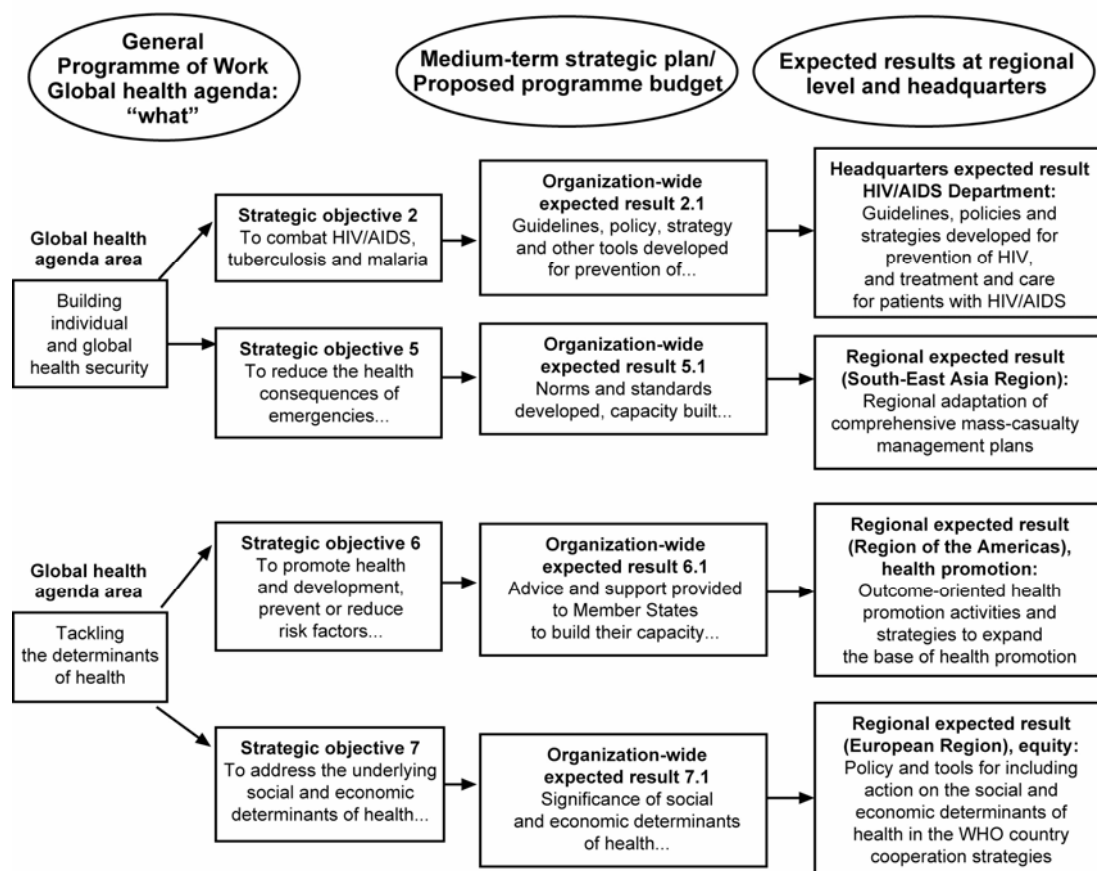
54. As confirmed by the analysis of 132 country cooperation strategies, these broad strategic objectives and related expected results provide a flexible programme structure that better reflects the needs of countries and regions. Collaboration throughout the Organization is facilitated by means of Organization-wide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

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

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



The results chain: example



WHO 07.04

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

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

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

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

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

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

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

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

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

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

Effective financing of the Medium-term strategic plan

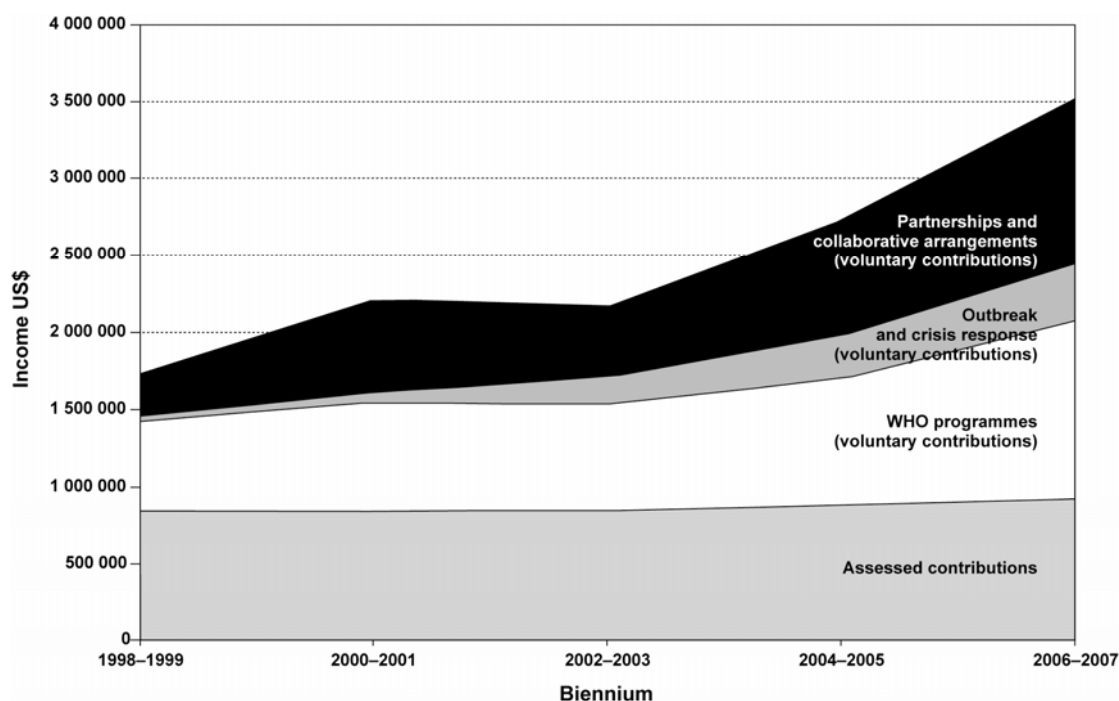
66. WHO has adopted a results-based management approach to determining resource requirements, with an integrated budget comprising all sources of funding. The costs of achieving the results concerned in a given time frame are therefore financed with funds from different sources.

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

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

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

Figure 2: Trend in the composition of WHO income



WHO 08.57

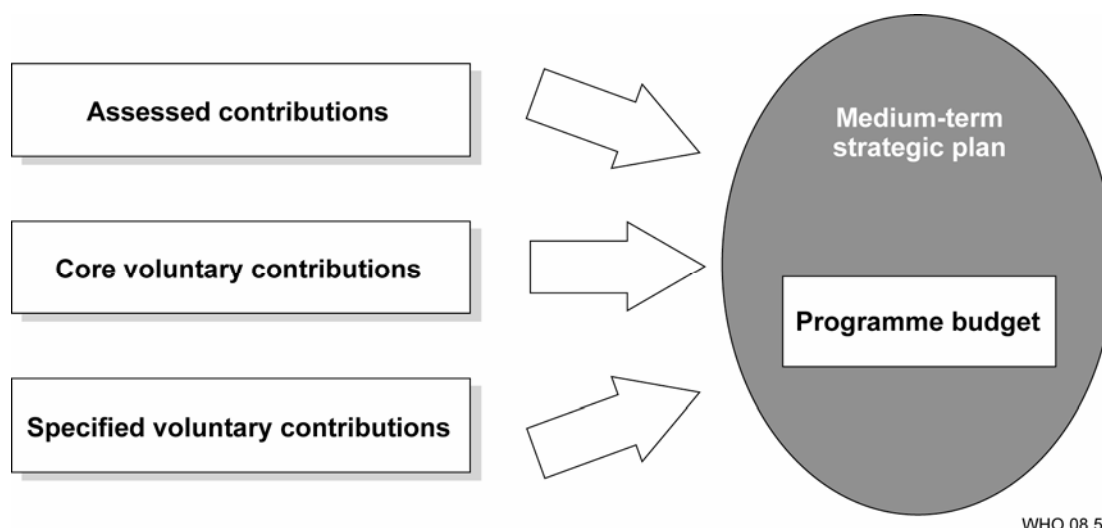
69. This evolving situation has also led to the international health and development community increasingly working through partnerships and other collaborative arrangements in which WHO often plays a key role. Several of these partnerships are hosted by WHO and included in the programme budget. However,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

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

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

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

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



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

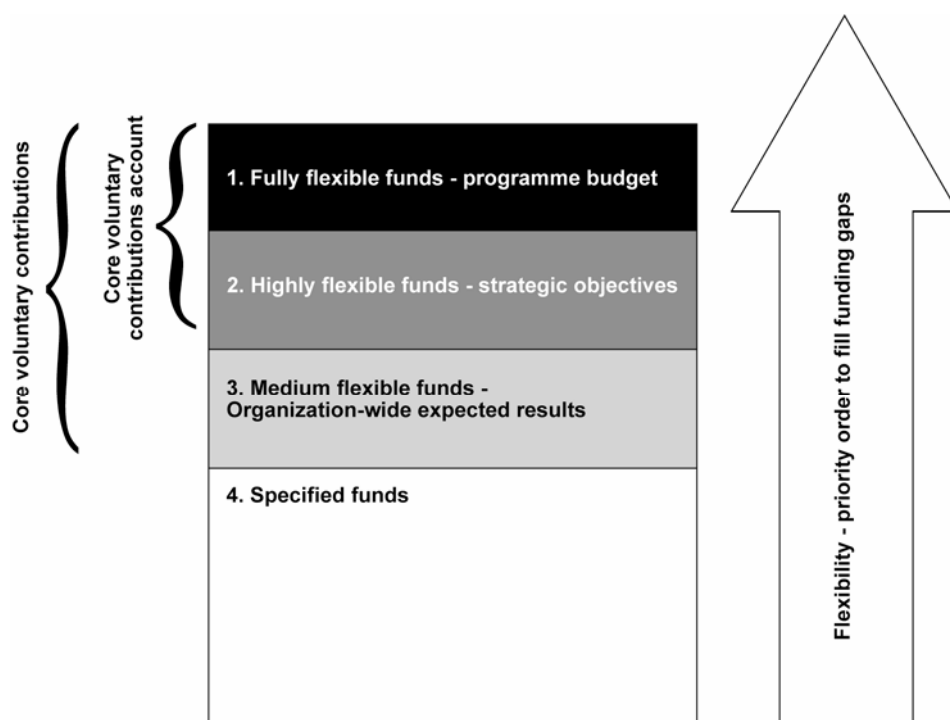
74. Miscellaneous income is derived mainly from interest earned on assessed-contribution funds, collections of arrears of assessed contributions, and assessed contributions remaining unspent at the end of a biennium.

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

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

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

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

Figure 4: Stratification of voluntary income by flexibility

WHO 08.58

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

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

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

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

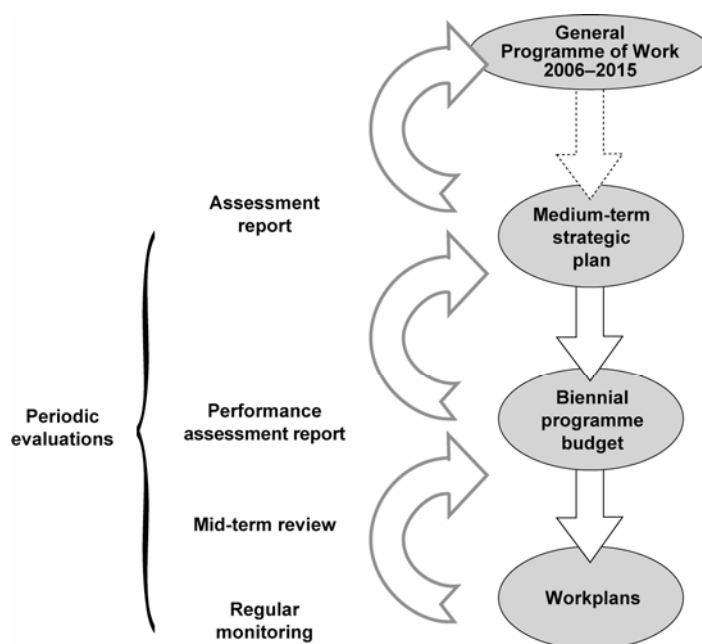
83. **Specified voluntary contributions.** Currently the Organization is financed largely from voluntary contributions intended for a specific purpose. In the biennium 2006-2007 specified contributions constituted about 83% of all voluntary contributions received. Although all these contributions are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

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

Monitoring, assessment and evaluation

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

Figure 5. Monitoring, assessment and evaluation instruments



WHO 06.153

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

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

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

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

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

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

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

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

¹ See paragraph 30.

STRATEGIC OBJECTIVES

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

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

Lessons learnt

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

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

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

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

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

STRATEGIC APPROACHES

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

Lessons learnt

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

The Secretariat will focus on:

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

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

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

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

The Secretariat will focus on:

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

MEDIUM-TERM STRATEGIC PLAN 2008–2013 (AMENDED)

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

ORGANIZATION-WIDE EXPECTED RESULTS

1.1 Policy and technical support provided to Member States in order to maximize equitable access of all people to vaccines of assured quality, including new immunization products and technologies, and to integrate other essential child-health interventions with immunization.	INDICATORS		
	1.1.1 <u>Number of Member States with at least 90% national vaccination coverage (DTP3)</u>	1.1.2 <u>Number of Member States that have introduced <i>Haemophilus influenzae</i> type b vaccine in their national immunization schedule</u>	
	BASELINE 2008		
	114	104	
	TARGETS TO BE ACHIEVED BY 2009		
	130	135	
	TARGETS TO BE ACHIEVED BY 2011		
	140	150	
	TARGETS TO BE ACHIEVED BY 2013		
	150	160	
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009 153 584	<u>Proposed budget</u> 2010–2011 345 100	Estimates 2012–2013 181 000	
JUSTIFICATION			
<p><i>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.</i></p>			

<p>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.</p>	INDICATORS		
	<p>1.2.1 <u>Percentage of final country reports demonstrating interruption of wild poliovirus transmission and containment of wild poliovirus stocks accepted by the relevant regional commission for the certification of poliomyelitis eradication</u></p>	<p>1.2.2 <u>Percentage of Member States using trivalent oral poliovirus vaccine that have a timeline and strategy for eventually stopping its use in routine immunization programmes</u></p>	
	BASELINE 2008		
	63%	0%	
	TARGETS TO BE ACHIEVED BY 2009		
	75%	0%	
	TARGETS TO BE ACHIEVED BY 2011		
	98%	75%	
	TARGETS TO BE ACHIEVED BY 2013		
	100%	100%	
	RESOURCES (US\$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	262 615	478 100	240 000
JUSTIFICATION			
<p><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></p>			

<p>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.</p>	INDICATORS			
	<p>1.3.1 <u>Number of Member States certified for eradication of dracunculiasis</u></p>	<p>1.3.2 <u>Number of Member States that have eliminated leprosy at subnational levels</u></p>	<p>1.3.3 <u>Number of reported cases of human African trypanosomiasis for all endemic countries</u></p>	<p>1.3.4 <u>Number of Member States having achieved the recommended target coverage of population at risk of lymphatic filariasis, schistosomiasis and soil-transmitted helminthiases through regular anthelmintic preventive chemotherapy</u></p>
	BASELINE 2008			
	72	6	11 500	11
	TARGETS TO BE ACHIEVED BY 2009			
	79	10	10 000	15
	TARGETS TO BE ACHIEVED BY 2011			
	82	13	8 500	20
	TARGETS TO BE ACHIEVED BY 2013			
	191	18	7 500	25
	RESOURCES (US\$ THOUSAND)			
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
	131 669	191 800	185 000	

MEDIUM-TERM STRATEGIC PLAN 2008–2013 (AMENDED)

	<p>JUSTIFICATION</p> <p><i>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.</i></p>
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<p>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.</p>	INDICATORS		
	1.4.1 Number of Member States with <u>surveillance systems and training for all communicable diseases of public health importance for the country</u>		1.4.2 Percentage of Member States for which <u>WHO/UNICEF joint reporting forms on immunization surveillance and monitoring are received on time at global level in accordance with established time-lines</u>
	BASELINE 2008		
	60	115	
	TARGETS TO BE ACHIEVED BY 2009		
	80	135	
	TARGETS TO BE ACHIEVED BY 2011		
	150	150	
	TARGETS TO BE ACHIEVED BY 2013		
	193	165	
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
79 668	122 500	87 000	
JUSTIFICATION			
<p><i>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.</i></p>			

<p>1.5 New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed and validated, with scientists from developing countries</p>	INDICATORS		
	1.5.1 Number of new and improved tools or <u>implementation strategies, developed with significant contribution from WHO, introduced by the public sector in at least one developing country</u>		1.5.2 Proportion of peer-reviewed publications based on WHO-supported research where the main author's institution is in a developing country
	BASELINE 2008		
	None	48%	
	TARGETS TO BE ACHIEVED BY 2009		
4	55%		

increasingly taking the lead in this research.	TARGETS TO BE ACHIEVED BY 2011		
	9	58%	
	TARGETS TO BE ACHIEVED BY 2013		
	124	60%	
	RESOURCES (US\$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	72 334	117 700	42 000
JUSTIFICATION			
<p><i>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.</i></p>			

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 <u>Number of Member States that have completed the assessment and developed a national action plan to achieve core capacities for surveillance and response in line with their obligations under the International Health Regulations (2005)</u>	1.6.2 <u>Number of Member States whose national laboratory system is engaged in at least one external quality-control programme for epidemic-prone communicable diseases</u>	
	BASELINE 2008		
	50	90	
	TARGETS TO BE ACHIEVED BY 2009		
	180	135	
	TARGETS TO BE ACHIEVED BY 2011		
		160	
	TARGETS TO BE ACHIEVED BY 2013		
	193	193	
	RESOURCES (US\$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
76 485	64 200	120 000	
JUSTIFICATION			
<p><i>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.</i></p>			

1.7 Member States and the international community equipped to detect, assess, respond to and cope with major epidemic and pandemic-prone	INDICATORS		
	1.7.1 <u>Number of Member States having national preparedness plans and standard operating procedures in place for readiness and response to major epidemic-prone diseases</u>	1.7.2 <u>Number of international coordination mechanisms for supplying essential vaccines, medicines and equipment for use in mass interventions against major epidemic and pandemic-prone diseases</u>	
	BASELINE 2008		
90	4		

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diseases (e.g. influenza, meningitis, yellow fever, haemorrhagic fevers, plague and smallpox) through the development and implementation of tools, methodologies, practices, networks and partnerships for prevention, detection, preparedness and intervention.	TARGETS TO BE ACHIEVED BY 2009		
	135	7	
	TARGETS TO BE ACHIEVED BY 2011		
	165	8	
	TARGETS TO BE ACHIEVED BY 2013		
	193	9	
	RESOURCES (US\$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	61 516	163 300	76 000
	JUSTIFICATION		
<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>			

1.8 Regional and global capacity coordinated and made rapidly available to Member States for detection, verification, risk assessment and response to epidemics and other public health emergencies of international concern.	INDICATORS		
	1.8.1 <u>Number of WHO locations with the global event-management system in place to support coordination of risk assessment, communications and field operations for headquarters, regional and country offices</u>	1.8.2 <u>Proportion of requests for assistance from Member States for which WHO mobilizes coordinated international support for disease investigation and containment efforts, characterization of events, and sustained containment of outbreaks</u>	
	BASELINE 2008		
	7	90%	
	TARGETS TO BE ACHIEVED BY 2009		
	60	100%	
	TARGETS TO BE ACHIEVED BY 2011		
	90	100%	
	TARGETS TO BE ACHIEVED BY 2013		
	120	100%	
	RESOURCES (US\$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	56 172	60 300	71 000
JUSTIFICATION			
<p><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></p>			

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

To combat HIV/AIDS, tuberculosis and malaria

Indicators and targets

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

ISSUES AND CHALLENGES

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

STRATEGIC APPROACHES

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

Lessons learnt

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

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

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

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

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

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

ASSUMPTIONS, RISKS AND OPTIONS

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

Lessons learnt

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

The Secretariat will focus on:

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

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

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

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

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

The Secretariat will focus on:

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

ORGANIZATION-WIDE EXPECTED RESULTS

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

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

<p>2.2 Policy and technical support provided to countries towards expanded gender-sensitive delivery of prevention, treatment and care interventions for HIV/AIDS, tuberculosis and malaria, including integrated training and service delivery; wider service-provider networks; and strengthened laboratory capacities and better linkages with other health services, such as those for sexual and reproductive health, maternal, newborn and child health, sexually transmitted infections, nutrition, drug-dependence treatment services, respiratory care, neglected diseases and environmental health.</p>	INDICATORS	
	<p>2.2.1 <u>Number of targeted Member States with comprehensive policies and medium-term plans in response to HIV, tuberculosis and malaria</u></p>	<p>2.2.2 <u>Proportion of high-burden countries monitoring provider initiated HIV testing and counselling in sexually transmitted infection and family planning services</u></p>
	BASELINE 2008	
	HIV/AIDS: 80/131 Tuberculosis: 50/87	0%
	TARGETS TO BE ACHIEVED BY 2009	
	HIV/AIDS: 131/131 Tuberculosis: 87/87	25%
	TARGETS TO BE ACHIEVED BY 2011	
	TARGETS TO BE ACHIEVED BY 2013	
	HIV/AIDS: all countries Tuberculosis: 148 Malaria: 43/43	75%
	RESOURCES (US\$ THOUSAND)	
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
258 132	235 300	300 000
JUSTIFICATION		
<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>		

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<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.</p>	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 <u>Number of Member States implementing quality-assured HIV/AIDS screening of all donated blood</u>	2.3.5 <u>Number of Member States administering all medical injections using sterile single use syringes</u>	
	BASELINE 2008					
	Five global standards	150 products	10 countries	77	115	
	TARGETS TO BE ACHIEVED BY 2009					
	10 new global standards	225 products	20 countries	134	154	
	TARGETS TO BE ACHIEVED BY 2011					
	TARGETS TO BE ACHIEVED BY 2013					
	20 new global standards	400 products	All targeted countries supported	193	193	
RESOURCES (US\$ THOUSAND)						
Budget 2008–2009 58 284	Proposed budget 2010–2011 73 300		Estimates 2012–2013 29 000			
JUSTIFICATION						
<p><i>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.</i></p>						

<p>2.4 Global, regional and national systems for surveillance, evaluation and monitoring strengthened and expanded to keep track of progress towards targets and allocation of resources for HIV/AIDS, tuberculosis and malaria control and to determine the impact of control efforts and the evolution of drug resistance.</p>	INDICATORS		
	<p>2.4.1 Number of Member States providing WHO with annual data on surveillance, monitoring or financial allocation data for inclusion in the annual global reports on control of HIV/AIDS, tuberculosis or malaria and the achievement of targets</p>	<p>2.4.2 Number of Member States reporting drug resistance surveillance data to WHO for HIV/AIDS, tuberculosis or malaria</p>	
	BASELINE 2008		
	HIV/AIDS: 48 Tuberculosis: 185 countries and territories Malaria: 107	HIV/AIDS: 13 Tuberculosis: 120 Malaria: 107	
	TARGETS TO BE ACHIEVED BY 2009		
	HIV/AIDS: 65 Tuberculosis: 189 Malaria: 107	HIV/AIDS: 40 Tuberculosis: 135 Malaria: 107	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	HIV/AIDS: 85 Tuberculosis: 193 Malaria: 107	HIV/AIDS: 50 Tuberculosis: 155 Malaria: 107	
	RESOURCES (US\$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
104 598	100 500	150 000	
JUSTIFICATION			
<p><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></p>			

<p>2.5 Political commitment sustained and mobilization of resources ensured through advocacy and nurturing of partnerships on HIV/AIDS, tuberculosis and malaria at country, regional and global levels; support provided to countries as appropriate to develop or strengthen and implement mechanisms for resource mobilization and utilization and</p>	INDICATORS		
	<p>2.5.1 Number of Member States with functional coordination mechanisms for HIV/AIDS, tuberculosis and malaria control</p>	<p>2.5.2 Number of Member States involving communities, persons affected by the diseases, civil-society organizations and the private sector in planning, design, implementation and evaluation of HIV/AIDS, tuberculosis and malaria programmes</p>	
	BASELINE 2008		
	HIV/AIDS: 80 Tuberculosis: 45 Malaria:	HIV/AIDS: 131 Tuberculosis: 65	
	TARGETS TO BE ACHIEVED BY 2009		
	HIV/AIDS: 131 Tuberculosis: 87 Malaria:	HIV/AIDS: 131 Tuberculosis: 87	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	TARGETS TO BE ACHIEVED BY 2013		
	TARGETS TO BE ACHIEVED BY 2013		

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increase the absorption capacity of available resources; and engagement of communities and affected persons increased to maximize the reach and performance of HIV/AIDS, tuberculosis and malaria control programmes.	TARGETS TO BE ACHIEVED BY 2013		
	HIV/AIDS: 131 Tuberculosis: 87 Malaria:	HIV/AIDS: 131 Tuberculosis: 87	
	RESOURCES (US\$ THOUSAND)		
	Budget 2008–2009 35 930	Proposed budget 2010–2011 62 700	Estimates 2012–2013 30 000
	JUSTIFICATION		
	<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.	INDICATORS		
	2.6.1 Number of new and improved tools (e.g. medicines, vaccines and diagnostic tools) receiving internationally recognized approval for use in HIV/AIDS, tuberculosis or malaria	2.6.2 Number of new and improved interventions and implementation strategies for HIV/AIDS, tuberculosis and malaria, whose effectiveness has been determined and evidence made available to appropriate institutions for policy decisions	2.6.3 Proportion of peer-reviewed publications arising from WHO-supported research on HIV/AIDS, tuberculosis or malaria and for which the main author's institution is based in a developing country
	BASELINE 2008		
	HIV:1 Tuberculosis:1	2	48%
	TARGETS TO BE ACHIEVED BY 2009		
	HIV: 3 Tuberculosis: 3	4	55%
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	HIV: 5 Tuberculosis: 6	8	60%
	RESOURCES (US\$ THOUSAND)		
Budget 2008–2009 103 454	Proposed budget 2010–2011 113 100	Estimates 2012–2013 81 000	
JUSTIFICATION			
<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 and visual impairment

Indicators and targets

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

ISSUES AND CHALLENGES

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

These causes are responsible for 75% of all deaths – a figure that is projected to increase over the next 10 years. Over the period 2006-2015, deaths from communicable conditions, maternal and perinatal conditions and nutritional deficiencies are expected to decrease by 3%; on the other hand, deaths from chronic noncommunicable 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.
- Scaling up of services for chronic noncommunicable conditions, mental disorders and violence and injuries is urgently needed to respond to the large treatment gap that currently exists.
- Prevention is an essential component of national plans for social and economic development as it leads to improvements in population health and a reduction in inequalities.
- Risk-factor prevention is the most cost-effective approach that low- and middle-income countries can adopt to control the adverse health and social outcomes attributable to these diseases.

STRATEGIC APPROACHES

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

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

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

The Secretariat will focus on:

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

ORGANIZATION-WIDE EXPECTED RESULTS

<p>3.1 Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities together with visual impairment, including blindness.</p>	INDICATORS			
	3.1.1 Number of <u>Member States</u> 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 <u>Number of Member States with a mental health budget of more than 1% of the total health budget</u>	3.1.4 <u>Number of Member States with a unit in the ministry of health or equivalent national health authority, with dedicated staff and budget, for the prevention and control of chronic noncommunicable conditions</u>
	BASELINE 2008			
	80	No report	140	67
	TARGETS TO BE ACHIEVED BY 2009			
	110	<u>Draft prepared</u>	150	90
	TARGETS TO BE ACHIEVED BY 2011			
	TARGETS TO BE ACHIEVED BY 2013			
	170	<u>Published in 6 languages</u>	180	160
RESOURCES (US\$ THOUSAND)				
Budget 2008–2009		Proposed budget 2010–2011		
25 837		35 600		
		Estimates 2012–2013		
		20 000		
JUSTIFICATION				
<p><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></p>				

<p>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 <u>neurological</u> disorders, violence, injuries and disabilities together with visual impairment, including blindness.</p>	INDICATORS			
	3.2.1 Number of <u>Member States that have national plans to prevent unintentional injuries or violence</u>	3.2.2 Number of <u>Member States that have initiated the process of developing a mental health policy or law</u>	3.2.3 Number of <u>Member States that have adopted a multisectoral national policy on chronic noncommunicable conditions</u>	3.2.4 Number of <u>Member States that are implementing comprehensive national plans for the prevention of hearing or visual impairment</u>
	BASELINE 2008			
	40	39	53	67
	TARGETS TO BE ACHIEVED BY 2009			
	50	48	75	75
	TARGETS TO BE ACHIEVED BY 2011			
	TARGETS TO BE ACHIEVED BY 2013			
	80	60	110	137
RESOURCES (US\$ THOUSAND)				
Budget 2008–2009		Proposed budget 2010–2011		
30 440		31 700		
		Estimates 2012–2013		
		33 000		

MEDIUM-TERM STRATEGIC PLAN 2008–2013 (AMENDED)

	JUSTIFICATION
	<i>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.</i>

3.3 Improvements made in Member States' capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable conditions, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.	INDICATORS					
	3.3.1 <u>Number of Member States that have submitted a complete assessment of their national road traffic injury prevention status to WHO during the biennium</u>	3.3.2 Number of Member States that have a published document containing national data on the prevalence and incidence of disabilities	3.3.3 <u>Number of low- and middle-income Member States with basic mental health indicators</u> annually reported	3.3.4 <u>Number of Member States with a national health reporting system and annual reports that include indicators for the four major noncommunicable conditions</u>	3.3.5 <u>Number of Member States documenting, according to population-based surveys, the burden of hearing or visual impairment</u>	
	BASELINE 2008					
	0	60	80	100	32	
	TARGETS TO BE ACHIEVED BY 2009					
	130	90	100	120	38	
	TARGETS TO BE ACHIEVED BY 2011					
	TARGETS TO BE ACHIEVED BY 2013					
	180	140	140	160	50	
RESOURCES (US\$ THOUSAND)						
Budget 2008–2009 23 987		Proposed budget 2010–2011 22 000		Estimates 2012–2013 35 000		
JUSTIFICATION						
<i>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.</i>						

3.4 Improved evidence compiled by WHO on the cost-effectiveness of interventions to tackle chronic noncommunicable conditions, mental and neurological and substance-use disorders, violence, injuries and disabilities together with visual impairment, including blindness.	INDICATORS	
	3.4.1 <u>Availability of evidence-based guidance on the effectiveness of interventions for the management of selected mental, behavioural or neurological disorders including those due to use of psychoactive substances</u>	3.4.2 <u>Availability of evidence-based guidance or guidelines on the effectiveness or cost-effectiveness of interventions for the prevention and management of chronic noncommunicable conditions</u>
	BASELINE 2008	
	None published and disseminated	2 published and disseminated
TARGETS TO BE ACHIEVED BY 2009		
Published and disseminated for 4 interventions	2 published and disseminated	

TARGETS TO BE ACHIEVED BY 2011		
TARGETS TO BE ACHIEVED BY 2013		
Published and disseminated for 12 interventions	6 published and disseminated	
RESOURCES (US\$ THOUSAND)		
Budget 2008–2009	<u>Proposed budget</u> 2010–2011	Estimates 2012–2013
23 700	21 700	30 000
JUSTIFICATION		
<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 promote mental health and to prevent mental and behavioural disorders, violence and injuries, together with hearing and visual impairment, including blindness.	INDICATORS		
	3.5.1 Number of guidelines published and widely disseminated on multisectoral interventions to prevent violence and unintentional injuries	3.5.2 <u>Number of Member States that have initiated community-based projects during the biennium to reduce suicides</u>	3.5.3 <u>Number of Member States implementing strategies recommended by WHO for the prevention of hearing or visual impairment</u>
	BASELINE 2008		
	4	0	67
	TARGETS TO BE ACHIEVED BY 2009		
	10	17	75
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	18	37	137
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	<u>Proposed budget</u> 2010–2011	Estimates 2012–2013	
21 476	21 600	69 000	
JUSTIFICATION			
<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>			

MEDIUM-TERM STRATEGIC PLAN 2008–2013 (AMENDED)

3.6 Guidance and support provided to Member States to improve the ability of their health and social systems to prevent and manage chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities together with visual impairment, including blindness.	INDICATORS				
	3.6.1 <u>Number of Member States that have incorporated trauma-care services for victims of injuries or violence into their health-care systems using WHO trauma-care guidelines</u>	3.6.2 <u>Number of Member States implementing community-based rehabilitation programmes</u>	3.6.3 <u>Number of low- and middle-income Member States that have completed an assessment of their mental health systems using the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS)</u>	3.6.4 <u>Number of low- and middle-income Member States implementing primary health-care strategies for screening and managing cardiovascular risk</u>	3.6.5 <u>Number of Member States with tobacco cessation support incorporated into primary health care, as defined in the WHO Report on the Global Tobacco Epidemic, 2008: the MPOWER package</u>
	BASELINE 2008				
	3	0	48	Precise data on current baseline unavailable	35
	TARGETS TO BE ACHIEVED BY 2009				
	8	10	72	12	37
	TARGETS TO BE ACHIEVED BY 2011				
	TARGETS TO BE ACHIEVED BY 2013				
	20	40	120	60	45
RESOURCES (US\$ THOUSAND)					
Budget 2008–2009	Proposed budget 2010–2011		Estimates 2012–2013		
32 664	29 200		43 000		
JUSTIFICATION					
<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

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

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

ISSUES AND CHALLENGES

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

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

Lessons learnt

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

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

Technical knowledge and programme experience indicate that effective interventions exist for most of the health problems covered by this strategic objective and that basic interventions are feasible and affordable even in resource-constrained settings. The Health Assembly set out agreed actions in 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, overstretched and under-resourced. Scaling-up implies the strengthening of a health system that maintains a suitable infrastructure, provides a reliable supply of essential medicines and commodities, operates functional referral systems, and retains competent and well-motivated health workers.

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

- 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

<p>4.1 Support provided to Member States to formulate a comprehensive policy, plan and strategy for scaling up towards universal access to effective interventions in collaboration with other programmes, paying attention to reducing gender inequality and health inequities, providing a continuum of care throughout the life course, integrating service delivery across different levels of the health system and strengthening coordination with civil society and the private sector.</p>	INDICATORS		
	<p>4.1.1 Number of targeted <u>Member States</u> that have an integrated policy on universal access to effective interventions for improving maternal, newborn and child health</p>		<p>4.1.2 Number of <u>Member States</u> that have developed, with WHO support, a policy on <u>achieving</u> universal access to sexual and reproductive health</p>
	BASELINE 2008		
	10		20
	TARGETS TO BE ACHIEVED BY 2009		
	20		30
	TARGETS TO BE ACHIEVED BY 2011		
	<u>40</u>		<u>40</u>
	TARGETS TO BE ACHIEVED BY 2013		
	68		50
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009		Proposed budget 2010–2011	Estimates 2012–2013
36 032		38 100	75 000
JUSTIFICATION			
<p><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></p>			

<p>4.2 National research capacity strengthened as necessary and new evidence, products, technologies, interventions and delivery approaches of global and/or national relevance available to improve maternal, newborn, child and adolescent health, to promote active and healthy ageing, and to improve sexual and reproductive health.</p>	INDICATORS			
	<p>4.2.1 Number of research centres <u>that have received an initial grant for</u> comprehensive institutional development and support</p>		<p>4.2.2 Number of completed studies on priority issues that <u>have been supported by WHO</u></p>	<p>4.2.3 Number of new or updated systematic reviews on best practices, policies and standards of care for <u>improving maternal, newborn, child and adolescent health, promoting active and healthy ageing or improving sexual and reproductive health</u></p>
	BASELINE 2008			
	None		None	None
	TARGETS TO BE ACHIEVED BY 2009			
	8		16	20
	TARGETS TO BE ACHIEVED BY 2011			
<u>16</u>		<u>32</u>	<u>40</u>	

TARGETS TO BE ACHIEVED BY 2013		
24	48	60
RESOURCES (US\$ THOUSAND)		
Budget 2008–2009 72 497	<u>Proposed budget</u> 2010–2011 68 300	Estimates 2012–2013 80 000
JUSTIFICATION		
<p><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></p>		

<p>4.3 Guidelines, approaches and tools for improving maternal care applied at the country level, including technical support provided to Member States for intensified action to ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods, particularly for poor and disadvantaged populations, with progress monitored.</p>	INDICATORS	
	4.3.1 <u>Number of Member States implementing strategies for increasing coverage with skilled care for childbirth</u>	
	BASELINE 2008	
	10	
	TARGETS TO BE ACHIEVED BY 2009	
	25	
	TARGETS TO BE ACHIEVED BY 2011	
	<u>50</u>	
	TARGETS TO BE ACHIEVED BY 2013	
	75	
RESOURCES (US\$ THOUSAND)		
Budget 2008–2009 65 389	<u>Proposed budget</u> 2010–2011 70 800	Estimates 2012–2013 130 000
JUSTIFICATION		
<p><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></p>		

<p>4.4 Guidelines, approaches and tools for improving neonatal survival and health applied at country level, with technical support provided to Member States for intensified action towards universal coverage, effective interventions and monitoring of progress.</p>	INDICATORS	
	4.4.1 <u>Number of Member States implementing strategies for increasing coverage with interventions for neonatal survival and health</u>	
	BASELINE 2008	
	20	
	TARGETS TO BE ACHIEVED BY 2009	
	40	
	TARGETS TO BE ACHIEVED BY 2011	
	<u>55</u>	
	RESOURCES (US\$ THOUSAND)	
	Budget 2008–2009 65 389	<u>Proposed budget</u> 2010–2011 70 800
JUSTIFICATION		
<p><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></p>		

MEDIUM-TERM STRATEGIC PLAN 2008–2013 (AMENDED)

TARGETS TO BE ACHIEVED BY 2013		
75		
RESOURCES (US\$ THOUSAND)		
Budget 2008–2009	<u>Proposed budget</u> 2010–2011	Estimates 2012–2013
50 790	31.3	115 000
JUSTIFICATION		
<p><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></p>		

<p>4.5 Guidelines, approaches and tools for improving child health and development applied at the country level, with technical support provided to Member States for intensified action towards universal coverage of the population with effective interventions and for monitoring progress, taking into consideration international and human-rights norms and standards, notably those stipulated in the Convention on the Rights of the Child.</p>	INDICATORS	
	<p>4.5.1 Number of <u>Member States</u> implementing strategies for increasing coverage with child health and development interventions</p>	<p>4.5.2 Number of <u>Member States</u> that have expanded coverage of the integrated management of childhood illness to more than 75% of target districts</p>
	BASELINE 2008	
	20	10
	TARGETS TO BE ACHIEVED BY 2009	
	40	30
	TARGETS TO BE ACHIEVED BY 2011	
	40	45
	TARGETS TO BE ACHIEVED BY 2013	
	75	60
RESOURCES (US\$ THOUSAND)		
Budget 2008–2009	<u>Proposed budget</u> 2010–2011	Estimates 2012–2013
41 776	58 400	93 000
JUSTIFICATION		
<p><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></p>		

<p>4.6 Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, and for the scaling up of a package of prevention,</p>	INDICATORS	
	<p>4.6.1 Number of <u>Member States</u> with a functioning adolescent health and development programme¹</p>	
	BASELINE 2008	
	30	
	TARGETS TO BE ACHIEVED BY 2009	
	50	
TARGETS TO BE ACHIEVED BY 2011		
75		

treatment and care interventions in accordance with established standards.	TARGETS TO BE ACHIEVED BY 2013		
	100		
	RESOURCES (US\$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	34 632	31 200	74 000
	JUSTIFICATION		
<p><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></p>			

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

4.7 Guidelines, approaches and tools made available, with provision of technical support to Member States for accelerated action towards implementing the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health, with particular emphasis on ensuring equitable access to good-quality sexual and reproductive health services, particularly in areas of unmet need, and with respect for human rights as they relate to sexual and reproductive health.	INDICATORS		
	4.7.1 Number of <u>Member States</u> implementing the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health <u>agreed at the 1994 International Conference on Population and Development (ICPD), its five-year review (ICPD+5), the Millennium Summit and the United Nations General Assembly in 2007</u>	4.7.2 Number of targeted <u>Member States</u> having reviewed their existing national laws, regulations or policies relating to sexual and reproductive health	
	BASELINE 2008		
	20	3	
	TARGETS TO BE ACHIEVED BY 2009		
	30	8	
	TARGETS TO BE ACHIEVED BY 2011		
	40	12	
	TARGETS TO BE ACHIEVED BY 2013		
	50	15	
	RESOURCES (US\$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
48 064	48 300	113 000	
JUSTIFICATION			
<p><i>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.</i></p>			

<p>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.</p>	INDICATORS		
	4.8.1 Number of Member States with a functioning active healthy ageing programme consistent with WHA58.16 “Strengthening active and healthy ageing”		
	BASELINE 2008		
	None		
	TARGETS TO BE ACHIEVED BY 2009		
	15		
	TARGETS TO BE ACHIEVED BY 2011		
	20		
	TARGETS TO BE ACHIEVED BY 2013		
	25		
	RESOURCES (US\$ THOUSAND)		
Budget 2008–2009		Proposed budget 2010–2011	Estimates 2012–2013
10 653		7 800	22 000
JUSTIFICATION			
<p><i>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”.</i></p>			

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

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

STRATEGIC APPROACHES

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

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

Lessons learnt

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

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

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

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

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

The Secretariat will focus on:

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

ORGANIZATION-WIDE EXPECTED RESULTS

<p>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.</p>	INDICATORS		
	<p>5.1.1 Proportion of <u>Member States</u> with national emergency preparedness plans that cover multiple hazards</p>	<p>5.1.2 Number of <u>Member States</u> implementing programmes for reducing the vulnerability of <u>health facilities to the effects of natural disasters</u></p>	
	BASELINE 2008		
	25%	20	
	TARGETS TO BE ACHIEVED BY 2009		
	60%	40	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	70%	60	
	RESOURCES (US\$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
45 614	49 900	51 000	
JUSTIFICATION			
<i>Efforts will be intensified in the biennium 2010–2011 and again in the biennium 2012–2013.</i>			

<p>5.2 Norms and standards developed and capacity built to <u>enable Member States to provide</u> timely response to disasters associated with natural hazards and conflict-related crises.</p>	INDICATORS		
	<p>5.2.1 <u>Operational platforms for surge capacity in place in regions and headquarters ready to be activated in acute-onset emergencies</u></p>	<p>5.2.2 Number of global and regional training programmes on <u>public health operations</u> in emergency response</p>	
	BASELINE 2008		
	50%	5	
	TARGETS TO BE ACHIEVED BY 2009		
	100%	16	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	100%	20	
	RESOURCES (US\$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
67 796	18 500	74 000	
JUSTIFICATION			
<i>Efforts will be intensified in the biennium 2010–2011 and again in the biennium 2012–2013.</i>			

MEDIUM-TERM STRATEGIC PLAN 2008–2013 (AMENDED)

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

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

<p>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.</p>	INDICATORS		
	<p>5.5.1 Proportion of <u>Member States</u> with national plans for preparedness, and alert and response activities in respect of chemical, radiological and environmental health emergencies</p>		<p>5.5.2 Number of <u>Member States</u> with focal points for the International Food Safety Authorities Network and for <u>the environmental health emergencies network</u></p>
	BASELINE 2008		
	30%	50	
	TARGETS TO BE ACHIEVED BY 2009		
	60%	75	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	70%	100	
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	<u>Proposed budget</u> 2010–2011	Estimates 2012–2013	
19 190	11 500	18 000	
JUSTIFICATION			
<p><i>Efforts will be intensified in the biennium 2010–2011 and again in the biennium 2012–2013.</i></p>			

<p>5.6 Effective communications issued, partnerships formed and coordination developed with other organizations in the United Nations system, governments, local and international nongovernmental organizations, academic institutions and professional associations at the country, regional and global levels.</p>	INDICATORS		
	<p>5.6.1 Proportion of <u>Member States affected by acute-onset emergencies and those with ongoing emergencies and a humanitarian coordinator in which the Inter-Agency Standing Committee Humanitarian Health Cluster is operational in line with IASC cluster standards in line with IASC cluster standards</u></p>		<p>5.6.2 Proportion of <u>Member States with ongoing emergencies and a humanitarian coordinator having a sustainable WHO technical presence covering emergency preparedness, response and recovery</u></p>
	BASELINE 2008		
	30%	30%	
	TARGETS TO BE ACHIEVED BY 2009		
	60%	60%	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	100%	90%	
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	<u>Proposed budget</u> 2010–2011	Estimates 2012–2013	
16 400	13 700	17 000	
JUSTIFICATION			
<p><i>Efforts will be intensified in the biennium 2010–2011 and again in the biennium 2012–2013.</i></p>			

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

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

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

Lessons learnt

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

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

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

WHO's Global Strategy on Diet, Physical Activity and Health, endorsed by Member States in 2004², provides all stakeholders with recommendations and policy options for tackling risk factors related to unhealthy diets and physical inactivity. As many of the determinants of healthy diets and physical activity lie outside the health sector, a major challenge for WHO and stakeholders is to facilitate multisectoral actions in order to scale up implementation of the Global Strategy at country level.

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

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

Lessons learnt

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

The Secretariat will focus on:

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

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

² Resolution WHA57.17.

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

STRATEGIC APPROACHES

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

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

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

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

The Secretariat will focus on:

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

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

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

ORGANIZATION-WIDE EXPECTED RESULTS

<p>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.</p>	INDICATORS		
	<p>6.1.1 Number of Member States that have <u>evaluated and reported on at least one of the action areas and commitments of the Global Conferences on Health Promotion.</u></p>		<p>6.1.2 Number of cities that have implemented <u>healthy urbanization programmes aimed at reducing health inequities</u></p>
	BASELINE 2008		
	24		6
	TARGETS TO BE ACHIEVED BY 2009		
	30		12
	TARGETS TO BE ACHIEVED BY 2011		
	42		24
	TARGETS TO BE ACHIEVED BY 2013		
	52		48
	RESOURCES (US\$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	38 879	60 900	66 000
JUSTIFICATION			
<p><i>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.</i></p>			

<p>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.</p>	INDICATORS		
	<p>6.2.1 Number of Member States with a <u>functioning national surveillance system for monitoring major risk factors to health among adults based on the WHO STEPwise approach to surveillance</u></p>		<p>6.2.2 Number of Member States with a <u>functioning national surveillance system for monitoring major risk factors to health among youth based on the Global school-based student health survey methodology</u></p>
	BASELINE 2008		
	25		25
	TARGETS TO BE ACHIEVED BY 2009		
	50		50
	TARGETS TO BE ACHIEVED BY 2011		
	60		60
	TARGETS TO BE ACHIEVED BY 2013		
	75		75
	RESOURCES (US\$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	23 807	14 600	31 000

MEDIUM-TERM STRATEGIC PLAN 2008–2013 (AMENDED)

	<p>JUSTIFICATION</p> <p><i>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.</i></p>
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<p>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.</p>	INDICATORS		
	<p>6.3.1 <u>Number of Member States having comparable adult tobacco prevalence data available from recent national representative surveys, such as the Global Adult Tobacco Survey (GATS) or STEPS</u></p>	<p>6.3.2 <u>Number of Member States with smoke-free legislation covering all legislative elements, types of places and institutions as defined in the WHO Report on the Global Tobacco Epidemic, 2008</u></p>	<p>6.3.3 <u>Number of Member States with bans on tobacco advertising, promotion and sponsorship as defined in the WHO Report on the Global Tobacco Epidemic, 2008</u></p>
	BASELINE 2008		
	44	16	20
	TARGETS TO BE ACHIEVED BY 2009		
	50	18	23
	TARGETS TO BE ACHIEVED BY 2011		
	<u>65</u>	<u>22</u>	<u>30</u>
	TARGETS TO BE ACHIEVED BY 2013		
	75	26	40
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
38 466	55 200	72 000	
JUSTIFICATION			
<p><i>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.</i></p>			

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

institutions in order to combat or prevent the public health problems concerned.	TARGETS TO BE ACHIEVED BY 2013		
	60	15	
	RESOURCES (US\$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	20 978	17 100	33 000
	JUSTIFICATION		
<p><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></p>			

6.5 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed and technical support provided to Member States with a high or increasing burden of disease or death associated with unhealthy diets and physical inactivity, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.	INDICATORS		
	6.5.1 <u>Number of Member States that have adopted multisectoral strategies and plans for healthy diets or physical activity, based on the WHO Global Strategy on Diet, Physical Activity and Health</u>	6.5.2 <u>Number of WHO technical tools that provide support to Member States in promoting healthy diets or physical activity</u>	
	BASELINE 2008		
	29	9	
	TARGETS TO BE ACHIEVED BY 2009		
	50	14	
	TARGETS TO BE ACHIEVED BY 2011		
	65	16	
	TARGETS TO BE ACHIEVED BY 2013		
	75	18	
	RESOURCES (US\$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
20 347	15 300	31 000	
JUSTIFICATION			
<p><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></p>			

MEDIUM-TERM STRATEGIC PLAN 2008–2013 (AMENDED)

6.6 Evidence-based and ethical policies, strategies, interventions, recommendations, standards and guidelines developed and technical support provided to Member States to promote safer sex and strengthen institutions in order to tackle and manage the social and individual consequences of unsafe sex.	INDICATORS		
	6.6.1 <u>Number of Member States generating evidence on the determinants or consequences of unsafe sex</u>		6.6.2 <u>Number of Member States generating comparable data on unsafe sex indicators using WHO STEPS surveillance tools</u>
	BASELINE 2008		
	4		0
	TARGETS TO BE ACHIEVED BY 2009		
	8		2
	TARGETS TO BE ACHIEVED BY 2011		
	10		5
	TARGETS TO BE ACHIEVED BY 2013		
	12		8
	RESOURCES (US\$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	18 580	14 000	30 000
JUSTIFICATION			
<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).

ISSUES AND CHALLENGES

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

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

Lessons learnt

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

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

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

STRATEGIC APPROACHES

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

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

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

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

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, including by devising common terminology, tools and advocacy materials; enlarging the knowledge base and implementation capacity; and ensuring coherent strategies;
- using the recommendations of the Commission on Social Determinants of Health to support policy action on the underlying causes of health inequities such as social exclusion, lack of educational and work opportunities as well as inequalities based on gender, age, disability, or ethnicity.

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

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 WHO regions with a regional strategy for addressing social and economic determinants of health as identified in the Report of the Commission on the Social Determinants of Health endorsed by the Director-General		
	BASELINE 2008		
	2		
	TARGETS TO BE ACHIEVED BY 2009		
	5		
	TARGETS TO BE ACHIEVED BY 2011		
	6		
TARGETS TO BE ACHIEVED BY 2013			
6			
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009		Proposed budget 2010–2011	Estimates 2012–2013
17 814		17 500	23 100

MEDIUM-TERM STRATEGIC PLAN 2008–2013 (AMENDED)

	JUSTIFICATION
	<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>

7.2 Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels to address social and economic determinants of health, including <u>understanding and acting upon the public health implications of trade and trade agreements</u> , and to encourage poverty-reduction and sustainable development.	INDICATORS		
	7.2.1 <u>Number of published country experiences on tackling social determinants for health equity</u>	7.2.2 <u>Number of tools to support countries in analysing the implications of trade and trade agreements for health.</u>	
	BASELINE 2008		
	2	7	
	TARGETS TO BE ACHIEVED BY 2009		
	10	7	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	38	10	
	RESOURCES (US\$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
16 499	21 900	21 400	
JUSTIFICATION			
<i>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.</i>			

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 <u>Number of country reports published during the biennium incorporating disaggregated data and analysis of health equity</u>		
	BASELINE 2008		
	25		
	TARGETS TO BE ACHIEVED BY 2009		
	35		
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	60		
	RESOURCES (US\$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
13 410	11 800	17 500	
JUSTIFICATION			
<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 <u>Number of tools produced for Member States or the Secretariat giving guidance on using a human rights-based approach to advance health</u>		7.4.2 <u>Number of tools produced for Member States or the Secretariat giving guidance on use of ethical analysis to improve health policies</u>
	BASELINE 2008		
	20		8
	TARGETS TO BE ACHIEVED BY 2009		
	28		12
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	45		20
	RESOURCES (US\$ THOUSAND)		
	Budget 2008–2009	<u>Proposed budget 2010–2011</u>	Estimates 2012–2013
	7 423	8 800	9 700
JUSTIFICATION			
<i>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.</i>			

7.5 Gender analysis and responsive actions incorporated into WHO's normative work and support provided to Member States for formulation of <u>gender-responsive</u> policies and programmes.	INDICATORS		
	7.5.1 <u>Number of WHO norms and standards developed or updated that are gender responsive</u>		7.5.2 <u>Number of Member States supported by WHO that have conducted one or more gender-mainstreaming activities in health programmes</u>
	BASELINE 2008		
	38		83
	TARGETS TO BE ACHIEVED BY 2009		
	54		107
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	74		155
	RESOURCES (US\$ THOUSAND)		
	Budget 2008–2009	<u>Proposed budget 2010–2011</u>	Estimates 2012–2013
	10 759	11 900	13 900
JUSTIFICATION			
<i>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.</i>			

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

Lessons learnt

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

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

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

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

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

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

STRATEGIC APPROACHES

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

Lessons learnt

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

The Secretariat will focus on:

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

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

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

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie the achievement of this strategic objective:

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

The Secretariat will focus on:

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

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

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

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

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

ORGANIZATION-WIDE EXPECTED RESULTS

8.1 Evidence-based assessments made, and norms and standards formulated and updated on major environmental hazards to health (e.g., poor air quality, chemical substances, electromagnetic fields, radon, poor-quality drinking-water and waste-water reuse)	INDICATORS		
	8.1.1 <u>Number of Member States that have conducted assessments of specific environmental threats to health or have quantified the environmental burden of disease with WHO technical support during the biennium</u>		8.1.2 <u>Number of new or updated WHO norms, standards or guidelines on occupational or environmental health issues published during the biennium</u>
	BASELINE 2008		
	TARGETS TO BE ACHIEVED BY 2009		5
			10
	TARGETS TO BE ACHIEVED BY 2011		
			<u>12 per year</u>
	TARGETS TO BE ACHIEVED BY 2013		
			15
	RESOURCES (US\$ THOUSAND)		
	Budget 2008–2009	<u>Proposed budget</u> 2010–2011	Estimates 2012–2013
	32 960	38 100	35 000
JUSTIFICATION			
<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>			

8.2 Technical support and guidance provided to Member States for the implementation of primary prevention interventions that reduce environmental hazards to health, enhance safety and promote public health, including in specific settings	INDICATORS		
	8.2.1 <u>Number of Member States implementing primary prevention interventions for reducing environmental risks to health, with WHO technical support, in at least one of the following settings: workplaces, homes or urban settings</u>		
	BASELINE 2008		
	TARGETS TO BE ACHIEVED BY 2009		
	TARGETS TO BE ACHIEVED BY 2011		

(e.g. workplaces, homes or urban settings) and among vulnerable population groups (e.g. children)	TARGETS TO BE ACHIEVED BY 2013		
	RESOURCES (US\$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	35 208	30 800	29 000
JUSTIFICATION			
<p><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></p>			

8.3 Technical assistance and support provided to Member States for strengthening national occupational and environmental health risk management systems, functions and services	INDICATORS		
	8.3.1 <u>Number of Member States that have implemented national action plans/policies for the management of occupational health risks, such as in relation to the Global Plan of Action on Workers' Health (2008–2017), with support from WHO</u>		
	BASELINE 2008		
	TARGETS TO BE ACHIEVED BY 2009		
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
21 224	19 800	33 000	
JUSTIFICATION			
<p><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></p>			

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

MEDIUM-TERM STRATEGIC PLAN 2008–2013 (AMENDED)

TARGETS TO BE ACHIEVED BY 2013		
RESOURCES (US\$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
21 000	14 900	32 000
JUSTIFICATION		
<p><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></p>		

<p>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 <u>development on environmental health and altered patterns of consumption</u> and production and to the damaging effect of evolving technologies</p>	INDICATORS		
	<p>8.5.1 <u>Number of studies or reports on new and re-emerging occupational and environmental health issues published or co-published by WHO</u></p>	<p>8.5.2 <u>Number of reports published or jointly published by WHO on progress made in achieving water and sanitation objectives of major international development frameworks, such as the Millennium Development Goals</u></p>	<p>8.5.3 <u>Number of high-level regional forums on environment and health issues organized or technically supported by WHO biennially</u></p>
	BASELINE 2008		
			3
	TARGETS TO BE ACHIEVED BY 2009		
			5
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
			6
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
20 064	19 000	23 000	
JUSTIFICATION			
<p><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</i></p>			

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

8.6 Evidence-based policies, strategies and recommendations developed, and technical support provided to Member States for identifying, preventing and tackling public health problems resulting from climate change	INDICATORS		
	8.6.1 <u>Number of studies or reports on the public health effects of climate change published or co- published by WHO</u>		8.6.2 <u>Number of countries that have implemented plans to enable the health sector to adapt to the health effects of climate change</u>
	BASELINE 2008		
	TARGETS TO BE ACHIEVED BY 2009		
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	<u>Proposed budget 2010–2011</u>	Estimates 2012–2013	
	24 100		
JUSTIFICATION			

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

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

Lessons learnt

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

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

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

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

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

STRATEGIC APPROACHES

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

The Secretariat will focus on:

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

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

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

ORGANIZATION-WIDE EXPECTED RESULTS

<p>9.1 Partnerships and alliances formed, leadership built and coordination and networking developed with all stakeholders at country, regional and global levels, in order to promote advocacy and communication, stimulate intersectoral actions, increase investment in nutrition, food-safety and food-security interventions, and develop and support a research agenda.</p>	INDICATORS		
	<p>9.1.1 Number of Member States that have <u>functional institutionalized coordination mechanisms to promote intersectoral approaches and actions in the area of food safety, food security or nutrition</u></p>	<p>9.1.2 Number of Member States that have included nutrition, food-safety and food-security activities <u>and a mechanism for their financing</u> in their sector-wide approaches or Poverty Reduction Strategy Papers</p>	
	BASELINE 2008		
	30	44	
	TARGETS TO BE ACHIEVED BY 2009		
	60	60	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	80	80	
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
16 975	20 900	10 000	
JUSTIFICATION			
<p><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></p>			

<p>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.</p>	INDICATORS		
	<p>9.2.1 Number of new nutrition and food-safety standards, guidelines or training manuals produced and disseminated to <u>Member States</u> and the international community</p>	<p>9.2.2 Number of new norms, standards, guidelines, tools and training materials for prevention and management of zoonotic and non-zoonotic foodborne diseases</p>	
	BASELINE 2008		
	None	None	
	TARGETS TO BE ACHIEVED BY 2009		
	15	3	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	50	10	
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
30 031	28 500	30 000	

MEDIUM-TERM STRATEGIC PLAN 2008–2013 (AMENDED)

	<p>JUSTIFICATION</p> <p><i>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.</i></p>
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<p>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.</p>	INDICATORS		
	9.3.1 Number of <u>Member States</u> that have adopted and implemented the WHO Child Growth Standards		9.3.2 Number of <u>Member States</u> that have nationally representative surveillance data on major forms of malnutrition
	BASELINE 2008		
	20		90
	TARGETS TO BE ACHIEVED BY 2009		
	50		100
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	100		150
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
18 509	16 700	15 000	
JUSTIFICATION			
<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>			

<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.</p>	INDICATORS					
	9.4.1 <u>Number of Member States that have implemented at least three high-priority actions recommended in the Global Strategy for Infant and Young Child Feeding</u>	9.4.2 Number of Member States that have implemented strategies to prevent and control micronutrient malnutrition	9.4.3 <u>Number of Member States that have implemented strategies to promote healthy dietary practices for preventing diet-related chronic diseases</u>	9.4.4 <u>Number of Member States that have included nutrition in their responses to HIV/AIDS</u>	9.4.5 <u>Number of Member States that have national preparedness and response plans for nutritional emergencies</u>	
	BASELINE 2008					
	60	40	40	65	30	
	TARGETS TO BE ACHIEVED BY 2009					
	90	70	70	65	45	
	TARGETS TO BE ACHIEVED BY 2011					
	TARGETS TO BE ACHIEVED BY 2013					
	120	80	80	80	70	
	RESOURCES (US\$ THOUSAND)					
	Budget 2008–2009		Proposed budget 2010–2011		Estimates 2012–2013	
	24 314		21 800		40 000	
JUSTIFICATION						
<p><i>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.</i></p>						

<p>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.</p>	INDICATORS		
	9.5.1 Number of Member States that have established or strengthened intersectoral collaboration for the prevention, control and surveillance of foodborne zoonotic diseases	9.5.2 Number of Member States that have initiated a <u>plan for the reduction in the incidence</u> of at least one major foodborne zoonotic disease	
	BASELINE 2008		
	20	50	
	TARGETS TO BE ACHIEVED BY 2009		
	20	50	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	40	70	
	RESOURCES (US\$ THOUSAND)		
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	17 032	14 800	30 000

MEDIUM-TERM STRATEGIC PLAN 2008–2013 (AMENDED)

	<p>JUSTIFICATION</p> <p><i>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.</i></p>
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<p>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.</p>	INDICATORS		
	9.6.1 Number of selected <u>Member States</u> 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 <u>Member States</u> that have built national systems for food safety with international links to emergency systems	
	BASELINE 2008		
	90	30	
	TARGETS TO BE ACHIEVED BY 2009		
	90	30	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	110	80	
	RESOURCES (US\$ THOUSAND)		
	Budget 2008–2009	<u>Proposed budget</u> 2010–2011	Estimates 2012–2013
	20 073	16 200	30 000
JUSTIFICATION			
<p><i>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.</i></p>			

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

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

Lessons learnt

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

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

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

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

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

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

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

Lessons learnt

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

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

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

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

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

STRATEGIC APPROACHES

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

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

Lessons learnt

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

The Secretariat will focus on:

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

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

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

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

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

The Secretariat will focus on:

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

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

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

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

The Secretariat will focus on:

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

ORGANIZATION-WIDE EXPECTED RESULTS

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

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

TARGETS TO BE ACHIEVED BY 2009			
Significant improvement compared to 2007-2008 country-specific baseline in at least 10%			
TARGETS TO BE ACHIEVED BY 2011			
TARGETS TO BE ACHIEVED BY 2013			
Significant improvement compared to country-specific baseline in 50%			
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
87 484	55 100	108 000	
JUSTIFICATION			
<p><i>The measures that need to be taken to improve the way in which national health systems are governed, steered and regulated are in essence country specific, but have to be informed by evidence, based on enhanced institutional capacities, and should result in improved policy formulation, for which appropriate accountability mechanisms are in place. Progress needs to be assessed objectively, using country- or region-specific benchmarks, and should cover key policy and strategy issues, with a focus on the articulation of service-delivery mechanisms, essential public-health functions, and policies governing pharmaceuticals, technologies, infrastructure development, human-resources, financing, and coordination of the contributions of all major stakeholders in the health sector.</i></p> <p><i>Improving capacities and practices will require systematic collaborative policy reviews that serve to build the evidence bases, create tools, determine benchmarks and norms, and incorporate them in the work of national institutions. The scope of capacity building is likely to expand over time as problems and their solutions are increasingly identified and documented. As WHO's own capacity increases, particularly at regional and country levels, demand for support is expected to grow and the level of support would have to increase accordingly.</i></p>			

10.3 Coordination of the various mechanisms (including donor assistance) that provide support to Member States in their efforts to achieve national targets for health-system development and global health goals improved.	INDICATORS		
	10.3.1 Number of Member states where the inputs of major stakeholders are harmonized with national policies, measured in line with the Paris Declaration on Aid Effectiveness		
	BASELINE 2008		
	To be established		
	TARGETS TO BE ACHIEVED BY 2009		
	Increase by 20% from 2008 baseline		
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	Increase by 30% from 2008 baseline		
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
15 801	14 700	17 000	

MEDIUM-TERM STRATEGIC PLAN 2008–2013 (AMENDED)

	<p>JUSTIFICATION</p> <p><i>Few Member States have mechanisms for coordination, harmonization and alignment of donor and other inputs in the health sector. In order to accelerate progress towards achievement of the Millennium Development Goals, WHO will continue to provide support to governments in their efforts to lead effectively interactions with partners.</i></p>
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<p>10.4 Country health-information systems that provide and use high-quality and timely information for health planning and for monitoring progress towards national and major international goals strengthened.</p>	INDICATORS		
	10.4.1 Proportion of low- and middle-income countries with adequate health statistics <u>and monitoring of health-related Millennium Development Goals</u> that meet agreed standards		
	BASELINE 2008		
	30%		
	TARGETS TO BE ACHIEVED BY 2009		
	35%		
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	66%		
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009		Proposed budget 2010–2011	Estimates 2012–2013
34 352		34 500	58 000
JUSTIFICATION			
<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, more resources have become available in 2006-2007. It is expected that growth will continue modestly beyond 2010 because strengthening health-information systems in countries will take many years, especially for some neglected areas such as vital registration systems.</i>			

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

TARGETS TO BE ACHIEVED BY 2013		
Over 90%	45	Mechanisms operating at global and all regional levels
RESOURCES (US\$ THOUSAND)		
Budget 2008–2009	<u>Programme budget</u> 2010–2011	Estimates 2012–2013
36 484	44 400	38 000
JUSTIFICATION		
<p><i>WHO's contribution to better knowledge and evidence for health decision-making will expand modestly, maintaining and strengthening WHO's position as a world and regional leader in monitoring the health situation. The continuation of the Organization's normative work on classifications in a new era of information technology is expected to lead to a full revision in 2011 of the International Statistical Classification of Diseases and Related Health Problems. A moderate increase in budget is expected in order to meet the demand for WHO's work in this area.</i></p>		

10.6 National health research for development of health systems strengthened in the context of regional and international research and engagement of civil society.	INDICATORS		
	10.6.1 Proportion of low- and middle-income countries in which national health-research systems meet internationally agreed <u>minimum standards</u>	10.6.2 Number of <u>Member states</u> complying with the recommendation to dedicate at least 2% of their health budget to research (Commission on Health Research for Development, 1990)	
	BASELINE 2008		
	10%-15% (to be refined)	Less than 25% (to be refined)	
	TARGETS TO BE ACHIEVED BY 2009		
	25%	10% increase from baseline 2008	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	50%	25% increase from baseline 2008	
	RESOURCES (US\$ THOUSAND)		
Budget 2008–2009	<u>Proposed budget</u> 2010–2011	Estimates 2012–2013	
21 088	20 000	38 000	
JUSTIFICATION			
<p><i>In view of the current situation in many Member States and globally, overcoming the limitations of national health research for health-system development will be a gradual and long-term process. An increasing number of Member States should become involved during the next decade. The Alliance for Health Policy and Systems Research will play an important role in generating and channelling resources to finance high-priority health-systems research.</i></p>			

10.7 Knowledge management and eHealth policies and strategies developed and implemented in order to strengthen health systems.	INDICATORS		
	10.7.1 Number of <u>Member states</u> adopting knowledge management policies in order to bridge the “know-how” gap particularly aimed to decrease the digital divide	10.7.2 Number of <u>Member states</u> with access to <u>electronic international scientific journals</u> and knowledge archives in health sciences as assessed by the WHO Global Observatory for eHealth biannual survey	10.7.3 Proportion of <u>Member states</u> with eHealth policies, strategies and regulatory frameworks as assessed by the WHO Global Observatory for eHealth biannual survey

MEDIUM-TERM STRATEGIC PLAN 2008–2013 (AMENDED)

BASELINE 2008		
15	60	15
TARGETS TO BE ACHIEVED BY 2009		
30	90	30
TARGETS TO BE ACHIEVED BY 2011		
TARGETS TO BE ACHIEVED BY 2013		
70	120	70
RESOURCES (US\$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Budget 2008–2009
39 064	27 400	39 064
JUSTIFICATION		
<p><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 in order to include and provide support to an increasing number of Member States.</i></p>		

10.8 Health-workforce information and knowledge base strengthened, and country capacities for policy analysis, planning, implementation, information-sharing and research built up	INDICATORS		
	10.8.1 <u>Number of countries reporting two or more national data points on human resources for health within the past five years, reported in the Global Atlas of the Health Workforce</u>	10.8.2 <u>Number of Member states with an national policy and planning unit for human resources for health</u>	
	BASELINE 2008		
	63	40	
	TARGETS TO BE ACHIEVED BY 2009		
	75	50	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	96	60	
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
76 216	46 400	67 000	
JUSTIFICATION			
<p><i>Availability of skilled health workers contributes to improved health outcomes, such as maternal, infant and child survival. Yet development of the health workforce cannot be dealt with in isolation. Dialogue between stakeholders and work across sectors are required in order to analyse human-resources constraints and to identify and implement effective solutions. The knowledge base in human resources for health needs to be further developed. Data and information needs to be collected and analysed in order to determine appropriate indicators with which to monitor global and regional situations and trends in the health workforce. Research needs to be supported and further stimulated in order to expand knowledge and to identify and promote best practices in health-workforce development. These efforts should eventually be reflected in increased capacity of countries to promote health-workforce development, assure political commitment, and create an environment that enables formulation of national policies and plans and pursuit of their implementation, in order to reduce shortages and redress the maldistribution of health workers. Capacity of WHO at all levels needs to be strengthened in order to provide support for health-workforce development in countries.</i></p>			

10.9 Technical support provided to Member States, with a focus on those facing severe health-workforce difficulties in order to improve the production, distribution, skill mix and retention of the health workforce.	INDICATORS		
	10.9.1 <u>Proportion of 57 countries with critical shortage of health workforce, as identified in <i>The world health report 2006</i> with a multi-year HRH plan</u>	10.9.2 <u>Proportion of 57 countries with critical shortage of health workforce, as identified in <i>The world health report 2006</i> which have an investment plan for scaling up training and education of health workers</u>	
	BASELINE 2008		
	Less than 10%	Less than 10%	
	TARGETS TO BE ACHIEVED BY 2009		
	At least 10%	At least 10%	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	At least 50%	At least 50%	
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	<u>Proposed budget 2010–2011</u>	Estimates 2012–2013	
40 041	66 500	62 000	
JUSTIFICATION			
<i>Resolutions WHA59.23 and WHA59.27 called for a rapid scaling up of health-workforce production and a further strengthening of nursing and midwifery in order to respond to the global crisis of human resources for health. Shortages and imbalances in the health workforce are at a critical level in 57 countries. National institutions need to be strengthened in order to improve production capacity and quality of education and training of the health workforce. Tools, guidelines and other technical support will be provided so as to ensure that countries can build their health workforce across the continuum of entry, working life and exit. Migration of health workers will be given special attention, and efforts to manage international migration will be renewed, in collaboration with global partners.</i>			

10.10 Evidence-based policy and technical support provided to Member States in order to improve health-system financing in terms of the availability of funds, social and financial-risk protection, equity, access to services and efficiency of resource use.	INDICATORS		
	10.10.1 Number of Member states provided with technical and policy support to raise additional funds for health; to reduce financial barriers to access, incidence of financial catastrophe, and impoverishment linked to health payments; <u>or</u> to improve social protection and the efficiency and equity of resource use	10.10.1 Number of key policy briefs prepared, disseminated and their use supported, which document best practices on revenue-raising, pooling and purchasing, including contracting, provision of interventions and services, and handling of fragmentation in systems associated with vertical programmes and inflow of international funds	
	BASELINE 2008		
	15	6 technical briefs for policy-makers	
	TARGETS TO BE ACHIEVED BY 2009		
	40	12 technical briefs	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	90	20 technical briefs	
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	<u>Proposed budget 2010–2011</u>	Estimates 2012–2013	
31 249	33 200	41 000	

	JUSTIFICATION		
	<i>Requests for support from Member States have substantially increased on ways to improve the efficiency and/or equity of their health-financing systems, and to extend financial-risk protection to vulnerable groups. Response requires the assessment and dissemination of experiences and best practices across settings. To meet the rising demand, a significant increase in resources is required for 2008–2009, with modest increases subsequently.</i>		
10.11 Norms, standards and measurement tools developed for tracking resources, estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe, impoverishment, and social exclusion, and their use supported and monitored.	INDICATORS		
	10.11.1 Key tools, norms and standards to guide policy development and implementation developed, disseminated and their use supported, according to expressed need, that comprise resource tracking and allocation, budgeting, financial management, economic consequences of disease and social exclusion, organization and efficiency of service delivery, including contracting, <u>or</u> the incidence of financial catastrophe and impoverishment	10.11.2 Number of Member states provided with technical support for using WHO tools to track and evaluate the adequacy and use of funds, to estimate future financial needs, to manage and monitor available funds, <u>or</u> to track the impact of financing policy on households	
	BASELINE 2008		
	Tools <u>produced and disseminated</u> on national health accounts, costing, financial catastrophe and impoverishment, cost-effectiveness, implications of health-insurance design, and contracting	15	
	TARGETS TO BE ACHIEVED BY 2009		
	Additional tools developed for resource tracking, additionally and economic burden; existing tools revised where necessary; framework drawn up for formulation of financing policy	30	
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	Tools and frameworks modified, updates and disseminated as necessary	50	
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	<u>Proposed budget 2010–2011</u>	Estimates 2012–2013	
23 896	18 500	28 000	
JUSTIFICATION			
<i>Demand is rising for WHO to provide norms or guidelines on methods to estimate the economic impact of illness, to track expenditures on particular diseases, or to identify and monitor households suffering financial catastrophe and impoverishment as a result of out-of-pocket payments for health services. In order to meet this demand capacity needs to be expanded substantially, together with the ability to provide support to policy-makers seeking to use the resulting norms and standards.</i>			

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

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

TARGETS TO BE ACHIEVED BY 2011		
TARGETS TO BE ACHIEVED BY 2013		
100% increase		
RESOURCES (US\$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
	34 500	
JUSTIFICATION		
<p><i><u>Patient safety has become a global health agenda. WHO will provide norms and guidelines to support member states in estimating and tracking the nature and the size of the problem. WHO will also provide evidence-based guidelines for improving safety in priority areas. The response of WHO needs to be comprehensive. The Secretariat and Member States must work together to improve safety and coordinate international expertise.</u></i></p>		

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

Lessons learnt

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

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

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

STRATEGIC APPROACHES

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

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

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

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

The Secretariat will focus on:

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

The following risks may hinder achievement of the strategic objective:

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

The Secretariat will focus on:

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

ORGANIZATION-WIDE EXPECTED RESULTS

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

MEDIUM-TERM STRATEGIC PLAN 2008–2013 (AMENDED)

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

JUSTIFICATION

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

11.2 International norms, standards and guidelines for the quality, safety, efficacy and cost-effective use of medical products and technologies developed and their national and/or regional implementation advocated and supported.	INDICATORS			
	11.2.1 Number of new or updated global quality standards, reference preparations, guidelines and tools for improving the provision, management, use, quality, or effective regulation of medical products and technologies	11.2.2 Number of assigned International Nonproprietary Names for medical products	11.2.3 Number of priority medicines, vaccines, diagnostic tools and items of equipment that are prequalified for United Nations procurement	11.2.4 Number of Member States for <u>which the functionality of the national regulatory authorities has been assessed or supported</u>
	BASELINE 2008			
	30 per biennium	8900	150	20
	TARGETS TO BE ACHIEVED BY 2009			
	30 additional	9100	250	30
	TARGETS TO BE ACHIEVED BY 2011			
	TARGETS TO BE ACHIEVED BY 2013			
	60 additional	9500	500	80
	RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013		
69 172	72 200	104 000		
JUSTIFICATION				
<p><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></p>				

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

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

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

Lessons learnt

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

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

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

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

STRATEGIC APPROACHES

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

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

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.

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of the strategic objective:

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

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

ORGANIZATION-WIDE EXPECTED RESULTS

12.1 Effective leadership and direction of the Organization exercised through enhancement of governance, and the coherence, accountability and synergy of WHO's work.	INDICATORS			
	12.1.1 <u>Proportion of documents submitted to governing bodies within constitutional deadlines in the six WHO official languages</u>	12.1.2 <u>Level of understanding by key stakeholders of WHO's role, priorities and key messages as provided by a stakeholder survey</u>		
	BASELINE 2008			
	50%	76% of stakeholders familiar/very familiar with WHO roles and priorities		
	TARGETS TO BE ACHIEVED BY 2009			
	75%	86% of stakeholders familiar/very familiar with WHO roles and priorities		
	TARGETS TO BE ACHIEVED BY 2011			
	TARGETS TO BE ACHIEVED BY 2013			
	90%	96% of stakeholders familiar/very familiar with WHO roles and priorities		
	RESOURCES (US\$ THOUSAND)			
	Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
87 222	156 900	108 128		
JUSTIFICATION				
<i>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.</i>				
12.2 Effective WHO country presence ¹ established to implement WHO country cooperation strategies that are aligned with Member States' health and development agendas, and harmonized with the United Nations country team and other development partners.	INDICATORS			
	12.2.1 <u>Number of Member States where WHO is aligning its country cooperation strategy with the country's priorities and development cycle and harmonizing its work with the United Nations and other development partners within relevant frameworks, such as the United Nations Development Assistance Framework, Poverty Reduction Strategy Papers and Sector-Wide Approaches</u>	12.2.2 <u>Proportion of WHO country offices which have reviewed and adjusted their core capacity in accordance with their country cooperation strategy</u>	12.2.3 <u>Proportion of country workplans that are consistent with their country cooperation strategy</u>	
	BASELINE 2008			
	40	20%		
	TARGETS TO BE ACHIEVED BY 2009			
	80	40%		
	TARGETS TO BE ACHIEVED BY 2011			

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

MEDIUM-TERM STRATEGIC PLAN 2008–2013 (AMENDED)

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

12.3 Global health and development mechanisms established to provide more sustained and predictable technical and financial resources for health on the basis of a common health agenda which responds to the health needs and priorities of Member States.	INDICATORS		
	<u>12.3.1 Number of health partnerships in which WHO participates that work according to the best practice principles for Global Health Partnerships</u>	<u>12.3.2 Proportion of health partnerships managed by WHO that comply with WHO partnership policy guidance</u>	<u>12.3.3 Proportion of countries where WHO is leading or actively engaged in health and development partnerships (formal and informal), including in the context of reforms of the United Nations system</u>
	BASELINE 2008		
	3	0%	Less than 20%
	TARGETS TO BE ACHIEVED BY 2009		
	10	14 %	Over 50%
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	50	100%	To be established by 2009
	RESOURCES (US\$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
21 030	33 800	26 058	
JUSTIFICATION			
<i>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.</i>			

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

TARGETS TO BE ACHIEVED BY 2013		
80 million/7 million	40 000	
RESOURCES (US\$ THOUSAND)		
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013
34 964	32 400	43 333
JUSTIFICATION		
<i>In line with WHO's work, the activities related to this Organization-wide expected result will slightly increase.</i>		

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

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

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

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

Lessons learnt

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

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

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

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

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

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

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

The Secretariat will focus on:

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

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

STRATEGIC APPROACHES

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of the strategic objective:

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

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

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

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

ORGANIZATION-WIDE EXPECTED RESULTS

13.1 Work of the Organization guided by strategic and operational plans that build on lessons learnt, reflect country needs, are elaborated across the Organization, and used to monitor performance and evaluate results.	INDICATORS		
	13.1.1 <u>Proportion of country workplans that have been peer reviewed with respect to their technical quality, that they incorporate lessons learnt and reflect country needs</u>		13.1.2 <u>Office Specific Expected Results (OSERs) for which progress status has been updated within the established timeframes for periodic reporting</u>
	BASELINE 2008		
	0%		60%
	TARGETS TO BE ACHIEVED BY 2009		
			80%
	TARGETS TO BE ACHIEVED BY 2011		
	30%		
	TARGETS TO BE ACHIEVED BY 2013		
	60%		90%
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
36 916	40 800	43 805	
JUSTIFICATION			
<p><i>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.</i></p>			

13.2 Sound financial practices and efficient management of financial resources achieved through continuous monitoring and mobilization of resources to ensure the alignment of resources with the programme budgets.	INDICATORS		
	13.2.1 Degree of compliance of WHO with International Public Sector Accounting Standards		13.2.2 <u>Proportion of voluntary contributions that are classified as “core voluntary contribution”</u>
	BASELINE 2008		
	Accounting Standards not implemented		
	TARGETS TO BE ACHIEVED BY 2009		
	International Public Sector Accounting Standards implemented		
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009	Proposed budget 2010–2011	Estimates 2012–2013	
60 654	67 800	72 538	
JUSTIFICATION			
<p><i>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.</i></p>			

13.3 Human resource policies and practices in place to attract and retain top talent, promote learning and professional development, manage performance, and foster ethical behaviour.	INDICATORS		
	13.3.1 Proportion of offices ¹ with approved human resources plans for a biennium	13.3.2 Number of staff assuming a new position or moving to a new location during a biennium (<u>delayed until 2010 - 2011 biennium</u>)	13.3.3 <u>Proportion of staff in compliance with the cycle of the Performance Management Development System</u>
	BASELINE 2008		
	40%		65%
	TARGETS TO BE ACHIEVED BY 2009		
	75%		75%
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	100%		95%
	RESOURCES (US\$ THOUSAND)		
	Budget 2008–2009	<u>Proposed budget 2010–2011</u>	Estimates 2012–2013
	29 630	37 000	35 549
JUSTIFICATION			
<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>			

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

13.4 Management strategies, policies and practices in place for information systems, that ensure reliable, secure and cost-effective solutions while meeting the changing needs of the Organization.	INDICATORS		
	13.4.1 Number of information technology disciplines ¹ implemented Organization-wide according to <u>to industry-best-practices benchmarks</u>	13.4.2 Proportion of offices using consistent real-time management information	
	BASELINE 2008		
	0		
	TARGETS TO BE ACHIEVED BY 2009		
	3		
	TARGETS TO BE ACHIEVED BY 2011		
	<u>5</u>		
	TARGETS TO BE ACHIEVED BY 2013		
	7		
	RESOURCES (US\$ THOUSAND)		
	Budget 2008–2009	<u>Proposed budget 2010–2011</u>	Estimates 2012–2013
	106 228	120 300	127 483
JUSTIFICATION			
<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>			

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

MEDIUM-TERM STRATEGIC PLAN 2008–2013 (AMENDED)

13.5 Managerial and administrative support services ¹ necessary for the efficient functioning of the Organization provided in accordance with service-level agreements that emphasize quality and responsiveness.	INDICATORS		
	13.5.1 Proportion of services delivered <u>by the global service centre</u> according to criteria in service-level agreements		
	BASELINE 2008		
	0%		
	TARGETS TO BE ACHIEVED BY 2009		
	75%		
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
	100%		
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009		Proposed budget 2010–2011	Estimates 2012–2013
149 647		130 100	179 217
JUSTIFICATION			
<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>			

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

13.6 Working environment conducive to the well-being and safety of staff in all locations.	INDICATORS		
	13.6.1 Proportion of planned projects <u>included in the Capital master plan completed for a given biennium</u>	13.6.2 Proportion of locations that <u>are compliant with Minimum Operating Safety Standards (MOSS)</u>	
	BASELINE 2008		
			65%
	TARGETS TO BE ACHIEVED BY 2009		
			75%
	TARGETS TO BE ACHIEVED BY 2011		
	TARGETS TO BE ACHIEVED BY 2013		
			95%
RESOURCES (US\$ THOUSAND)			
Budget 2008–2009		Proposed budget 2010–2011	Estimates 2012–2013
159 297		149 600	181 408
JUSTIFICATION			
<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>			