STRATEGIC OBJECTIVES

STRATEGIC OBJECTIVE 1

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

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

Lessons learnt

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

than 1000 epidemics of international concern over the past five years.

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

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

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

Lessons learnt

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

The Secretariat will focus on:

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

STRATEGIC APPROACHES

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

evidence-based policy decisions on public health interventions.

The Secretariat will focus on:

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

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

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

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

ORGANIZATION-WIDE EXPECTED RESULTS

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

INDICATORS			
1.1.1 Number of developing countries with at least 90% national vaccination coverage and at least 80% vaccination coverage in every administrative unit	**1.1.2** Number of developing countries supported to make decisions about appropriate changes and additions to the immunization schedule, including the introduction of new vaccines and/or new technologies	**1.1.3** Number of essential child-health interventions integrated with immunization for which guidelines on common programme management are available	**1.1.4** Number of countries that have established either legislation or a specified national budget line in order to ensure sustainable financing of immunization
BASELINE			
39 countries	25 countries	1 intervention	166 countries
TARGETS TO BE ACHIEVED BY 2009			
90/165 countries	60/165 countries	5 interventions	180/193 countries
TARGETS TO BE ACHIEVED BY 2013			
140/165 countries	117/165 countries	9 interventions	193/193 countries

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
153 584	166 000	181 000

JUSTIFICATION

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

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

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

	TARGETS TO BE ACHIEVED BY 2009			
	100% of 135 countries	75% of reports	About 1000 facilities	20 countries
	TARGETS TO BE ACHIEVED BY 2013			
	100% of 135 countries	All reports	<20 facilities	35 countries

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
262 615	260 000	240 000

JUSTIFICATION

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

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

INDICATORS			
1.3.1 Number of countries certified for eradication of dracunculiasis	**1.3.2** Number of countries that have eliminated leprosy at national and subnational levels	**1.3.3** Size of the target population at risk of lymphatic filariasis in endemic countries for mass drug administration or preventive chemotherapy	**1.3.4** Coverage of at-risk school-age children in disease-endemic countries with regular treatment against schistosomiasis and soil-transmitted helminthiases
BASELINE			
3 countries	6 countries	700 million	30% coverage
TARGETS TO BE ACHIEVED BY 2009			
10 countries	22 countries	900 million	56% coverage
TARGETS TO BE ACHIEVED BY 2013			
20 countries	24 countries	1200 million	75% coverage

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
131 669	170 000	185 000

JUSTIFICATION

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

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

INDICATORS

1.4.1 Percentage of countries with integrated surveillance of all communicable diseases of public health importance	**1.4.2** Number of countries receiving technical assistance from WHO to adapt generic surveillance and communicable disease-monitoring tools or protocols to specific country situations	**1.4.3** Percentage of countries for which joint reporting forms on immunization surveillance and monitoring are received on time at global level in accordance with established time-lines	**1.4.4** Percentage of countries supported by WHO to establish a system at district level to record, analyse and evaluate the quality and safety of vaccine/drug/ intervention delivery, including antimicrobial resistance and health-care associated infections
BASELINE			
30% of countries	40 countries	50% of countries	Not currently monitored
TARGETS TO BE ACHIEVED BY 2009			
50% of 193 countries	65 countries	75% of 193 countries	25% of 193 countries
TARGETS TO BE ACHIEVED BY 2013			
75% of 193 countries	117 countries	95% of 193 countries	75% of 193 countries

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
79 668	79 000	87 000

JUSTIFICATION

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

1.5 New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed and validated, with scientists from developing countries increasingly taking the lead in this research.

INDICATORS

1.5.1 Number of consensus reports published on global research needs and priorities for a disease or type of intervention	**1.5.2** Number of new and improved tools (e.g. medicines, vaccines or diagnostics) receiving internationally recognized approval for use	**1.5.3** Number of new and improved interventions and implementation strategies whose effectiveness has been determined and the evidence made available to appropriate institutions for policy decisions	**1.5.4** Proportion of peer-reviewed publications based on WHO-supported research where the main author's institution is in a developing country
BASELINE			
None	None	None	48% of publications
TARGETS TO BE ACHIEVED BY 2009			
3 reports	2 tools	3 interventions	55% of publications

TARGETS TO BE ACHIEVED BY 2013			
6 reports	6 tools	8 interventions	60% of publications

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
72 334	38 000	42 000

JUSTIFICATION

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

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

INDICATORS			
1.6.1 Number of countries that have completed the assessment or self-assessment of core capacities for surveillance and response, in line with their obligations under the International Health Regulations (2005)	**1.6.2** Number of countries supported by WHO to develop national plans of action or strategy papers to meet minimum core capacity requirements for early warning and response in line with their obligations under the International Health Regulations (2005)	**1.6.3** Number of countries whose national laboratory system is engaged in at least one internal and one external quality-control programme for epidemic-prone communicable diseases	**1.6.4** Number of countries participating in training programmes focusing on strengthening early-warning systems or mechanisms, public health laboratories and outbreak-response capacities
BASELINE			
100 countries	80 countries	90 countries	100 countries
TARGETS TO BE ACHIEVED BY 2009			
150 countries	115 countries	135 countries	150 countries
TARGETS TO BE ACHIEVED BY 2013			
193 countries	193 countries	193 countries	193 countries

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
76 485	98 000	120 000

JUSTIFICATION

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

1.7 Member States and the international community equipped to detect, assess, respond to and cope with major epidemic and pandemic-prone diseases (e.g. influenza, meningitis, yellow fever, haemorrhagic fevers, plague and smallpox) through the development and implementation of tools, methodologies, practices, networks and partnerships for prevention, detection, preparedness and intervention.

INDICATORS

1.7.1 Number of countries having national preparedness plans that are funded and standard operating procedures in place for major epidemic-prone diseases (e.g. pandemic influenza)	**1.7.2** Number of international support mechanisms for diagnosis and mass intervention (e.g. international laboratory surveillance networks and vaccine-stockpiling mechanisms)	**1.7.3** Number of countries with basic capacity in place for safe laboratory handling of dangerous pathogens and safe isolation of patients who are contagious
BASELINE		
90 countries	5 mechanisms	70 countries
TARGETS TO BE ACHIEVED BY 2009		
135 countries	7 mechanisms	100 countries
TARGETS TO BE ACHIEVED BY 2013		
193 countries	9 mechanisms	193 countries

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
61 516	69 000	76 000

JUSTIFICATION

Strong programmes and projects on diseases or specific themes are vital for WHO to ensure that serious threats are dealt with systematically and that WHO maintains its much-needed global expertise in vital areas (e.g. influenza, smallpox, biosafety, epidemics caused by deliberate release of pathogens, and yellow fever). The avian influenza crisis has highlighted the need for the Secretariat to accelerate work with Member States in order to ensure that their ability to detect, assess, respond to and cope with the threat of known epidemic-prone and emerging infectious diseases. The development of standard operating procedures and stockpiling of necessary medicines and vaccines are crucial for mitigating the potential impact of these diseases. Maintaining and expanding existing networks and partnerships providing support to Member States in the different aspects of preparedness and response to specific epidemic risks, and developing new ones where required, are essential elements of WHO's strategy. By the end of 2007, all Member States will have national preparedness plans devised, implemented and tested, thus providing the backbone to the response to a potential pandemic.

1.8 Regional and global capacity coordinated and made rapidly available to Member States for detection, verification, risk assessment and response to epidemics and other public health emergencies of international concern.

INDICATORS

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

TARGETS TO BE ACHIEVED BY 2013

120 (headquarters, regional offices and most country offices)	400 institutions	100% of requests	2 days

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
56 172	64 000	71 000

JUSTIFICATION

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

STRATEGIC OBJECTIVE 2

To combat HIV/AIDS, tuberculosis and malaria

Indicators and targets

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

ISSUES AND CHALLENGES

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

STRATEGIC APPROACHES

Major impetus will be given to promoting the delivery of, and universal access to, essential interventions for prevention, treatment, care and support in order to halt disease transmission and reduce morbidity and mortality. At the primary-care level, interventions can be harmonized in order to maximize the effectiveness of a given contact of a patient with the health system, and to provide the best entry points. Emphasis will be placed on maximizing prevention; 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 crises; ensuring relevance to sociocultural contexts;

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.

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 effects, and making adjustments as necessary. It will also require substantially increasing resources, reinforcing health

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.

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 supported countries that have achieved the national intervention targets for HIV/AIDS consistent with the goal of universal access to HIV/AIDS prevention, treatment and care	**2.1.2** Number of supported countries that have achieved the national intervention targets for malaria	**2.1.3** Number of countries that have achieved the targets for detection (70% case detection) and treatment (85% success rate) of tuberculosis	**2.1.4** Proportion of high-burden countries that have achieved targets for prevention and control of sexually transmitted infections (70% of persons with sexually transmitted infections at primary point-of-care sites appropriately diagnosed, treated and counselled)
	BASELINE			
	No country	5/107 countries	50/211 countries and territories	30% of high-burden countries
	TARGETS TO BE ACHIEVED BY 2009			
	193 countries	53/107 countries	100/211 countries and territories	60% of high-burden countries

	TARGETS TO BE ACHIEVED BY 2013			
	193 countries	All countries endemic for malaria having achieved 80% of intervention targets	All countries and territories exceeding 70% case detection and 85% treatment success rates	All high-burden countries
	RESOURCES (US$ THOUSAND)			
	Budget 2008-2009 146 534	Estimates 2010-2011 136 000		Estimates 2012-2013 150 000
	JUSTIFICATION			
	WHO is firmly committed to maximizing access to interventions against HIV/AIDS, tuberculosis and malaria, pursuant to various Health Assembly resolutions, the global health-sector strategy for HIV/AIDS, the Stop TB strategy, the Global Plan to Stop TB 2006-2015, the Global Strategic Plan 2005-2015 to Roll Back Malaria; the Global Strategy for the Prevention and Control of Sexually Transmitted Infections, and the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health; articulation of its contribution to scaling up towards universal access to HIV/AIDS prevention, care and treatment (and the need to advance work done under the "3 by 5" Initiative); and to achieving the Millennium Development Goals and other internationally agreed goals. Most of the resources are for country and regional level activities.			
2.2 Policy and technical support provided to countries towards expanded gender-sensitive delivery of prevention, treatment and care interventions for HIV/AIDS, tuberculosis and malaria, including integrated training 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.	**INDICATORS**			
	2.2.1 Number of targeted countries with integrated/ coordinated gender-sensitive policies on HIV/AIDS, tuberculosis and malaria	**2.2.2** Number of countries with sound national strategic plans for the health workforce, including policies and management practices on incentives, regulation and retention, with attention to the specific issues raised by HIV/AIDS, tuberculosis and malaria	**2.2.3** Number of countries monitoring access to gender-sensitive, good-quality health services for HIV/AIDS, tuberculosis and malaria	**2.2.4** Number of countries with plans for monitoring provider-initiated HIV testing and counselling in sexual and reproductive health (sexually transmitted infection and family planning services)
	BASELINE			
	HIV/AIDS: to be established Tuberculosis: 63 countries Malaria: 32/43 countries	Baseline will be established in 2007 through a survey to determine the number of countries that have evidence-based health workforce policies/plans that incorporate response to HIV/AIDS, tuberculosis and malaria	HIV/AIDS: 30 countries Tuberculosis: 100/211 countries and territories Malaria: 43 countries	Baseline to be established
	TARGETS TO BE ACHIEVED BY 2009			
	HIV/AIDS: 74 countries Tuberculosis: 74 countries Malaria: 43/43 countries	The number of countries with evidence-based health workforce policies/plans that incorporate response to HIV/AIDS, tuberculosis and malaria increased by 30% (compared to the baseline that will have been established in 2007)	HIV/AIDS: 75% of all countries Tuberculosis: all 211 countries and territories Malaria: 43/43 countries	15 of 49 high-burden countries (30%)

	TARGETS TO BE ACHIEVED BY 2013			
	HIV/AIDS: all countries Tuberculosis: 148 countries Malaria: 43/43 countries	The number of countries having evidence-based policies and plans for the health workforce that incorporate responses to HIV/AIDS, tuberculosis and malaria increased by 50% (compared with the 2008-2009 figure)	HIV: 75% of all countries Tuberculosis: all 211 countries and territories Malaria: 43/43 countries	40 of 49 high-burden countries (80%)

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
258 132	280 000	300 000

JUSTIFICATION

WHO plays a critical role in supporting countries to scale up effective and gender-sensitive interventions to all those who need them; to remove the human resources obstacles to progress; to create or maximize synergies among existing programmes and service-delivery modes and to ensure that vulnerable and high-risk populations benefit from the interventions.

2.3 Global guidance and technical support provided on policies and programmes in order to promote equitable access to essential medicines, diagnostic tools and health technologies of assured quality for the prevention and treatment of HIV/AIDS, tuberculosis and malaria, and their rational use by prescribers and consumers, and, in order to ensure uninterrupted supplies of diagnostics, safe blood and blood products, injections and other essential health technologies and commodities.	**INDICATORS**				
	2.3.1 Number of new or updated global norms and quality standards for medicines and diagnostic tools for HIV/AIDS, tuberculosis and malaria	**2.3.2** Number of priority medicines and diagnostic tools for HIV/AIDS, tuberculosis and malaria that have been assessed and pre-qualified for United Nations procurement	**2.3.3** Number of targeted countries receiving support to increase access to affordable essential medicines for HIV/AIDS, tuberculosis and malaria whose supply is integrated into national pharmaceutical systems (the number of targeted countries is determined for the six-year period)	**2.3.4** Cumulative number of patients with tuberculosis for whom treatment has been provided through the Global Drug Facility	**2.3.5** Number of countries implementing quality-assured HIV/AIDS screening of all donated blood and administering all medical injections with safe equipment as part of strategy to prevent transmission of HIV associated with health care
	BASELINE				
	Five global standards	150 products	10 countries	10 million	77 countries with high-quality HIV/AIDS screening of all donated blood and 115 countries providing all medical injections with safe equipment

	TARGETS TO BE ACHIEVED BY 2009				
	10 new global standards	225 products	20 countries	14 million	134 countries with high-quality HIV screening of all donated blood and 154 countries where all medical injections are administered with safe equipment
	TARGETS TO BE ACHIEVED BY 2013				
	20 new global standards	400 products	All targeted countries supported	22 million	193 countries achieving high-quality HIV screening of all donated blood and administering all medical injections with safe equipment

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
58 284	26 000	29 000

JUSTIFICATION

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

2.4 Global, regional and national systems for surveillance, evaluation and monitoring strengthened and expanded to keep track of progress towards targets and allocation of resources for HIV/AIDS, tuberculosis and malaria control and to determine the impact of control efforts and the evolution of drug resistance.	**INDICATORS**		
	2.4.1 Number of countries that regularly collect, analyse and report data on surveillance coverage, outcome and impact using WHO's standardized methodologies, including appropriate age- and sex-disaggregation	**2.4.2** Number of targeted countries providing WHO with annual data on surveillance, monitoring and financial allocation data for inclusion in the annual global reports on control of HIV/AIDS, tuberculosis and malaria and the achievement of targets	**2.4.3** Number of countries reporting age- and sex-disaggregated data from surveillance and monitoring of HIV/AIDS, tuberculosis and malaria drug resistance
	BASELINE		
	HIV/AIDS: 48/132 low- and middle-income countries Tuberculosis: 100/211 countries and territories Malaria: 30/107 countries	HIV/AIDS: all countries Tuberculosis: 211/211 countries and territories Malaria: 107/107 countries	HIV/AIDS: 8 countries (January 2006) and 16 countries (January 2007) Tuberculosis: 133/211 countries and territories Malaria: 107/107 countries
	TARGETS TO BE ACHIEVED BY 2009		
	HIV/AIDS: 65/132 countries Tuberculosis: 150/211 countries and territories Malaria: 107/107 countries	HIV/AIDS: all countries Tuberculosis: 211/211 countries and territories Malaria: 107/107 countries	HIV/AIDS: all high-burden countries having set up drug-resistance surveillance systems using WHO methodology Tuberculosis: 152/211 countries and territories Malaria: all malaria-endemic countries having set up drug-resistance surveillance systems using WHO methodology

	TARGETS TO BE ACHIEVED BY 2013		
	HIV/AIDS: 85/132 countries Tuberculosis: 211/211 countries and territories Malaria: 107/107 countries	HIV/AIDS: all countries Tuberculosis: 211/211 countries and territories Malaria: all targeted countries	HIV/AIDS: all countries requesting assistance providing annual national reports on HIV/AIDS drug resistance based on WHO guidelines Tuberculosis: 160/211 countries and territories Malaria: 107/107 countries

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
104 598	136 000	150 000

JUSTIFICATION

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

2.5 Political commitment sustained and mobilization of resources ensured through advocacy and nurturing of partnerships on HIV/AIDS, tuberculosis and malaria at country, regional and global levels; support provided to countries as appropriate to develop or strengthen and implement mechanisms for resource mobilization and utilization and increase the absorption capacity of available resources; and engagement of communities and affected persons increased to maximize the reach and performance of HIV/AIDS, tuberculosis and malaria control programmes.	**INDICATORS**		
	2.5.1 Number of targeted countries with functional partnerships for HIV/AIDS, tuberculosis and malaria control	**2.5.2** Proportion of targeted countries that receive WHO support in accessing financial resources or increasing absorption of funds for HIV/AIDS, tuberculosis and malaria	**2.5.3** Proportion of countries involving communities, persons affected by the diseases, civil-society organizations and the private sector in planning, design, implementation and evaluation of HIV/AIDS, tuberculosis and malaria programmes
	BASELINE		
	HIV/AIDS: 85% of 126 low- and middle-income countries reporting in 2005 had national HIV/AIDS coordinating bodies Tuberculosis: 30 targeted countries Malaria: 10/46 targeted countries	HIV/AIDS: 70 countries by September 2006 Tuberculosis: all high-burden countries Malaria: 30% of countries requesting support	HIV/AIDS: all countries Tuberculosis: 30/87 countries Malaria: 30% of targeted countries
	TARGETS TO BE ACHIEVED BY 2009		
	HIV/AIDS: all countries Tuberculosis: 43/87 countries Malaria: 33/46 targeted countries	HIV/AIDS: all high-burden countries requesting support Tuberculosis: all tuberculosis high-burden and high-incidence countries requesting support Malaria: 50% of targeted countries requesting support	HIV/AIDS: all countries Tuberculosis: 43/87 countries Malaria: 50% of targeted countries
	TARGETS TO BE ACHIEVED BY 2013		
	HIV/AIDS: all countries Tuberculosis: 87 countries Malaria: 42/46 targeted countries	HIV/AIDS: all countries requesting support Tuberculosis: all targeted countries requesting support Malaria: all targeted countries	HIV/AIDS: all countries Tuberculosis: all targeted countries Malaria: all targeted countries

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
35 930	28 000	30 000

JUSTIFICATION

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

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

INDICATORS		
2.6.1 Number of new and improved tools (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		
1	2	48% of all peer-reviewed publications
TARGETS TO BE ACHIEVED BY 2009		
2 (cumulative)	4 (cumulative)	55% of all peer-reviewed publications
TARGETS TO BE ACHIEVED BY 2013		
4 (cumulative)	8 (cumulative)	60% of all peer-reviewed publications

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
103 454	74 000	81 000

JUSTIFICATION

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

STRATEGIC OBJECTIVE 3

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

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

Lessons learnt

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

STRATEGIC APPROACHES

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

The Secretariat will focus on:

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

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

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

ORGANIZATION-WIDE EXPECTED RESULTS

3.1 Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities and visual impairment, including blindness.

INDICATORS			
3.1.1 Number of targeted countries whose health ministries have a focal point or a unit for injuries and violence prevention with its own budget	**3.1.2** *The world report on disability and rehabilitation* published and launched, in response to resolution WHA58.23	**3.1.3** Number of targeted countries whose health ministries have a unit for mental health with its own budget	**3.1.4** Proportion of targeted countries whose health ministries have a unit or department for chronic noncommunicable conditions with its own budget
BASELINE			
80 targeted countries	No report	90 targeted countries	10% of targeted countries
TARGETS TO BE ACHIEVED BY 2009			
120 targeted countries	Draft report prepared	120 targeted countries	30% of targeted countries
TARGETS TO BE ACHIEVED BY 2013			
193 countries	Report published in 6 languages	193 countries	85% of targeted countries

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
25 837	24 000	20 000

JUSTIFICATION

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.

3.2 Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities and visual impairment, including blindness.

INDICATORS				
3.2.1 Number of targeted countries that have and are implementing national plans to prevent unintentional injuries and violence	**3.2.2** Number of targeted countries that have and are implementing national plans in respect of disability and rehabilitation	**3.2.3** Number of countries receiving and utilizing guidance on policies, strategies and regulations in respect of mental, behavioural and neurological disorders including those due to use of psychoactive substances	**3.2.4** Proportion of targeted countries that have and are implementing a nationally approved policy for the prevention and control of chronic noncommunicable conditions	**3.2.5** Proportion of targeted countries that have and are implementing comprehensive national plans for the prevention of hearing and visual impairment, including blindness
BASELINE				
40 targeted countries	35 targeted countries	70 countries	10% of targeted countries	10% of targeted countries
TARGETS TO BE ACHIEVED BY 2009				
70 targeted countries	60 targeted countries	72 countries	30% of targeted countries	30% of targeted countries
TARGETS TO BE ACHIEVED BY 2013				
120 targeted countries	100 targeted countries	193 countries	85% of targeted countries	85% of targeted countries

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
30 440	33 000	33 000

JUSTIFICATION

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

3.3 Improvements made in Member States' capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities and visual impairment, including blindness.

INDICATORS

3.3.1 Number of targeted countries that have a published document containing a national compilation of data on the magnitude, causes and consequences of violence and injuries	**3.3.2** Number of targeted countries that have a published document containing a national compilation of data on the prevalence and incidence of disabilities	**3.3.3** Number of targeted countries establishing or substantially strengthening national or regional information systems on the magnitude, causes and consequences of mental, behavioural and neurological disorders, including those due to use of psychoactive substances	**3.3.4** Proportion of targeted countries with a national health reporting system and annual reports that include indicators of chronic, noncommunicable conditions	**3.3.5** Proportion of targeted countries documenting the burden of hearing and visual impairment, including blindness
BASELINE				
40 targeted countries	60 targeted countries	24 targeted countries	10% of targeted countries	10% of targeted countries
TARGETS TO BE ACHIEVED BY 2009				
70 targeted countries	90 targeted countries	36 targeted countries	30% of targeted countries	30% of targeted countries
TARGETS TO BE ACHIEVED BY 2013				
120 targeted countries	140 targeted countries	72 targeted countries	85% of targeted countries	85% of targeted countries

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
23 987	31 000	35 000

JUSTIFICATION

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

3.4 Improved evidence compiled by WHO on the cost-effectiveness of interventions to tackle chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities and visual impairment, including blindness.

INDICATORS

3.4.1 Availability of evidence on the cost-effectiveness of widely available interventions for the management of selected mental, behavioural and neurological disorders including those due to use of psychoactive substances	**3.4.2** Availability of summarized evidence on the cost-effectiveness of a core package of interventions for chronic noncommunicable conditions together with an estimate of the global cost of implementation
BASELINE	
No evidence made available	Evidence for individual interventions available
TARGETS TO BE ACHIEVED BY 2009	
Evidence made available for 4 interventions	Core package completed
TARGETS TO BE ACHIEVED BY 2013	
Evidence made available for 12 interventions	Expanded and desirable packages completed, and approach adapted for country implementation

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
23 700	24 000	30 000

JUSTIFICATION

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

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

INDICATORS

3.5.1 Number of guidelines published and widely disseminated on multisectoral interventions to prevent violence and unintentional injuries	**3.5.2** Availability of guidance on promotion of mental health and on prevention of selected mental, behavioural and neurological disorders, including those due to use of psychoactive substances	**3.5.3** Proportion of targeted countries implementing strategies recommended by WHO for population-wide prevention of hearing and visual impairment, including blindness
BASELINE		
4 guidelines published and disseminated	No guidance made available	10% of countries
TARGETS TO BE ACHIEVED BY 2009		
12 guidelines published and disseminated	Guidance on 2 disorders prepared and made available	30% of countries
TARGETS TO BE ACHIEVED BY 2013		
18 guidelines published and disseminated	Guidance on 4 disorders prepared and made available	85% of countries

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
21 476	51 000	69 000

JUSTIFICATION

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

3.6 Guidance and support provided to Member States to improve the ability of their health and social systems to prevent and manage chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities and visual impairment, including blindness.					
	INDICATORS				
	3.6.1 Number of targeted countries whose health-care systems are better able to respond to unintentional injuries and violence as a result of using WHO's guidelines	**3.6.2** Number of countries with strengthened rehabilitation services as a result of using the recommendations in *The world report on disability and rehabilitation* and in related WHO guidelines	**3.6.3** Number of countries conducting a systematic assessment of their mental health systems by means of WHO's assessment instrument for mental health systems, and using the information obtained to plan the strengthening of national mental health systems	**3.6.4** Proportion of targeted countries implementing integrated primary health-care strategies recommended by WHO in the management of chronic non-communicable conditions	**3.6.5** Number of countries with strengthened health-system services for the treatment of tobacco dependence as a result of using WHO's policy recommendations
	BASELINE				
	12 targeted countries	No country	48 countries	10% of targeted countries	No country
	TARGETS TO BE ACHIEVED BY 2009				
	30 targeted countries	10 countries	72 countries	30% of targeted countries	10 countries
	TARGETS TO BE ACHIEVED BY 2013				
	70 targeted countries	80 countries	144 countries	85% of targeted countries	30 countries

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
32 664	33 000	43 000

JUSTIFICATION

Resources will be used for the provision of documents, training, workshops and direct support for the strengthening of health and rehabilitation services in low- and middle-income countries, in order to ensure that such countries improve their response to chronic noncommunicable conditions, mental and behavioural disorders, violence, injuries and disabilities.

STRATEGIC OBJECTIVE 4

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

Indicators and targets

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

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

ISSUES AND CHALLENGES

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

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

Lessons learnt

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

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

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

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

STRATEGIC APPROACHES

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

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

Lessons learnt

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

The Secretariat will focus on:

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

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

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

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

The Secretariat will focus on:

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie attainment of this strategic objective:

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

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

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

ORGANIZATION-WIDE EXPECTED RESULTS

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

INDICATORS		
4.1.1 Number of targeted countries that have an integrated policy on universal access to effective interventions for improving maternal, newborn and child health	**4.1.2** Number of countries that have a policy on universal access to sexual and reproductive health	**4.1.3** Number of countries that have a policy on the promotion of active and healthy ageing
BASELINE		
10 countries	20 countries	None
TARGETS TO BE ACHIEVED BY 2009		
20 countries	30 countries	25 countries
TARGETS TO BE ACHIEVED BY 2013		
100 countries	80 countries	40 countries

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
36 032	55 000	75 000

JUSTIFICATION

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

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

INDICATORS		
4.2.1 Number of new research centres strengthened through comprehensive institutional development and support	**4.2.2** Number of completed studies on priority issues in the relevant field of health	**4.2.3** Number of new or updated systematic reviews on best practices, policies and standards of care
BASELINE		
None	None	None
TARGETS TO BE ACHIEVED BY 2009		
4 centres	12 studies	15 reviews
TARGETS TO BE ACHIEVED BY 2013		
10 centres	34 studies	40 reviews

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
72 497	75 000	80 000

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

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

INDICATORS

4.3.1 Number of countries with at least 50% of target districts implementing strategies to ensure skilled care for every birth	**4.3.2** Number of countries adapting and utilizing policy, technical and managerial norms and guidelines on integrated management of pregnancy and childbirth
BASELINE	
10 countries	10 countries
TARGETS TO BE ACHIEVED BY 2009	
25 countries	25 countries
TARGETS TO BE ACHIEVED BY 2013	
75 countries	75 countries

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
65 389	107 000	130 000

JUSTIFICATION

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

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

INDICATORS

4.4.1 Number of countries with at least 50% of target districts implementing strategies for neonatal survival and health	**4.4.2** Number of countries that have adapted, and in which 50% or more of target districts are implementing, the packages of interventions for integrated management of both childhood illness and pregnancy and childbirth, which include those for the full newborn period
BASELINE	
20 countries	20 countries
TARGETS TO BE ACHIEVED BY 2009	
40 countries	40 countries
TARGETS TO BE ACHIEVED BY 2013	
75 countries	75 countries

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
50 790	88 000	115 000

JUSTIFICATION

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

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

INDICATORS

4.5.1 Number of countries implementing strategies for increasing coverage with child health and development interventions	**4.5.2** Number of countries that have expanded geographical coverage of the integrated management of childhood illness to more than 75% of target districts
BASELINE	
20 countries	10 countries
TARGETS TO BE ACHIEVED BY 2009	
50 countries	30 countries
TARGETS TO BE ACHIEVED BY 2013	
80 countries	60 countries

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
41 776	75 000	93 000

JUSTIFICATION

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

4.6 Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, and for the scaling up of a package of prevention, treatment and care interventions in accordance with established standards.

INDICATORS

4.6.1 Number of countries with a functioning adolescent health and development programme[1]

BASELINE

15 countries

TARGETS TO BE ACHIEVED BY 2009

50 countries

TARGETS TO BE ACHIEVED BY 2013

100 countries

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
34 632	55 000	74 000

JUSTIFICATION

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

[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 countries implementing the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health	**4.7.2** Number of targeted countries having reviewed their existing national laws, regulations or policies relating to sexual and reproductive health
BASELINE	
20 countries	3 countries
TARGETS TO BE ACHIEVED BY 2009	
30 countries	8 countries
TARGETS TO BE ACHIEVED BY 2013	
80 countries	15 countries

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
48 064	80 000	113 000

JUSTIFICATION

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

4.8 Guidelines, approaches, tools, and technical assistance provided to Member States for increased advocacy for consideration of ageing as a public health issue, for the development and implementation of policies and programmes aiming at maintaining maximum functional capacity throughout the life course and for the training of health-care providers in approaches that ensure healthy ageing.

INDICATORS

4.8.1 Number of targeted countries that have implemented community-based policies with a focus on strengthening primary health-care capacity to deal with ageing issues	**4.8.2** Number of targeted countries that have implemented multisectoral policies reflecting the Secretariat's active ageing policy framework
BASELINE	
None	None
TARGETS TO BE ACHIEVED BY 2009	
10 countries	15 countries
TARGETS TO BE ACHIEVED BY 2013	
20 countries	25 countries

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
10 653	16 000	22 000

JUSTIFICATION

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

STRATEGIC OBJECTIVE 5

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

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

STRATEGIC APPROACHES

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

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

Lessons learnt

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

information services; and restoration of the health infrastructure.

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

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

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

The Secretariat will focus on:

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

ORGANIZATION-WIDE EXPECTED RESULTS

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

	TARGETS TO BE ACHIEVED BY 2009			
	60% of countries	40% of countries	80% of countries	40 countries
	TARGETS TO BE ACHIEVED BY 2013			
	70% of countries	55% of countries	90% of countries	60 countries

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
45 614	49 000	51 000

JUSTIFICATION

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

5.2 Norms and standards developed, capacity built and technical support provided to Member States for a timely response to disasters associated with natural hazards and to conflict-related crises.

INDICATORS		
5.2.1 Proportion of emergencies for which health and nutrition assessments and tracking exercises are being implemented	**5.2.2** Number of global and regional training programmes on health operations in emergency response	**5.2.3** Proportion of emergencies for which interventions for maternal, newborn and child health are in place
BASELINE		
15% of emergencies	5 training programmes	30% of emergencies
TARGETS TO BE ACHIEVED BY 2009		
60% of emergencies	16 training programmes	75% of emergencies
TARGETS TO BE ACHIEVED BY 2013		
80% of emergencies	20 training programmes	85% of emergencies

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
67 796	71 000	74 000

JUSTIFICATION

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

5.3 Norms and standards developed, capacity built and technical support provided to Member States for assessing needs and for planning and implementing interventions during the transition and recovery phases of conflicts and disasters.

INDICATORS		
5.3.1 Number of post-conflict and post-disaster needs assessments conducted that contain a gender-responsive health component	**5.3.2** Number of humanitarian action plans for complex emergencies and formulation processes for consolidated appeals with strategic and operational components for health included	**5.3.3** Number of countries in transition or recovery situations benefiting from needs assessments and technical support in the areas of maternal and newborn health, mental health and nutrition
BASELINE		
2 needs assessments	8 plans	5 countries
TARGETS TO BE ACHIEVED BY 2009		
6 needs assessments	20 plans	15 countries
TARGETS TO BE ACHIEVED BY 2013		
8 needs assessments	25 plans	20 countries

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
46 465	59 000	65 000

JUSTIFICATION

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

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

INDICATORS

5.4.1 Proportion of emergency-affected countries where a comprehensive communicable disease-risk assessment has been conducted and an epidemiological profile and toolkit developed and disseminated to partner agencies	**5.4.2** Proportion of situations involving acute natural disasters or conflicts for which a disease-surveillance and early-warning system has been activated and where communicable disease-control interventions have been implemented
BASELINE	
50% of countries	60% of situations
TARGETS TO BE ACHIEVED BY 2009	
100% of countries	100% of situations
TARGETS TO BE ACHIEVED BY 2013	
100% of countries	100% of situations

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
22 948	45 000	53 000

JUSTIFICATION

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

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

INDICATORS

5.5.1 Number of expert networks in place for responding to food-safety and environmental public health emergencies	**5.5.2** Proportion of countries with national plans for preparedness, and alert and response activities in respect of chemical, radiological and environmental health emergencies	**5.5.3** Number of countries with focal points for the International Food Safety Authorities Network and for environmental health emergencies	**5.5.4** Proportion of food-safety and environmental health emergencies benefiting from intersectoral collaboration and assistance	**5.5.5** Proportion of countries achieving a state of preparedness and completing stockpiling of necessary items in order to ensure a prompt response to chemical and radiological emergencies
BASELINE				
10 networks	30% of countries	50 countries	25% of emergencies	20% of countries
TARGETS TO BE ACHIEVED BY 2009				
20 networks	60% of countries	75 countries	65% of emergencies	50% of countries
TARGETS TO BE ACHIEVED BY 2013				
30 networks	70% of countries	100 countries	100% of emergencies	100% of countries

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
19 190	17 000	18 000

JUSTIFICATION

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

5.6 Effective communications issued, partnerships formed and coordination developed with other organizations in the United Nations system, governments, local and international nongovernmental organizations, academic institutions and professional associations at the country, regional and global levels.	**INDICATORS**		
	5.6.1 Proportion of affected or pilot countries in which the United Nations Inter-Agency Standing Committee Humanitarian Health Cluster is operational (in addition to the functioning Health Cluster at global level) and that have annual action plans in place	**5.6.2** Number of emergency-related interagency mechanisms and working groups where WHO is actively involved	**5.6.3** Proportion of disasters and crises covered with a comprehensive communication strategy
	BASELINE		
	60% of countries	8 mechanisms	35% of disasters and crises
	TARGETS TO BE ACHIEVED BY 2009		
	100% of countries	16 mechanisms	100% of disasters and crises
	TARGETS TO BE ACHIEVED BY 2013		
	100% of countries	20 mechanisms	100% of disasters and crises

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
16 400	16 000	17 000

JUSTIFICATION

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

STRATEGIC OBJECTIVE 6

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

Indicators and targets

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

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

Lessons learnt

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

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

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

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

Lessons learnt

- Preventing risk factors is the most cost-effective approach that low- and middle-income countries can adopt for tackling the adverse health and social outcomes with which these risk factors are associated.
- Evidence from multilevel research shows that initiatives empowering 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 evidence-based ethical policies, strategies and technical guidance, 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, giving priority to countries with the highest burdens of lifestyle-related conditions and to those in which the burdens are increasing;
- encouraging increased investment at all levels and building capacity within the Secretariat, especially in regional and country offices, to meet WHO's needs in relation to health promotion, and prevention or reduction of the occurrence of risk factors associated with lifestyle;

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

In the area of health promotion, significant efforts are required to strengthen leadership and build capacity to take

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

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

- that there is additional investment in financial and human resources to build capacity for health promotion and for preventing risk factors;
- that effective partnerships and multisectoral and multidisciplinary collaborations are established in relation to equitable policies, mechanisms, networks and actions and with the involvement of all stakeholders at national, regional and international levels;
- that there is a commitment to comprehensive and integrated policies, plans and programmes addressing common risk factors, together with a recognition that 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;
- that health promotion and prevention efforts with regard to the risk factors may be adversely affected by the low priority afforded to this area and the scarcity of resources allocated to it as a result by the Secretariat and countries. Continued advocacy for increased investment is essential in order to minimize this risk;
- that integrated approaches to prevention or reduction of risk factors may compromise the capacity of both the Secretariat and countries to provide expertise in relation to specific diseases and risk factors. In order to avoid that outcome, adequate resources for integrated approaches, as well as a critical mass of expertise in major areas, must be maintained.

The Secretariat will focus on:

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

ORGANIZATION-WIDE EXPECTED RESULTS

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

INDICATORS	
6.1.1 Number of countries receiving support to develop outcome-oriented health-promotion activities or strategies to expand the finance base of health promotion	**6.1.2** Level(s) at which multisectoral mechanisms or networks strengthened for health-promotion and prevention activities in respect of major risk factors at national level
BASELINE	
24 countries	No partnership established
TARGETS TO BE ACHIEVED BY 2009	
50 countries	Global health-promotion partnership established
TARGETS TO BE ACHIEVED BY 2013	
100 countries	Health-promotion interagency groups established at regional and country levels

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
38 879	52 000	66 000

JUSTIFICATION

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

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

INDICATORS	
6.2.1 Proportion of eligible countries receiving support with, as a result, a functioning national surveillance system for major health risk factors in adults, or that are producing regular reports on such risk factors	**6.2.2** Proportion of eligible countries receiving support with, as a result, a functioning national surveillance system for major health risk factors in youth, or that are producing regular reports on such risk factors
BASELINE	
10% of eligible countries	10% of eligible countries
TARGETS TO BE ACHIEVED BY 2009	
35% of eligible countries	35% of eligible countries
TARGETS TO BE ACHIEVED BY 2013	
85% of eligible countries	85% of eligible countries

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
23 807	25 000	31 000

JUSTIFICATION

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

6.3 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease and death associated with tobacco use, enabling them to strengthen institutions in order to tackle or prevent the public health problems concerned; support also provided to the Conference of the Parties to the WHO Framework Convention on Tobacco Control for implementation of the provisions of the Convention and development and implementation of protocols and guidelines.

INDICATORS

6.3.1 Number of countries with legislation, or its equivalent, in relation to the following: smoking bans in health-care and educational facilities, bans on direct and indirect advertising of tobacco products in national media, and health warnings on tobacco products consistent with the relevant articles of the WHO Framework Convention on Tobacco Control	**6.3.2** Number of countries with comparable national data – disaggregated by age and sex – on prevalence of tobacco use	**6.3.3** Number of countries that have established or reinforced a national coordinating mechanism or focal point for tobacco control	**6.3.4** Number of guidelines agreed and number of protocols adopted by the Conference of the Parties
BASELINE			
10 countries	10 countries	20 countries	1 output
TARGETS TO BE ACHIEVED BY 2009			
30 countries	35 countries	40 countries	2 outputs
TARGETS TO BE ACHIEVED BY 2013			
100 countries	70 countries	130 countries	5 outputs

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
38 466	54 000	72 000

JUSTIFICATION

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

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

INDICATORS

6.4.1 Number of countries receiving support with, as a result, policies, plans and programmes for preventing public health problems caused by alcohol, drugs and other psychoactive substance use	**6.4.2** Number of policies, strategies, recommendations, standards and guidelines developed according to WHO's procedures in order to provide support to Member States in preventing or reducing public health problems caused by alcohol, drugs and other psychoactive substance use
BASELINE	
25 countries	5 outputs
TARGETS TO BE ACHIEVED BY 2009	
50 countries	15 outputs
TARGETS TO BE ACHIEVED BY 2013	
100 countries	25 outputs

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
20 978	26 000	33 000

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

6.5 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed and technical support provided to Member States with a high or increasing burden of disease or death associated with unhealthy diets and physical inactivity, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.	**INDICATORS**	
	6.5.1 Number of countries receiving support and, as a result, completing the development and implementation of policies, plans and programmes for improving diets and increasing physical activity, including the Global Strategy on Diet, Physical Activity and Health	**6.5.2** Number of policies, strategies, recommendations, standards and guidelines developed according to WHO's procedures in order to provide support to Member States in promoting healthy diets and physical activity
	BASELINE	
	20 countries	4 outputs
	TARGETS TO BE ACHIEVED BY 2009	
	50 countries	15 outputs
	TARGETS TO BE ACHIEVED BY 2013	
	150 countries	30 outputs

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
20 347	25 000	31 000

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

6.6 Evidence-based and ethical policies, strategies, interventions, recommendations, standards and guidelines developed and technical support provided to Member States to promote safer sex and strengthen institutions in order to tackle and manage the social and individual consequences of unsafe sex.	**INDICATORS**	
	6.6.1 Number of countries with evidence available on the determinants and consequences of unsafe sex permitting the identification of effective interventions and subsequent preparation of guidelines	**6.6.2** Number of countries receiving support that have initiated or implemented new or more effective interventions at individual, family and community levels in order to promote safer sexual behaviours
	BASELINE	
	5 countries	5 countries
	TARGETS TO BE ACHIEVED BY 2009	
	Research implemented on determinants and consequences of unsafe sex in order to develop 3 evidence-based guidelines for promoting safer sexual behaviours	10 countries supported in developing evidence-based interventions and in assessing the implementation of interventions at individual, family and community levels in order to promote safer sexual behaviours
	TARGETS TO BE ACHIEVED BY 2013	
	10 countries supported by WHO that have validated and implemented 3 new or adapted guidelines	10 countries supported by WHO that have implemented WHO's guidelines and scaled up interventions to promote safer sexual behaviours

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
18 580	24 000	30 000

JUSTIFICATION

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

STRATEGIC OBJECTIVE 7

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

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.

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

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

Lessons learnt

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

STRATEGIC APPROACHES

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

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

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

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

The Secretariat will focus on:

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

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

The Secretariat will focus on:

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

ASSUMPTIONS, RISKS AND OPTIONS

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

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

The main risks that prevent achieving this strategic objective are:

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

ORGANIZATION-WIDE EXPECTED RESULTS

7.1 Significance of social and economic determinants of health recognized throughout the Organization and incorporated into normative work and technical collaboration with Member States and other partners.

INDICATORS		
7.1.1 Number of countries that have implemented key policy recommendations of the Commission on the Social Determinants of Health	**7.1.2** Number of countries whose WHO Country Cooperation Strategy documents include action on the social and economic determinants of health	**7.1.3** Number of WHO regions with a strategy for action on the social and economic determinants of health
BASELINE		
8 countries	7 countries	2 regions
TARGETS TO BE ACHIEVED BY 2009		
12 countries	14 countries	5 regions
TARGETS TO BE ACHIEVED BY 2013		
42 countries	28 countries	6 regions

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
17 814	20 800	23 100

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

7.2 Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels in order to address social and economic determinants of health and to encourage poverty-reduction and sustainable development.

INDICATORS		
7.2.1 Number of countries whose health policies target the social and economic determinants of health on an intersectoral basis	**7.2.2** Number of subregional, regional and global forums organized (alone or with other international organizations) for policy-makers, programme-implementers and civil society on intersectoral actions to address the social and economic determinants of health and to achieve the Millennium Development Goals	**7.2.3** Number of tools developed and disseminated for assessing the impact of non-health sectors on health and health equity
BASELINE		
2 countries	1 forum	None
TARGETS TO BE ACHIEVED BY 2009		
10 countries	2 forums	1 tool
TARGETS TO BE ACHIEVED BY 2013		
38 countries	6 forums	3 tools

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
16 499	19 300	21 400

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

7.3 Social and economic data relevant to health collected, collated and analysed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).

INDICATORS		
7.3.1 Number of countries having health data of sufficient quality to assess and track health equity among key population groups	**7.3.2** Number of countries with at least one national policy on health equity that incorporates an analysis of disaggregated data	**7.3.3** Number of countries with at least one national programme on health equity that uses disaggregated data
BASELINE		
39 countries	None	None
TARGETS TO BE ACHIEVED BY 2009		
45 countries	27 countries	27 countries
TARGETS TO BE ACHIEVED BY 2013		
55 countries	55 countries	55 countries

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
13 410	15 700	17 500

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

7.4 Ethics- and rights-based approaches to health promoted within WHO and at national and global levels.	**INDICATORS**	
	7.4.1 Number of tools and guidance documents developed for Member States and other stakeholders on how to use human rights to advance health.	**7.4.2** Number of tools and guidance documents produced for Member States and other stake-holders on use of ethical analysis to improve health policies
	BASELINE	
	20	8
	TARGETS TO BE ACHIEVED BY 2009	
	28	12
	TARGETS TO BE ACHIEVED BY 2013	
	45	20

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
7 423	8 700	9 700

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

7.5 Gender analysis and responsive actions incorporated into WHO's normative work and support provided to Member States for formulation of gender-sensitive policies and programmes.	**INDICATORS**		
	7.5.1 Number of publications that contribute to building evidence on the impact of gender equity on health and on effective strategies to address it	**7.5.2** Number of tools and guidance documents produced for Member States on use of gender analysis in health	**7.5.3** Number of WHO staff and partners who have participated in WHO capacity-building courses on gender and health
	BASELINE		
	50	20	446
	TARGETS TO BE ACHIEVED BY 2009		
	56	25	991
	TARGETS TO BE ACHIEVED BY 2013		
	63	28	1731

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
10 759	12 500	13 900

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

STRATEGIC OBJECTIVE 8

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

Rapid changes in lifestyles, increasing urbanization, production and energy consumption, climatic 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. These hazards range from the global spread of new infections to new or more widespread exposures to physical and chemical agents, radiation or psychosocial pressures. Finally, for effective health sector action, risks have to be reduced in the sectors and the settings where they

Lessons learnt

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

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

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

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

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

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

Lessons learnt

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

The Secretariat will focus on:

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

STRATEGIC APPROACHES

In order to address the root causes of environmental threats to health, the health sector will need to adopt the following overarching strategies: to provide leadership on health aspects of international environment and sectoral policies; to advocate and establish partnerships for coordinated multisectoral activities and integrated policies to reduce health risks from the environment; and to promote development frameworks and strategies that benefit health.

Management of public health risks requires intensifying institutional and technical capacities for assessing environmental and occupational health risks and for

evaluating the impacts of policies. Preparedness for, and response to, environmental emergencies and disasters and emerging threats deserve particular attention in health sector development.

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

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

The Secretariat will focus on:

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie the achievement of this strategic objective:

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

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

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

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

ORGANIZATION-WIDE EXPECTED RESULTS

8.1 Evidence-based assessments made, and norms and guidance formulated and updated on major environmental hazards to health (e.g., poor air quality, chemical substances, electromagnetic fields, radon, poor-quality drinking-water and waste-water reuse); technical support provided for the implementation of international environmental agreements and for monitoring progress towards achievement of the Millennium Development Goals.

INDICATORS			
8.1.1 Number of new or updated assessments of risk and/or environmental burden of disease	**8.1.2** Number of new or updated norms, standards and good practice guidelines	**8.1.3** Number of monitored Millennium Development Goal indicators relating to environmental hazards	**8.1.4** Number of international environmental agreements whose implementation is supported by WHO
BASELINE			
3 assessments per year	5 outputs per year	3 Millennium Development Goal indicators monitored/reported each year	2 agreements supported technically
TARGETS TO BE ACHIEVED BY 2009			
10 assessments per year	10 outputs per year	3 Millennium Development Goal indicators monitored/reported each year	4 conventions or international policy frameworks supported technically
TARGETS TO BE ACHIEVED BY 2013			
15 assessments per year	15 outputs per year	3 Millennium Development Goal indicators monitored/reported each year	6 conventions or international policy frameworks supported technically

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
32 960	40 000	44 000

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

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

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
35 208	26 000	29 000

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

8.3 Technical assistance and support provided to Member States for strengthening occupational and environmental health policy-making, planning of preventive interventions, service delivery and surveillance.	**INDICATORS**	
	8.3.1 Number of high-priority countries receiving technical and logistical support for developing and implementing policies for strengthening the delivery of occupational and environmental health services and surveillance	**8.3.2** Number of national organizations or universities implementing WHO-led initiatives to reduce occupational risks (e.g. among workers in the informal economy, to implement the WHO global strategy for occupational health for all, or to eliminate silicosis)
	BASELINE	
	No country receiving specific support for strengthening environmental health services; 5 countries receiving advice on strengthening surveillance	2 organizations
	TARGETS TO BE ACHIEVED BY 2009	
	10 countries receiving advice on strengthening occupational and environmental health services; 10 countries receiving advice on strengthening surveillance	10 organizations
	TARGETS TO BE ACHIEVED BY 2013	
	15 countries receiving advice on strengthening occupational and environmental health services; 15 countries receiving advice on strengthening surveillance	15 organizations

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
21 224	30 000	33 000

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

8.4 Guidance, tools and initiatives created in order to support the health sector to influence policies in priority sectors, assess health impacts, determine costs and benefits of policy alternatives in those sectors, and select investments in non-health sectors that improve health, the environment and safety.

INDICATORS

8.4.1 Establishment of initiatives to frame and implement at global and national levels policies in other sectors that take health into account, using WHO's technical and logistical support	**8.4.2** Production and promotion in target countries of sector-specific guidance and tools for assessment of health impacts and economic costs and benefits and promotion of health and safety	**8.4.3** Establishment of networks and partnerships to drive change in specific sectors or settings, including an outreach and communications strategy	**8.4.4** Number of regional or national events conducted with WHO's technical support with the aim of building capacity and strengthening institutions in health and other sectors for improving policies relating to occupational and environmental health in at least 3 economic sectors

BASELINE

Initiatives implemented globally for 1 sector and nationally in 2 countries	Tools and guidance produced for 1 sector	Networks established for 1 sector	One regional event conducted

TARGETS TO BE ACHIEVED BY 2009

Initiatives implemented globally for 3 sectors and nationally in at least 10 countries	Tools and guidance produced for 3 sectors	Networks established for 3 sectors, with communications strategy implemented	10 regional or national events conducted with WHO technical support

TARGETS TO BE ACHIEVED BY 2013

Initiatives implemented globally for 5 sectors, and nationally in at least 15 countries	Tools and guidance produced for 5 sectors	Networks established for 5 sectors, with communications strategy implemented	20 regional or national events conducted with WHO technical support

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
21 000	29 000	32 000

JUSTIFICATION

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

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

INDICATORS

8.5.1 Establishment of a research institute on key emerging and re-emerging occupational and environmental health concerns in development	**8.5.2** Impact, in terms of coverage by mass media, of outreach and communications strategy on occupational and environmental issues implemented globally and in partnership	**8.5.3** Availability of biennial report on trends, scenarios, and key development issues and their health impacts	**8.5.4** Organization of a regular high-level forum on health and environment for global and regional policy-makers and stakeholders
BASELINE			
No institute	Mass media citation of work by WHO or partners on priority issues in occupational and environmental health in 2007	No report	No global forum; three regional forums held
TARGETS TO BE ACHIEVED BY 2009			
Institute under development	5% increase in citations	First "Global Environmental Health Outlook" published	First global forum and 4 regional forums held
TARGETS TO BE ACHIEVED BY 2013			
Functioning institute	10% increase over baseline in citations	Second and third issues of "Global Environmental Health Outlook" published	Second global forum and 5 regional forums held

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
20 064	21 000	23 000

JUSTIFICATION

Environmental and occupational health risks are directly linked to patterns of consumption and production and to policies in different sectors of the economy; at present, however, there is no consensus on the trends in these patterns and policies or their implications for risks to health. The consequence is short-term thinking and responses to environmental risks to health and inadequate prevention and responses. The Secretariat's work will put in place a global, multi-year strategy for outreach and communication; produce strategic analyses; result in high-impact publications (including reports on the global outlook for environmental health); provide approaches to knowledge management; and engage governments and high-level stakeholders in the response to the issues through global and regional forums and links with networks of practitioners. It will build on existing economic and environmental analyses, reviewing the potential impacts of social and economic trends, monitoring the impact of policies, disseminating information on good practice and making recommendations for action that improves equity in occupational and environmental health.

STRATEGIC OBJECTIVE 9

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

Despite the impact of all forms of malnutrition on mortality, morbidity and national economies, only 1.8% of the total resources for health-related development assistance is allocated to nutrition. Only 0.7% of the World Bank's total assistance to developing countries is for nutrition and food security. At country level, the financial commitment is even lower. To achieve strategic objective set out above, necessary financial, human and political resources will be required to build, promote and implement a nutrition, food-safety and food-security agenda at global, regional and country levels, in both stable

Lessons learnt

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

and emergency situations, that is intersectoral, science-based, comprehensive, integrated and action-oriented. Such an agenda should address the whole spectrum of nutrition, food safety and food security issues related to attainment of the Millennium Development Goals and other international commitments related to nutrition and food safety, including the prevention of foodborne, zoonotic and diet-related chronic diseases and micronutrient malnutrition.

Despite declining prevalence of underweight children in most regions, the fall is not sharp enough for the target for reduction of child malnutrition set out in the first Millennium Development Goal to be achieved by 2015. Furthermore, in Africa the rates continue to rise. The link between poverty, hunger and child undernutrition is loose, so that increased wealth does not automatically lead to the alleviation of hunger and child undernutrition. Hence, direct programme investment is necessary to reduce child undernutrition. Successful efforts to alleviate most forms of malnutrition should ensure that benefits are concentrated mainly among the poor. Unless more progress is made in eliminating hunger and malnutrition, it will be difficult to achieve many of the other Millennium Development Goals. There are critical interactions between undernutrition and most of the following Goals: child mortality (Goal 4), maternal health (Goal 5) and HIV/AIDS and malaria (Goal 6). Although less direct, the interactions between undernutrition and poverty (Goal 1), education (Goal 2) and gender equality (Goal 3) are equally important. Unless a special effort is made to tackle the hunger and child undernutrition targets set out in the first Millennium Development Goal, achievement of all of the other Goals will be compromised.

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

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

STRATEGIC APPROACHES

To achieve this strategic objective, food safety and food security must play a central role in national development policies, in agricultural development, and in animal- and food-production processes, with special emphasis on reaching the most biologically and socially vulnerable populations. Key actions should include developing and implementing ethically and culturally acceptable essential interventions, and improving access to those interventions;

The Secretariat will focus on:

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

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

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

The Secretariat will focus on:

- promoting policy development through broad-based alliances in inclusive processes at all levels to achieve sustainable and effective implementation; increasing technical support to Member States to strengthen their national capabilities in identifying problems and best policy options; implementing the requisite nutrition, food-safety and food-security interventions, including in relevant intersectoral actions; monitoring progress and assessing impacts;
- enhancing WHO's presence at regional and country levels and its nutrition and food-safety capacity in order to provide the requisite support to Member States;
- enhancing institutional and human capacity and develop leadership in nutrition and food safety, building and maintaining an interactive network of practitioners at global, regional and local levels;
- working with national governments to develop national food-control systems and providing tools to aid this process; supporting national and regional control programmes for zoonotic and non-zoonotic foodborne diseases in order to ensure development of sustainable food production.

ORGANIZATION-WIDE EXPECTED RESULTS

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

safety and food-security interventions, and develop and support a research agenda.

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
16 975	15 000	10 000

JUSTIFICATION

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

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

INDICATORS	
9.2.1 Number of new nutrition and food-safety standards, guidelines and training manuals produced and disseminated to countries and the international community	**9.2.2** Number of new norms, standards, guidelines, tools and training materials for prevention and management of zoonotic and non-zoonotic foodborne diseases
BASELINE	
None	None
TARGETS TO BE ACHIEVED BY 2009	
15 norms	3 norms
TARGETS TO BE ACHIEVED BY 2013	
50 norms	10 norms

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
30 031	30 000	30 000

JUSTIFICATION

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

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

INDICATORS	
9.3.1 Number of countries that have adopted and implemented the WHO Child Growth Standards	**9.3.2** Number of countries that have nationally representative surveillance data on major forms of malnutrition
BASELINE	
20 countries	90 countries
TARGETS TO BE ACHIEVED BY 2009	
50 countries	100 countries
TARGETS TO BE ACHIEVED BY 2013	
100 countries	150 countries

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
18 509	15 000	15 000

JUSTIFICATION

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

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

INDICATORS

9.4.1 Number of selected countries receiving WHO support that have developed and implemented at least three high-priority actions recommended by the Global Strategy for Infant and Young Child Feeding	**9.4.2** Number of selected countries receiving WHO support that have developed and implemented strategies to prevent and control micronutrient malnutrition	**9.4.3** Number of selected countries receiving WHO support that have developed and implemented strategies to promote healthy dietary practices in order to prevent diet-related chronic disease	**9.4.4** Number of selected low-income countries receiving WHO support that have included nutrition in their comprehensive responses to HIV/AIDS and other epidemics	**9.4.5** Number of selected countries receiving WHO support that have strengthened national preparedness and response to nutritional emergencies
BASELINE				
30 countries	10 countries	10 countries	35 countries	None
TARGETS TO BE ACHIEVED BY 2009				
60 countries	30 countries	30 countries	35 countries	15 countries
TARGETS TO BE ACHIEVED BY 2013				
90 countries	50 countries	50 countries	50 countries	40 countries

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
24 314	40 000	40 000

JUSTIFICATION

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

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

INDICATORS

9.5.1 Number of countries that have established or strengthened intersectoral collaboration for the prevention, control and surveillance of foodborne zoonotic diseases	**9.5.2** Number of countries that have initiated or strengthened programmes for the surveillance and control of at least one major foodborne zoonotic disease
BASELINE	
20 countries	50 countries
TARGETS TO BE ACHIEVED BY 2009	
20 countries	50 countries
TARGETS TO BE ACHIEVED BY 2013	
40 countries	70 countries

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
17 032	30 000	30 000

JUSTIFICATION

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

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

INDICATORS

9.6.1 Number of selected countries receiving support to participate in international standard-setting activities related to food, such as those of the Codex Alimentarius Commission	**9.6.2** Number of selected countries receiving support from WHO that have built national systems for food safety and foodborne zoonoses with international links to emergency systems
BASELINE	
90 countries	None
TARGETS TO BE ACHIEVED BY 2009	
90 countries	None
TARGETS TO BE ACHIEVED BY 2013	
110 countries	50 countries

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
20 073	30 000	30 000

JUSTIFICATION

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

STRATEGIC OBJECTIVE 10

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
- Improvement in the leadership and governance of health systems compared to regionally agreed benchmarks in at least five out of 10 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 proportion of households suffering from financial catastrophe and impoverishment as a result of health spending (while ensuring that use of needed services is maintained or increased) in 20 countries with currently high out-of-pocket payments
- 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. 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 medical products and technologies; effective management of public and

Lessons learnt

- 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 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.
- 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.

nonpublic providers; fair, adequate and 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 care and 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 should be in place.

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; unsatisfactory working conditions; a weak knowledge base; a narrow focus on the public sector; and lack of coordination between sectors.

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.

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,

Lessons learnt

- 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.
- 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.

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; integrated primary health care, 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.

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.

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;
- 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;
- 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;

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

WHO will provide support to Member States in setting up mechanisms, procedures and incentives that encourage all stakeholders - including public and nonpublic providers and provider organizations - to work together to improve service delivery and eliminate exclusion from access to 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;
- 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;
- 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;

The Secretariat will focus on:

- 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;
- to provide support for countries' monitoring of trends in health systems and performance, backed up by relevant research and eHealth platforms;
- 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.

- 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.

ORGANIZATION-WIDE EXPECTED RESULTS

<table>
<tr><td rowspan="11">10.1 Management and organization of integrated, population-based health-service delivery through public and nonpublic providers and networks improved, reflecting the principles of integrated primary health care, scaling up coverage, equity and quality of health services, and enhancing health outcomes.</td><td colspan="4">INDICATORS</td></tr>
<tr><td colspan="2">10.1.1 Proportion of countries that show evidence of reduced coverage, equity and quality gaps, as measured through agreed composite indicators over a range of interventions</td><td colspan="2">10.1.2 Number of countries that show progress in embedding disease-specific programmes in general health services</td></tr>
<tr><td colspan="4">BASELINE</td></tr>
<tr><td colspan="4">Country-specific baseline to be established in 2007-2008</td></tr>
<tr><td colspan="4">TARGETS TO BE ACHIEVED BY 2009</td></tr>
<tr><td colspan="4">Significant improvement compared to 2007-2008 country-specific baseline in 20% of countries</td></tr>
<tr><td colspan="4">TARGETS TO BE ACHIEVED BY 2013</td></tr>
<tr><td colspan="4">Significant improvement compared to 2007-2008 country-specific baseline</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">RESOURCES (US$ THOUSAND)</td></tr>
<tr><td>Budget 2008-2009</td><td>Estimates 2010-2011</td><td colspan="2">Estimates 2012-2013</td></tr>
<tr><td>73 379</td><td>87 000</td><td colspan="2">96 000</td></tr>
<tr><td colspan="4">JUSTIFICATION</td></tr>
<tr><td colspan="4">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.</td></tr>
</table>

<table>
<tr><td rowspan="4">10.2 National capacities for governance and leadership improved through evidence-based policy dialogue, effective governance and leadership, institutional capacity-building for policy analysis, greater transparency and accountability for performance, and more effective intersectoral collaboration.</td><td colspan="4">INDICATORS</td></tr>
<tr><td>10.2.1 Proportion of countries that, against regionally agreed benchmarks, show evidence of improving institutional capacities for policy analysis, policy formulation, strategic planning, regulation, interinstitutional coordination and implementation of reform</td><td>10.2.2 Proportion of countries 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 policies and their implementation</td><td>10.2.3 Proportion of countries that, against regionally agreed benchmarks, show evidence of improved performance in regulation, policy formulation, and policy implementation</td><td>10.2.4 Proportion of countries that, against regionally agreed benchmarks, establish effective intersectoral cooperation mechanisms to improve health-systems' performance for better health outcomes</td></tr>
<tr><td colspan="4">BASELINE</td></tr>
<tr><td colspan="4">Country-specific baselines to be established in 2007-2008</td></tr>
</table>

	TARGETS TO BE ACHIEVED BY 2009
	Significant improvement compared to 2007-2008 country-specific baseline in at least 10% of countries
	TARGETS TO BE ACHIEVED BY 2013
	Significant improvement compared to country-specific baseline in 50% of countries

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
87 484	93 000	108 000

JUSTIFICATION

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

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

10.3 Coordination of the various mechanisms (including donor assistance) that provide support to Member States in their efforts to achieve national targets for health-system development and global health goals improved.	**INDICATORS**
	10.3.1 Number of countries where the inputs of major stakeholders are harmonized with national policies, measured in line with the Paris Declaration on Aid Effectiveness
	BASELINE
	To be established in 2007-2008
	TARGETS TO BE ACHIEVED BY 2009
	Increase by 20% from 2007-2008 baseline
	TARGETS TO BE ACHIEVED BY 2013
	Increase by 30% from 2007-2008 baseline

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
15 801	15 000	17 000

JUSTIFICATION

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

10.4 Country health-information systems that provide and use high-quality and timely information for health planning and for monitoring progress towards national and major	**INDICATORS**
	10.4.1 Proportion of low- and middle-income countries with adequate health statistics that meet agreed standards.
	BASELINE
	30% of low- and middle-income countries
	TARGETS TO BE ACHIEVED BY 2009
	35%

international goals strengthened.	**TARGETS TO BE ACHIEVED BY 2013**
	66%

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
34 352	55 000	58 000

JUSTIFICATION

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

10.5. Better knowledge and evidence for health decision-making assured through consolidation and publication of existing evidence, facilitation of knowledge generation in priority areas, and global leadership in health research policy and coordination, including with regard to ethical conduct.	**INDICATORS**	
10.5.1 Use and quality of Organization-wide databases of core health statistics and evidence that cover all high-priority health issues	**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 and promotion of standards such as the International Statistical Classification of Diseases and Related Health Problems	**10.5.3** Effective research for health coordination and leadership mechanisms established and maintained at global and regional levels, including ACHR
BASELINE		
Two-thirds of countries	20	Mechanisms operating at global and some regional levels
TARGETS TO BE ACHIEVED BY 2009		
Recent country health statistical profiles for 80% of Member States.	30	Mechanisms operating at global and all regional levels
TARGETS TO BE ACHIEVED BY 2013		
Over 90%	45	As in 2009

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
36 484	33 000	38 000

JUSTIFICATION

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

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

INDICATORS

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

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
21 088	34 000	38 000

JUSTIFICATION

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

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

INDICATORS

10.7.1 Number of countries adopting knowledge management strategies in order to bridge the "know-do" gap	**10.7.2** Number of low- and middle-income countries with access to essential scientific information and knowledge	**10.7.3** Proportion of countries with evidence-based eHealth frameworks and services
BASELINE		
15	60	10%
TARGETS TO BE ACHIEVED BY 2009		
30	90	30%
TARGETS TO BE ACHIEVED BY 2013		
70	120	75%

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
39 064	34 000	37 000

JUSTIFICATION

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

10.8 Health-workforce information and knowledge base strengthened, and country capacities for policy analysis, planning,

INDICATORS

10.8.1 Proportion of countries regularly reporting validated statistics on human resources for health (e.g. population-to-providers ratios, rural/urban distribution of health workers)	**10.8.2** Number of countries facing severe health-workforce difficulties effectively transforming resource inputs from partnerships, bilateral assistance and similar mechanisms into measurable outputs for health-workforce development

implementation, information-sharing and research built up

BASELINE

Proportion of 193 countries reached by 2007	Number of countries reached by 2007 out of the 57 countries facing severe health-workforce difficulties

TARGETS TO BE ACHIEVED BY 2009

50% of the 193 countries	At least 10 more countries facing severe health-workforce difficulties

TARGETS TO BE ACHIEVED BY 2013

75% of the 193 countries	At least 20 more countries facing severe health-workforce difficulties

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
76 216	70 000	67 000

JUSTIFICATION

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

10.9 Technical support provided to Member States, with a focus on those facing severe health-workforce difficulties in order to improve the production, distribution, skill mix and retention of the health workforce.

INDICATORS

10.9.1 Number of countries facing severe health-workforce difficulties that use evidence-based practices, tools and guidelines to implement and monitor national health-workforce development, including migration	**10.9.2** Number of countries facing severe health-workforce difficulties that adopt updated norms and standards related to the education, training and practice of different categories of health occupations

BASELINE

Number of countries reached by 2007, particularly among 57 countries facing severe health-workforce difficulties	Number of countries reached by 2007, particularly among 57 countries facing severe health-workforce difficulties

TARGETS TO BE ACHIEVED BY 2009

10 additional countries facing severe health-workforce difficulties that adopt relevant technical frameworks, tools and guidelines	10 more countries facing severe health-workforce difficulties that adopt updated norms and standards

TARGETS TO BE ACHIEVED BY 2013

30 more countries facing severe health-workforce difficulties	30 more countries facing severe health-workforce difficulties	30 more countries facing severe health-workforce difficulties

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
40 041	65 000	62 000

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

10.10 Evidence-based policy and technical support provided to Member States in order to improve health-system financing in terms of the availability of funds, social and financial-risk protection, equity, access to services and efficiency of resource use.	**INDICATORS**	
	10.10.1 Number of countries 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; and 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	
	15 countries	6 technical briefs for policy-makers
	TARGETS TO BE ACHIEVED BY 2009	
	40 countries	12 technical briefs
	TARGETS TO BE ACHIEVED BY 2013	
	90 countries	20 technical briefs

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
31 249	39 000	41 000

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

10.11 Norms, standards and measurement tools developed for tracking resources, estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe, impoverishment, and social exclusion, and their use supported and monitored.	**INDICATORS**	
	10.11.1 Key tools, norms and standards to guide policy development and implementation developed, disseminated and their use supported, according to expressed need, that comprise resource tracking and allocation, budgeting, financial management, economic consequences of disease and social exclusion, organization and efficiency of service delivery, including contracting, and the incidence of financial catastrophe and impoverishment	**10.11.2** Number of countries 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, and to track the impact of financing policy on households
	BASELINE	
	Tools available on national health accounts, costing, financial catastrophe and impoverishment, cost-effectiveness, implications of health-insurance design, and contracting	15 countries
	TARGETS TO BE ACHIEVED BY 2009	
	Additional tools developed for resource	30 countries

	tracking, additionality and economic burden; existing tools revised where necessary; framework drawn up for formulation of financing policy	
	TARGETS TO BE ACHIEVED BY 2013	
	Tools and frameworks modified, updates and disseminated as necessary	50 countries

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
23 896	27 000	28 000

JUSTIFICATION

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

10.12 Steps taken to advocate additional funds for health where necessary; to build capacity in framing of health-financing policy and interpretation and use of financial information; and to stimulate the generation and translation of knowledge to support policy development.	**INDICATORS**	
	10.12.1 WHO presence and leadership in international, regional and national partnerships and use of its evidence in order to increase financing for health in low-income countries, and 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	**10.12.2** Number of countries provided with support to build capacity in the formulation of health financing policies and strategies and the interpretation of financial data, and with key information on health expenditures, financing, efficiency and equity to guide the process
	BASELINE	
	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 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	Estimates 2010-2011	Estimates 2012-2013
35 000	44 000	47 000

JUSTIFICATION

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.

STRATEGIC OBJECTIVE 11

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

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.

comprehensive national policies and supply systems for medical products and technologies.

STRATEGIC APPROACHES

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

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

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

Emphasis will be 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 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.

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

- that expanding access to essential products and technologies of assured quality and improving their use by health workers and consumers will remain priorities for Member States and therefore the Secretariat;
- that WHO will resist undue political and commercial pressure and will continue to fulfil its constitutional and international treaty obligations with regard to the development of international pharmaceutical norms and standards for products and technologies;

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;

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

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
39 305	40 000	44 000

JUSTIFICATION

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

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, and 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 countries whose national regulatory authorities have been assessed, supported and accredited
BASELINE			
30 per biennium	8900 names	150 products	20 countries
TARGETS TO BE ACHIEVED BY 2009			
30 additional outputs	9100 names	250 products	30 countries
TARGETS TO BE ACHIEVED BY 2013			
A further 60 additional outputs	9500 names	500 products	80 countries

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
69 172	95 000	104 000

JUSTIFICATION

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

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

INDICATORS

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

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
25 556	30 000	34 000

JUSTIFICATION

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.

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

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

Lessons learnt

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

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

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

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

Lessons learnt

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

STRATEGIC APPROACHES

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

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

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of the strategic objective:

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

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

ORGANIZATION-WIDE EXPECTED RESULTS

12.1 Effective leadership and direction of the Organization exercised through enhancement of governance, and the coherence, accountability and synergy of WHO's work.	**INDICATORS**			
	12.1.1 Proportion of resolutions adopted that focus on policy and can be implemented at global, regional and national levels	**12.1.2** Proportion of documents submitted to governing bodies within constitutional deadlines, in all official languages	**12.1.3** Level of understanding by key stakeholders of WHO's role, priorities and key messages	**12.1.4** Percentage of oversight projects completed under the annual workplan which seek to evaluate and improve processes for risk management, control and governance
	BASELINE			
	20%	50%	Survey to be carried out	100%

	TARGETS TO BE ACHIEVED BY 2009			
	40%	75%	10% increase over survey baseline	100%
	TARGETS TO BE ACHIEVED BY 2013			
	50%	90%	25% increase over survey baseline	100%

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
87 222	97 927	108 128

JUSTIFICATION

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

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

INDICATORS		
12.2.1 Number of Member States using country cooperation strategies as a basis for planning WHO's country work and for harmonizing cooperation with the United Nations country team members and other development partners	**12.2.2** Proportion of countries where WHO's presence reflects the respective Country Cooperation Strategy	**12.2.3** Number of countries in which harmonized mechanism to assess the contribution of the Secretariat to national health outcomes is implemented
BASELINE		
40	20%	3
TARGETS TO BE ACHIEVED BY 2009		
80	40%	25
TARGETS TO BE ACHIEVED BY 2013		
135	80%	80

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
71 128	79 228	87 481

JUSTIFICATION

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

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

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

INDICATORS			
12.3.1 Proportion of external aid flows to health supplied through flexible and long-term instruments	**12.3.2** Proportion of health partnerships in which WHO participates and that work according to the Best Practice Principles for Global Health Partnerships	**12.3.3** Proportion of trade agreements appropriately reflecting public health interests, as outlined in WHO guidance	**12.3.4** Proportion of countries where WHO is leading or actively engaged in health and development partnerships (formal and informal), including in the context of reforms of the United Nations system
BASELINE			
Not yet established	Not yet established	Less than 5%	Less than 20%

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

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
21 030	23 600	26 058

JUSTIFICATION

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

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 Number of countries that have access to relevant health information and advocacy material for the effective delivery of health programmes as reflected in the country cooperation strategies	**12.4.2** Average number of page views/visits per month to the WHO web site	**12.4.3** Number of multilingual (non-English) pages available on the WHO web site	**12.4.4** Number of WHO publications sold per biennium
	BASELINE			
	To be established	28 million/3.5 million	12 733	350 000
	TARGETS TO BE ACHIEVED BY 2009			
	Baseline plus 20%	48 million/5 million	22 000	400 000
	TARGETS TO BE ACHIEVED BY 2013			
	Baseline plus 50%	80 million/7 million	40 000	500 000

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
34 964	39 245	43 333

JUSTIFICATION

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

STRATEGIC OBJECTIVE 13

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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 is a challenge in a situation in which more than 70% of the Organization's resources are voluntary contributions. Regular monitoring of, and reporting on, resources across the Organization has improved. However, more flexibility is required in the financing from partners together with more effective use of funds internally for better alignment of resources with the programme budget and lowering of transaction costs.

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

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.

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

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

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.

STRATEGIC APPROACHES

In order to achieve the strategic objective and respond to the above challenges, broad complementary approaches are required. Over the past two to three years significant efforts have been made in internal reforms to enhance the Secretariat's administrative and managerial capabilities, efforts that are starting to show results. These approaches will be intensified during the next six years, and include the move from an organization managed mainly through tight, overly bureaucratic controls to post facto monitoring in support of greater delegation and accountability; the shift of responsibility for, and decision-making on, the use of resources closer to where programmes are implemented; 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.

In addition the 10-year capital master plan for WHO will offer a strategic and integrated approach to managing and maintaining the Organization's physical infrastructure at all locations. The plan will help to manage the rescheduling of real-estate projects in line with budgetary priorities and within the approved budget. It will also help to ensure that the projects meet operational needs and organizational objectives in a cost-effective way.

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 Proportion of approved workplans that incorporate lessons learnt from the previous biennium as identified in the programme budget performance assessment and have been drawn up in a consultative process involving the three levels of the Organization	**13.1.2** Proportion of reports on strategic objectives for the mid-term review and programme budget performance assessment that have been peer reviewed and submitted in a timely fashion		
	BASELINE			
	50%	50%		
	TARGETS TO BE ACHIEVED BY 2009			
	80%	80%		
	TARGETS TO BE ACHIEVED BY 2013			
	90%	90%		

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
36 916	40 383	43 805

JUSTIFICATION

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

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

INDICATORS		
13.2.1 Degree of compliance of WHO with International Public Sector Accounting Standards	**13.2.2** Proportion of strategic objectives with expenditure levels meeting programme budget targets	**13.2.3** Proportion of voluntary contributions that are un-earmarked
BASELINE		
Accounting Standards not implemented	70% (areas of work)	15%
TARGETS TO BE ACHIEVED BY 2009		
International Public Sector Accounting Standards implemented	80%	20%
TARGETS TO BE ACHIEVED BY 2013		
	100%	30%

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
60 654	66 871	72 538

JUSTIFICATION

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

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	**13.3.3** Proportion of staff in compliance with the cycle of the Performance Management Development System, i.e. objectives and development needs have been discussed between staff and supervisor
BASELINE		
40%	About 100	65%
TARGETS TO BE ACHIEVED BY 2009		
75%	300	75%
TARGETS TO BE ACHIEVED BY 2013		
100%	400	95%

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
29 630	32 772	35 549

JUSTIFICATION

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

[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 Proportion of known proposals, projects, and applications tracked on a regular basis through global portfolio management processes	**13.4.2** Number of information technology disciplines[1] implemented Organization-wide according to best-practice benchmarks	**13.4.3** Proportion of offices using consistent real-time management information
BASELINE		
40%	0 (only localized implementation)	0% office-specific management information
TARGETS TO BE ACHIEVED BY 2009		
75%	5	75%
TARGETS TO BE ACHIEVED BY 2013		
95%	9	90%

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
106 228	117 523	127 483

JUSTIFICATION

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

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

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 according to criteria in service-level agreements	**13.5.2** Proportion of procedures delivered according to criteria in emergency standard operating procedures
BASELINE	
0% (agreements currently under development)	0% (procedures currently under development)
TARGETS TO BE ACHIEVED BY 2009	
75%	75%
TARGETS TO BE ACHIEVED BY 2013	
100%	100%

RESOURCES (US$ THOUSAND)		
Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
149 647	165 216	179 217

JUSTIFICATION

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

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

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

INDICATORS

13.6.1 Timeliness of implementation of the capital master plan, within the approved budget	**13.6.2** Proportion of locations that have implemented policies and plans to improve staff health and safety in the workplace, including compliance with Minimum Operating Safety Standards
BASELINE	
Plan being submitted to the Executive Board at its 120th session	65%
TARGETS TO BE ACHIEVED BY 2009	
On target	75%
TARGETS TO BE ACHIEVED BY 2013	
On target	95%

RESOURCES (US$ THOUSAND)

Budget 2008-2009	Estimates 2010-2011	Estimates 2012-2013
159 297	167 235	181 408

JUSTIFICATION

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