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.

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 unprecendented 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.

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;

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.

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.

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

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

ORGANIZATION-WIDE EXPECTED RESULTS

9.1 Partnerships and alliances formed, leadership built and coordination and networking developed with all stakeholders at country, regional and global levels, in order to promote advocacy and communication, stimulate intersectoral actions, increase investment in nutrition, food-	**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)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
16 964	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)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
30 250	30 000	30 000

JUSTIFICATION

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

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

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)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
18 395	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)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
24 219	40 000	40 000

JUSTIFICATION

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

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

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

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
16 907	30 000	30 000

JUSTIFICATION

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

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

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

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
19 965	30 000	30 000

JUSTIFICATION

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

STRATEGIC OBJECTIVE 10

To improve the organization, management and delivery of health services

Indicators and targets

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

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

ISSUES AND CHALLENGES

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

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

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

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

Lessons learnt

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

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

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

STRATEGIC APPROACHES

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

ASSUMPTIONS, RISKS AND OPTIONS

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

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

The Secretariat will focus on:

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

ORGANIZATION-WIDE EXPECTED RESULTS

10.1 Standards, best practices and principles of equity endorsed by, or developed with support from, WHO increasingly reflected in service-delivery policies and their implementation in Member States.

INDICATORS

10.1.1 Coverage and access as measured through composite indicators over a range of interventions: equity in the distribution of a range of high-priority health interventions across a country and by socioeconomic status; technical and organizational quality, including compliance with minimum standards of care and patient safety and improved responsiveness; efficiency as measured by a score for outputs of health services related to a given set of financial and human resources inputs

BASELINE

Country-specific baselines to be established in 2006-2007

TARGETS TO BE ACHIEVED BY 2009

Significant improvement compared to country-specific baseline in at least 25% of countries

TARGETS TO BE ACHIEVED BY 2013

Significant improvement compared to country-specific baseline in at least 50% of countries

RESOURCES (US$ THOUSAND)

Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
53 500	50 000	60 000

JUSTIFICATION

The increase in resources required is due to the increased emphasis in the General Programme of Work on health systems. As WHO's capacity increases particularly at country and regional levels, it is expected that the demand for support and the level of support provided will have to increase accordingly.

10.2 Organizational and managerial capacities of service-delivery institutions and networks in Member States strengthened.

INDICATORS

10.2.1 Proportion of countries that demonstrate progress in identifying and correcting inadequacies in organizational and managerial capacity in their institutions and networks

BASELINE

To be determined by country-specific mapping exercises in 2006

TARGETS TO BE ACHIEVED BY 2009

Major weaknesses remedied in 10% of countries

TARGETS TO BE ACHIEVED BY 2013

Major weaknesses remedied in 25% of countries

RESOURCES (US$ THOUSAND)

Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
36 394	37 000	50 000

JUSTIFICATION

The increase in resources required is due to the increased emphasis in the General Programme of Work on health systems. As WHO's capacity increases, particularly at country and regional levels, it is expected that the demand for support will grow and the level of support provided will have to increase accordingly.

10.3 Mechanisms and regulatory systems in place in Member States in order to ensure synergy between public and non-public service-delivery systems that lead to better overall service delivery.

INDICATORS

10.3.1 Proportion of countries that show evidence of improved regulatory capacities

BASELINE

To be determined by country-specific mapping exercises in 2006

TARGETS TO BE ACHIEVED BY 2009

Major weaknesses remedied in 10% of countries

TARGETS TO BE ACHIEVED BY 2013

Major weaknesses remedied in 25% of countries

RESOURCES (US$ THOUSAND)

Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
22 172	35 000	40 000

JUSTIFICATION

The increase in resources required is due to the increased emphasis in the General Programme of Work on health systems. As WHO's capacity increases particularly at country and regional levels, it is expected that the demand for support will grow and the level of support provided will have to increase accordingly. The expectation that the potential growth of WHO's budget is limited explains the slower rate of increase in 2012–2013.

10.4 Policy, structural and managerial changes in the health services architecture of Member States implemented in order to ensure that disease-specific programmes are adequately embedded in general health services so as to enhance overall performance of health service delivery.

INDICATORS

10.4.1 Proportion of countries that demonstrate progress in embedding disease-specific programmes in general health services

BASELINE

To be determined by country-specific mapping

TARGETS TO BE ACHIEVED BY 2009

Major fragmentation problems corrected in 10% of countries

TARGETS TO BE ACHIEVED BY 2013

Major fragmentation problems corrected in 25% of countries

RESOURCES (US$ THOUSAND)

Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
31 934	40 000	36 000

JUSTIFICATION

This is an area in which currently much work is undertaken globally and an increased investment is necessary. Through combined country-level and global efforts it is expected that reforms in this area will have acquired momentum over the next five years, allowing for progressive reduction of funding.

STRATEGIC OBJECTIVE 11

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

Indicators and targets

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

ISSUES AND CHALLENGES

Many countries experience the following weaknesses or difficulties.

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

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

Lessons learnt

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

mechanisms and information to ensure accountability and transparency are lacking

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

STRATEGIC APPROACHES

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

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

The Secretariat will focus on:

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

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

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

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

ORGANIZATION-WIDE EXPECTED RESULTS

11.1 Country capacity and practices improved in national and local health-sector policy-making, regulation, strategic planning, implementation of reforms, and intersectoral and interinstitutional coordination.

INDICATORS	
11.1.1 Proportion of countries with adequate capacity for, and practices in, national and local health-sector policy-making, regulation, strategic planning, implementation of reforms and interinstitutional coordination	**11.1.2** Proportion of countries with institutionalized health-impact assessment
BASELINE	
25% of countries (to be refined)	10% of countries (to be refined)
TARGETS TO BE ACHIEVED BY 2009	
Increase by 10% from baseline	Increase by 10% from baseline
TARGETS TO BE ACHIEVED BY 2013	
Increase by 25% from 2006 baseline	Increase by 20% from 2006 baseline

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
31 450	28 000	32 000

JUSTIFICATION

Contributing to the implementation of sound governance of health systems in Member States will take many years of work, not only to initiate the processes and build the necessary skills and competencies, but also to sustain progress. It is expected that WHO's work will expand, including provision of support to countries for institutionalized performance assessment of health systems.

11.2 Coordination of donor assistance improved at the global and country levels in order to achieve national targets for health-system development and global health goals.

INDICATORS	
11.2.1 Proportion of countries where the priorities of major donors to the health sector are harmonized and aligned with those of the government	**11.2.2** The proportion of health priorities that are not adequately funded
BASELINE	
A quarter of major recipient countries	Half all priorities not well funded
TARGETS TO BE ACHIEVED BY 2009	
Increase by 20%	Decrease by 15% from baseline
TARGETS TO BE ACHIEVED BY 2013	
Increase by 30% from 2006 baseline	Decrease by 25% from 2006 baseline

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
4 771	5 000	5 000

	JUSTIFICATION
	Hitherto, only a few Member States have reached a level of highly-effective and efficient coordination of donor assistance. In the context of expanding the response and making progress towards attaining the Millennium Development Goals, WHO will continue to need to be involved in this area at country, regional and global levels.

11.3 Member States' health-information systems strengthened to provide and use high-quality and timely information for health planning and monitoring of countries' and major international goals.	**INDICATORS**
	11.3.1 Proportion of low- and middle-income countries with adequate health-information systems in line with international standards, set by WHO and the Health Metrics Network
	BASELINE
	30% of countries
	TARGETS TO BE ACHIEVED BY 2009
	35% of countries
	TARGETS TO BE ACHIEVED BY 2013
	66% of countries

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
34 986	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, many more resources have become available in 2006-2007 and it is expected that growth will continue modestly beyond 2010 because strengthening health-information systems in countries will take many years, especially for some neglected areas such as vital registration systems.

11.4 Knowledge and evidence for health decision-making enhanced by consolidation and publication of existing evidence, facilitation of knowledge generation in priority areas, and global leadership in health-research policy and coordination, including steps to ensure ethical conduct.	**INDICATORS**		
	11.4.1 Use and quality of Organization-wide database system of core health statistics and evidence that covers all high-priority health issues	**11.4.2** 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	**11.4.3** Establishment and maintenance of effective research for health coordination and leadership mechanisms at global and regional levels, including ACHR
	BASELINE		
	Two thirds of countries	20 countries	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 countries	Mechanisms operating at global and all regional levels
	TARGETS TO BE ACHIEVED BY 2013		
	Profiles for more than 90% of Member States	45 countries	Mechanisms operating at global and all regional levels

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
33 109	33 000	38 000

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

11.5 National health research for health-systems development strengthened, within the context of regional and international research and engagement of civil society.

INDICATORS	
11.5.1 Proportion of low- and middle-income countries in which national health-research systems meet internationally-agreed minimum standards (to be defined)	**11.5.2** Proportion of countries complying with the call for action in the Mexico Statement on Health Research for governments to commit to fund the necessary health research (at least 2% of their health budget to research recommended)
BASELINE	
10% to 15% of countries (to be refined)	Less than 25% of countries (to be refined)
TARGETS TO BE ACHIEVED BY 2009	
25% of countries	10% increase
TARGETS TO BE ACHIEVED BY 2013	
50% of countries	25% increase from baseline

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
20 954	34 000	38 000

JUSTIFICATION

Overcoming the limitations of national health research for health-systems development, within the context of regional and international research and engagement of civil society, is a major objective of this expected result. Given the current situation in many Member States and at global level, improvement will be gradual and long term, with an increasing number of Member States involved during the next decade. The Alliance for Health Policy and Systems Research will play an important role in generating and channelling resources to fund high-priority health-systems research.

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

INDICATORS		
11.6.1 Number of countries (health ministries and schools of public health) adopting knowledge-management strategies to bridge the gap between knowledge and its application	**11.6.2** Number of low- and middle-income countries with access to essential scientific information and knowledge	**11.6.3** Proportion of countries with evidence-based eHealth frameworks and services
BASELINE		
15 countries	60 countries	10% of countries
TARGETS TO BE ACHIEVED BY 2009		
30 countries	90 countries	30% of countries
TARGETS TO BE ACHIEVED BY 2013		
70 countries	120 countries	75% of countries

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
36 050	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 to include and support an increasing number of Member States.

STRATEGIC OBJECTIVE 12

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

Lessons learnt

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

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

STRATEGIC APPROACHES

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

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

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

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

The Secretariat will focus on:

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

The following risks may hinder achievement of the strategic objective:

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

The Secretariat will focus on:

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

ORGANIZATION-WIDE EXPECTED RESULTS

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

INDICATORS			
12.1.1 Number of countries receiving support to formulate and implement official national policies on access, quality and use of essential medical products and technologies	**12.1.2** Number of countries receiving support to design or strengthen comprehensive national procurement and supply systems	**12.1.3** Number of countries receiving support to formulate and implement national strategies and regulatory mechanisms for blood and blood products and infection control	**12.1.4** Publication of a biennial global report on medicine prices, availability and affordability
BASELINE			
62 countries	20 countries	46 countries	Report published in 2007
TARGETS TO BE ACHIEVED BY 2009			
68 countries	25 countries	52 countries	Report published
TARGETS TO BE ACHIEVED BY 2013			
78 countries	35 countries	64 countries	2 reports published (2011 and 2013)

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
38 489	40 000	44 000

JUSTIFICATION

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

12.2 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			
12.2.1 Number of new or updated global quality standards, reference preparations, guidelines and tools for promoting the quality and effective regulation of medical products and technologies	**12.2.2** Number of assigned International Nonproprietary Names for medical products	**12.2.3** Number of priority medicines, vaccines, diagnostic tools and items of equipment that are prequalified for United Nations procurement	**12.2.4** 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	100 products	30 countries
	TARGETS TO BE ACHIEVED BY 2013			
	A further 60 additional outputs	9500 names	500 products	80 countries

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
66 990	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.

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

INDICATORS	
12.3.1 Number of national or regional programmes receiving support for promoting sound and cost-effective use of medical products and technologies	**12.3.2** Number of countries using national lists, updated within the past five years, of essential medicines, vaccines and technologies for public procurement and/or reimbursement
BASELINE	
5 programmes	80 countries
TARGETS TO BE ACHIEVED BY 2009	
10 programmes	90 countries
TARGETS TO BE ACHIEVED BY 2013	
20 programmes	100 countries

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
24 896	30 000	34 000

JUSTIFICATION

Most new funding agencies, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, pay insufficient attention to promoting the rational use by prescribers and consumers of the medicines they supply. This omission can lead to health outcomes not being fully attained and considerable waste of economic resources.

STRATEGIC OBJECTIVE 13

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

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

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

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

Lessons learnt

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

[1] *The world health report 2006: working for health.* Geneva, World Health Organization, 2006.

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

The Secretariat will focus on:

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

STRATEGIC APPROACHES

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

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

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

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

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of this strategic objective:

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

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

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

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

ORGANIZATION-WIDE EXPECTED RESULTS

13.1 Capacity of Member States strengthened for leading in health workforce development.	**INDICATORS**				
	13.1.1 Number of countries with evidence-based policies, plans and strategies for strengthening the health workforce in the areas of production, distribution, retention and productivity	**13.1.2** Number of countries with strengthened planning and development capacities and their health ministries and allied national institutions for development of human resources for health	**13.1.3** Number of countries with strengthened national institutions for increasing production of different types of health workers	**13.1.4** Number of countries with effective accreditation mechanisms for health education institutions	**13.1.5** Number of countries with bilateral agreements and other mechanisms for managing migration
	BASELINE				
	Number of countries reached by 2007, out of the 57 countries in crisis	Number of countries reached by 2007, out of the 57 countries in crisis	Number of countries reached by 2007, out of the 57 countries in crisis	Number of countries reached by 2007, out of the 57 countries in crisis	Number of countries reached by 2007, out of the 57 countries in crisis
	TARGETS TO BE ACHIEVED BY 2009				
	At least 10 more countries over baseline	At least 10 more countries over baseline	At least 10 more countries over baseline	At least 10 more countries over baseline	At least 10 more countries over baseline
	TARGETS TO BE ACHIEVED BY 2013				
	At least 20 more countries over baseline	At least 20 more countries over baseline	At least 20 more countries over baseline	At least 20 more countries over baseline	At least 20 more countries over baseline

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
31 651	30 000	29 000

	JUSTIFICATION *There is strong evidence that availability of skilled health workers contributes to improved health outcomes in areas such as maternal, infant and child survival. For this reason, capacity should be built in countries to enable them to take the lead in advocating for the health workforce and in creating and maintaining the political commitment and the enabling environment that are needed for formulating national policies and plans, and pursuing their implementation, in order to combat the shortage and inappropriate distribution of health workers. WHO's capacity needs to be strengthened at all levels in order to support health workforce development in countries.*

13.2 Information and knowledge base for developing the health workforce strengthened at national, regional and global levels.

INDICATORS

13.2.1 Number of countries with well maintained and regularly updated databases for health-workforce development	**13.2.2** Provision by countries of good-quality data at least once a year for the global health atlas	**13.2.3** Regional observatories established to assess and monitor the situation of the health workforce in countries	**13.2.4** Proportion of comprehensive and coherent research programmes established to inform on human resources for health development and implementation of policy
BASELINE			
Number of countries reached by 2007, out of the 57 countries in crisis	Global atlas on the health workforce in use	2 regional observatories established by the end of 2007	Baselines to be determined after completion of assessment in 2007
TARGETS TO BE ACHIEVED BY 2009			
At least 10 more countries	Global atlas updated at least once a year	2 further regional observatories established	30% more programmes
TARGETS TO BE ACHIEVED BY 2013			
At least 20 more countries over baseline	Global atlas updated at least once a year	Regional observatories established in all 6 regions	50% more programmes than in 2009

RESOURCES (US$ THOUSAND)

Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
18 113	23 000	22 000

JUSTIFICATION

The knowledge base in human resources for health development is weak and uneven in comparison with other areas of health-systems research, such as health financing or health-sector reform. Areas concerning the health workforce, such as assessment, planning, production, regulation and management, need to be better understood. Common technical frameworks are necessary in order to permit analysis of comparable situations, as well as identification of trends. Data and information must be collected and analysed in order to monitor the health-workforce situation at global and regional levels and the trend therein. Research needs to be supported and further stimulated in order to expand the knowledge base and identify and promote best practices in health-workforce development.

13.3 Technical support provided to Member States in crisis to reduce their shortages by improving the production, distribution and skill mix of their health workforce.

INDICATORS

13.3.1 Number of countries developing and using common technical frameworks, together with their accompanying tools and guidelines in order to facilitate the assessment, production, regulation and management of the health workforce (including in relation to its retention, performance and productivity)	**13.3.2** Number of countries adopting tools and guidelines for integrating human resources for health across priority programmes	**13.3.3** Number of countries adopting updated norms and standards related to the classification and licensing of different categories of health-care providers

	BASELINE		
	Existence of draft frameworks, tools and guidelines in all areas	Existence of tools and guidelines for integrating human resources for health across priority programmes	Norms and standards established for nursing and midwifery and other health professions
	TARGETS TO BE ACHIEVED BY 2009		
	20 countries adopting the technical frameworks	20 countries adopting the tools and guidelines	20 countries adopting the norms and standards
	TARGETS TO BE ACHIEVED BY 2013		
	30 more countries adopting the technical frameworks	30 more countries adopting the tools and guidelines	30 more countries adopting the norms and standards

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
44 986	65 000	62 000

JUSTIFICATION

Performance of health workers is measured against criteria involving availability, competence, responsiveness and productivity. Tools, guidelines and other technical support will be provided to ensure that countries can strengthen their health workforce across the continuum of entry, working life and exit. Country teams will be established that include: health-workforce experts from global, regional and country levels; representatives of other sectors, civil society and the professional associations; bilateral donors; and other relevant stakeholders.

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

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
25 002	17 000	16 000

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

STRATEGIC OBJECTIVE 14

To extend social protection through fair, adequate and sustainable financing

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

Lessons learnt

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

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

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

The Secretariat will focus on:

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

STRATEGIC APPROACHES

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

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

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

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

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

The Secretariat will focus on:

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

ASSUMPTIONS, RISKS AND OPTIONS

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

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

Possible risks are:

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

ORGANIZATION-WIDE EXPECTED RESULTS

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

	TARGETS TO BE ACHIEVED BY 2013
	90 countries — 20 technical briefs

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
32 605	39 000	41 000

JUSTIFICATION

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

14.2 International, regional and national advocacy, information and technical support designed to mobilize additional and predictable funding for health.

INDICATORS

14.2.1 WHO presence and leadership in international, regional and national partnerships to increase funding for health in poor countries	**14.2.2** WHO support to countries in the design and/or monitoring of Poverty Reduction Strategy Papers, sector-wide approaches, medium-term expenditure frameworks and other long-term financing mechanisms	**14.2.3** Number of technical briefs collating evidence on best practices for coordination of external financial assistance at global, regional and national levels in order to increase extent and to improve predictability of external assistance
BASELINE		
WHO participation in 2 global or regional partnerships on financing options	6 countries	1 technical brief for policy-makers disseminated
TARGETS TO BE ACHIEVED BY 2009		
WHO participation in 4 global or regional partnerships on financing options	16 countries	4 technical briefs
TARGETS TO BE ACHIEVED BY 2013		
WHO participation in 8 global or regional partnerships on financing options	40 countries	8 technical briefs

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
7 480	13 000	14 000

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 momentum internationally and to provide active support to countries to build health into country economic plans such as medium-term expenditure frameworks. This requires strengthening capacity of country offices as well as other levels of WHO.

14.3 Measurement tools developed to analyse transparency and accountability in health-financing systems, and technical support

INDICATORS

14.3.1 Number of countries provided with technical support for using WHO tools to track and evaluate the use of funds, to estimate future financial needs, and to manage and monitor available funds

BASELINE

15 countries

provided for their use, where needed.

TARGETS TO BE ACHIEVED BY 2009

30 countries

TARGETS TO BE ACHIEVED BY 2013

50 countries

RESOURCES (US$ THOUSAND)

Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
13 845	18 000	19 000

JUSTIFICATION

WHO is the only agency in the United Nations system that provides estimates of health expenditures for its 193 Member States. After consultation with countries, the estimates are published annually in The world health report. *At the request of countries, this relatively basic set of tables needs to be expanded to include expenditure by disease or condition and beneficiary. In addition, the tools available for countries to assess their financial requirements for expanding or monitoring programmes need to be expanded and capacity built in their use. This requires an initial increase in funding, followed by more modest increases after 2008 to enable support to be provided to more countries.*

14.4 Norms and standards developed for tracking resources, and estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe and impoverishment, and their implementation promoted, supported and monitored.

INDICATORS

14.4.1 Key tools, norms and standards to guide policy development and implementation developed, disseminated and their use supported, according to expressed need, but including resource tracking, the economic consequences of disease, costs and effects of interventions, financial catastrophe and impoverishment

BASELINE

Tools available to countries for national health accounts, costing financial catastrophe and impoverishment, and cost effectiveness

TARGETS TO BE ACHIEVED BY 2009

Additional tools for resource tracking, additionality and economic burden. Revision of existing tools where necessary. Framework on formulation of financing policy

TARGETS TO BE ACHIEVED BY 2013

Tools and frameworks modified, updated and disseminated as necessary

RESOURCES (US$ THOUSAND)

Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
10 639	9 000	9 000

JUSTIFICATION

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

14.5 Steps taken to build capacity in framing of health financial policy, and the production, interpretation and use of financial information.

INDICATORS

14.5.1 Number of countries provided with support to build capacity in the formulation of health financing policies and strategies, and in the collection and use of financial information such as health expenditures and costs, financial catastrophe and impoverishment, cost-effectiveness, and budgeting

BASELINE

25 countries

TARGETS TO BE ACHIEVED BY 2009

55 countries

	TARGETS TO BE ACHIEVED BY 2013
	90 countries

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
22 474	21 000	23 000

JUSTIFICATION

In many countries, skills in financial and economic planning and management for health are limited. The demands from Member States for support have increased rapidly, and an increase in the budget for 2008-2009 is required to meet the need to build capacity.

14.6 Steps taken to stimulate the generation, translation and dissemination of knowledge and to shape the research agenda.	**INDICATORS**
	14.6.1 Key information and knowledge on health expenditures, financing, efficiency and equity to guide policy development and implementation validated and disseminated
	BASELINE
	Annual updates of health expenditure for 193 Member States, and information on the extent of catastrophic expenditure and impoverishment for 70 countries where households are most at risk
	TARGETS TO BE ACHIEVED BY 2009
	Annual updates of health expenditure for 193 Member States, and updated or new information on the extent of catastrophic expenditure and impoverishment for 20 countries
	TARGETS TO BE ACHIEVED BY 2013
	Annual updates of health expenditure for 193 Member States, and extent of catastrophic expenditure and impoverishment updated for 20 countries

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
7 327	10 000	10 000

JUSTIFICATION

Member States are provided with key information on health expenditures, the effectiveness and costs of major interventions, and the extent of financial catastrophe and impoverishment relating to out-of-pocket payments. Considerable additional work needs to be done to ensure the timely dissemination of this information to policy-makers. Moreover, this work continues to identify many gaps in knowledge and unanswered questions that are crucial to policy-making, but the links between them and the researchers who could provide answers need to be strengthened. This requires an increase in funding throughout the period covered by the medium-term strategic plan.

STRATEGIC OBJECTIVE 15

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

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. The Organization should be equipped to communicate internally and externally in a timely and consistent way at global, region and country levels – both proactively and in times of crises – in order to demonstrate its leadership in health, provide essential health information, and ensure visibility.

Lessons learnt

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

[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 reform of the civil service or macroeconomic policy, which can have a major impact on the delivery of health services. The Secretariat, for its part, needs to ensure that it focuses its support around clearly articulated country strategies, that these are reflected and consistent with WHO's medium-term plans and programme budgets, and that the Organization's presence is matched to the needs and level of development of the country concerned in order to provide optimal support.

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

Lessons learnt

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

STRATEGIC APPROACHES

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

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

Other actions include promoting development of functional partnerships and a global health architecture that ensures equitable health outcomes at all levels; encouraging

harmonized approaches to health development and health security with organizations of the United Nations system, other international bodies, and other stakeholders in health; actively participating in the debate on reform of the United Nations system; and acting as a convener on health issues of global and regional importance.

ASSUMPTIONS, RISKS AND OPTIONS

The following assumptions underlie achievement of the strategic objective:

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

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

ORGANIZATION-WIDE EXPECTED RESULTS

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

	TARGETS TO BE ACHIEVED BY 2013			
	50%	100%	25% increase over survey baseline	100%

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
89 807	97 927	108 128

JUSTIFICATION

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

15.2 Effective WHO country presence[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		
15.2.1 Number of Member States using country cooperation strategies as a basis for planning WHO's country work and for harmonizing cooperation with the United Nations country team members and other development partners	**15.2.2** Proportion of countries where WHO's presence reflects the respective Country Cooperation Strategy	**15.2.3** Number of countries in which harmonized mechanism to assess the contribution of the Secretariat to national health outcomes is implemented
BASELINE		
40	20%	3
TARGETS TO BE ACHIEVED BY 2009		
80	40%	25
TARGETS TO BE ACHIEVED BY 2013		
135	80%	80

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
72 659	79 228	87 481

JUSTIFICATION

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

[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.

15.3 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

INDICATORS			
15.3.1 Proportion of external aid flows to health supplied through flexible and long-term instruments	**15.3.2** Proportion of health partnerships in which WHO participates and that work according to the Best Practice Principles for Global Health Partnerships	**15.3.3** Proportion of trade agreements appropriately reflecting public health interests, as outlined in WHO guidance	**15.3.4** 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)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
21 643	23 600	26 058

JUSTIFICATION

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

15.4 Essential multilingual health knowledge and advocacy material made accessible to Member States, health partners and other stakeholders through the effective exchange and sharing of knowledge.	**INDICATORS**			
	15.4.1 Number of countries that have access to relevant health information and advocacy material for the effective delivery of health programmes as reflected in the country cooperation strategies	**15.4.2** Average number of page views/visits per month to the WHO web site	**15.4.3** Number of multilingual (non-English) pages available on the WHO web site	**15.4.4** Number of WHO publications sold per biennium
	BASELINE			
	To be established	28 million/3.5 million	12 733	350 000
	TARGETS TO BE ACHIEVED BY 2009			
	Baseline plus 20%	48 million/5 million	22 000	400 000
	TARGETS TO BE ACHIEVED BY 2013			
	Baseline plus 50%	80 million/7 million	40 000	500 000

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
35 991	39 245	43 333

JUSTIFICATION

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

STRATEGIC OBJECTIVE 16

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

Indicators and targets

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

ISSUES AND CHALLENGES

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

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

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

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

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

WHO's results-based management framework has been strengthened through the work needed for preparation of the Eleventh General Programme of Work and the medium-term strategic plan. More can

Lessons learnt

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

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

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

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

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

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

The Secretariat will focus on:

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

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.

ASSUMPTIONS, RISKS AND OPTIONS

A key assumption is that there is support in WHO – both Member States and Secretariat – to continue and further accelerate the reforms under way. Indeed, improving managerial methods in a sustainable fashion requires strong leadership from senior management and commitment from all staff to ensure that strategies and policies are effectively translated into day-to-day practices and behaviour. Clear communication internally and externally will be essential to ensure that efforts to meet this objective remain relevant to the changing needs of the Organization.

It is also assumed that the changes in the external and internal environment that are likely to occur over the six-year period of the plan will not fundamentally alter the role and functions of WHO. Nonetheless, managerial reforms should help shape WHO into a more flexible organization that is able to adapt to change.

Pressures to contain administrative costs are likely to remain. The Secretariat will continue to minimize costs and ensure that all options are considered in this regard, including outsourcing or relocation opportunities. Such changes in ways of working are not without risk and must not be carried out to the detriment of institutional knowledge, quality, appropriate controls and accountability. This objective is inherently linked to the work of the rest of the Organization: increasing workload in other strategic objectives will require increased resources to support that work, even if the relationship is not necessarily linear.

ORGANIZATION-WIDE EXPECTED RESULTS

16.1 Work of the Organization guided by strategic and operational plans that build on lessons learnt, reflect country needs, are elaborated across the Organization, and used to monitor performance and evaluate results.	**INDICATORS**			
	16.1.1 Proportion of approved workplans that incorporate lessons learnt from the previous biennium as identified in the programme budget performance assessment and have been drawn up in a consultative process involving the three levels of the Organization	**16.1.2** Proportion of reports on strategic objectives for the mid-term review and programme budget performance assessment that have been peer reviewed and submitted in a timely fashion	**16.1.3** Percentage of evaluations and performance audit projects completed under the annual workplan in the application of the Organization's evaluation guidelines and other oversight policies	**16.1.4** Proportion of managers trained and certified on WHO's accountability mechanisms

	BASELINE			
	50%	50%	100%	0% (certification programme not yet in place)
	TARGETS TO BE ACHIEVED BY 2009			
	80%	80%	100%	90%
	TARGETS TO BE ACHIEVED BY 2013			
	90%	90%	100%	95%

RESOURCES (US$ THOUSAND)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
37 913	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.

16.2 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**		
	16.2.1 Degree of compliance of WHO with International Public Sector Accounting Standards	**16.2.2** Proportion of strategic objectives with expenditure levels meeting programme budget targets	**16.2.3** 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)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
62 780	66 871	72 538

JUSTIFICATION

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

16.3 Human resource policies and practices in place to attract and retain top talent, promote learning and professional development, manage	**INDICATORS**		
	16.3.1 Proportion of offices[1] with approved human resources plans for a biennium	**16.3.2** Number of staff assuming a new position or moving to a new location during a biennium	**16.3.3** 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

performance, and foster ethical behaviour.	**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)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
30 767	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).

16.4 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**		
	16.4.1 Proportion of known proposals, projects, and applications tracked on a regular basis through global portfolio management processes	**16.4.2** Number of information technology disciplines[1] implemented Organization-wide according to best-practice benchmarks	**16.4.3** 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)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
110 334	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.

16.5 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	
16.5.1 Proportion of services delivered according to criteria in service-level agreements	**16.5.2** 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)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
155 109	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.

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

INDICATORS	
16.6.1 Timeliness of implementation of the capital master plan, within the approved budget	**16.6.2** 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)		
Costs 2008-2009	Estimates 2010-2011	Estimates 2012-2013
157 006	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.