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DRAFT MEDIUM-TERM STRATEGIC PLAN 2008-2013
DRAFT PROPOSED PROGRAMME BUDGET 2008-2009

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Geneva, July 2006

CONTENT

Foreword by the Director-General

Executive summary

1. The Eleventh General Programme of Work, covering the 10-year period 2006-2015, provides a long-term perspective on determinants and trends in health and proposes action based on a seven-point global health agenda that charts the broad strategic framework and direction for the work of WHO Member States, their partners and the Secretariat. The seven points are:

1. investing in health to reduce poverty
2. building individual and global health security
3. promoting universal coverage, gender equality and health-related human rights
4. tackling the determinants of health
5. strengthening health systems and equitable access
6. harnessing knowledge, science and technology
7. strengthening governance, leadership and accountability.

2. As of the biennium 2008-2009, a six-year medium-term strategic plan, encompassing three biennial budget periods, will form the framework for WHO's results-based management, within which the global health agenda will be addressed. The draft medium-term strategic plan and draft proposed programme budget will enable WHO to respond in a flexible and dynamic manner to a changing international health environment.

3. Over the past 20 years, there have been major gains in life expectancy overall, but there are widening gaps in health, with some countries having witnessed reversals of earlier gains, due to factors such as infectious diseases, in particular HIV/AIDS, collapsing health services and deteriorating social and economic conditions. The target year for achieving the Millennium Development Goals is 2015 but the trends for health-related goals are not encouraging. The past ten years have seen a dramatic change in the global health architecture, with an increase in the number of international partnerships in health. Global health partnerships offer the potential to combine the different strengths of public and private organizations, along with civil-society groups, in tackling health problems. Demands on the United Nations system as a whole are increasing, as are demands for it to reform and show more clearly where value is added.

4. The challenges and constraints of the Organization and the lessons it has learnt provide the basis for its response. WHO is in a unique position to shape the global public-health architecture and agenda through consensus building and binding agreements. It will work to harmonize the health architecture at the country level and will engage in the reform process aimed at creating an effective country team under a common United Nations lead. WHO will also work with others to harmonize the global health architecture and provide forums for the increasing number and type of entities involved in order to engage in dialogue on local and global health challenges. WHO's governing bodies will continue to play their lead role, in the view of the increasing prominence of health in development and security agendas.

WHO will fulfil its priorities through six core functions set out in the Eleventh General Programme of Work:

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

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

6. Five main areas have been set for the period of the medium-term strategic plan:

1. providing support to countries in moving to universal coverage with effective public-health interventions
2. strengthening global health security
3. generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health
4. increasing institutional capacities to deliver health system functions under the strengthened governance of ministries of health
5. strengthening WHO's leadership at global and regional levels and supporting the work of governments at country level.

7. Work in these areas is organized around 16 cross-cutting objectives that provide a more strategic and responsive programme structure, reflecting the needs of Member States, facilitating effective collaboration across all levels of the Organization, and ensuring a results-based approach.

8. Comprehensive reform is under way to improve the management of the Organization in support of more efficient and effective implementation. It aims at improving management and administration; working efficiently across different but related programme areas, and across countries, regions and headquarters; working as a decentralized organization; recognizing the critical role of managers; working with partners, and within the United Nations system.

9. Effective financing of the draft Medium-term strategic plan will require an overall budget of US$4 263 million over the next two years, and up to XX thousand million over the full period of the strategic plan[1] on the basis of expected expenditures in the biennium 2006-2007, the Proposed programme budget would increase by 17.2%. This increase is justified by the ambitious yet realistic targets to be achieved in response to the growing demands made on the Organization. The increase is intended mainly for achieving the Millennium Development Goals for maternal and child health; raising the focus on noncommunicable diseases; implementing the International Health Regulations (2005), and making health development sustainable through greater attention to the determinants of health and strengthening of the health systems that underpin any adequate response by the health sector.

10. WHO aims to finance the draft Medium-term strategic plan through three sources of funds: assessed contributions and miscellaneous income, which together make up the regular budget; negotiated core voluntary contributions; and project-type voluntary contributions.

11. As a Member-State organization with global responsibility for normative technical work it is imperative for its credibility and integrity that a significant portion of the budget should be financed through assessed contributions. A regular budget amounting to US$1 000 million is thus proposed in order to maintain a reasonable balance between the two sources of funding. This represents a 9.3% increase compared to the biennium 2006-2007. At this level, assessed contributions would account for only 23% of the overall budget.

[1] The expected amount required for the last two bienniums of the plan is being calculated and will be included in the document to be submitted to the Executive Board at its 120th session (January 2007).

Part I Draft Medium-term strategic plan

I. RESPONDING TO CHALLENGES, GAPS AND FUTURE NEEDS

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

13. Over the past 20 years, there have been major gains in life expectancy overall, but there are widening gaps in health with some countries having witnessed reversals of earlier gains, due to factors such as infectious diseases, in particular HIV/AIDS, collapsing health services and deteriorating social and economic conditions. The target year for achieving the Millennium Development Goals is 2015, but the trends for health-related goals are not encouraging. The global health agenda is shaped by agreements adopted by world leaders. In September 2000, the United Nations Millennium Declaration committed countries to a global partnership to reduce poverty and improve health and education, along with promoting peace, human rights, gender equality and environmental sustainability.

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

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

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

16. The seven-point global health agenda as contained in the Eleventh General Programme of Work requires action from many different players across the international community, across society and across government. The seven points are set out below.

17. **Investing in health to reduce poverty.** In all countries, poverty is associated with higher childhood and maternal mortality, increased exposure to infectious diseases, and malnutrition. The link with poverty is reciprocal: improvements in health help reduce poverty, and the reduction of poverty improves health.

18. **Building individual and global health security.** Global health security is of increasing concern, as the health impacts of conflicts, natural disasters, disease outbreaks and zoonoses increase in frequency and magnitude. Trade in food across borders, and the large number of

people travelling between countries can accelerate the transmission of disease. At household level in poorer communities, prevention and control of infectious diseases is a priority, but equally important are health risks pertaining to food and water insecurity. Across many parts of the world, rape and sexual violence against women is widespread.

19. **Promoting universal coverage, gender equality and health-related human rights.** Inequitable access of poor and other marginalized groups to essential health services is a major challenge in many countries. The Millennium Development Goals acknowledge that women's empowerment and gender equality are prerequisites for development. All the health-related goals require action in this area if they are to be achieved.

20. **Tackling the determinants of health.** Serious efforts to improve the health of the world's most vulnerable people and reduce health inequities have to tackle the key determinants of health. Some of these, such as income, gender roles, education, and ethnicity, are related to social exclusion; others, such as living conditions, work environment, unsafe sex and the availability of food and water are related to exposure to risks. Broader economic, political and environmental determinants include urbanization, intellectual property rights, trade and subsidies, globalization, air pollution and climate change.

21. **Strengthening health systems and equitable access.** Without sustained and serious investment, health systems will not be able to progress towards universal coverage and gaps in implementation will not be closed. Strengthening, or in some cases rebuilding, health systems will be linked to broader processes of government such as reform of the civil service and public expenditure, decentralization, and poverty-reduction strategies.

22. **Harnessing knowledge, science and technology.** Much of the burden of premature death and disease could be significantly alleviated by relatively inexpensive and effective tools, applied within a coherent and coordinated set of public-health measures. Further scientific breakthroughs and new knowledge are also needed, however, to develop effective diagnostics, treatments and vaccines, to understand better the links between determinants and their consequences, and to develop interventions that are needed by the poor.

23. **Strengthening governance, leadership and accountability.** Strong political will, good governance and wise leadership are needed at national level. One of the central concerns of governments should be the health of the population. All public policy-making is an opportunity to bring more coherence to the delivery of health outcomes. Ministries of health should take the lead in promoting policy dialogues and intervention strategies across sectors, both public and private.

II. LESSONS THAT HAVE BEEN LEARNT

24. WHO is in a unique position to shape the global public-health agenda through consensus building and binding agreements. Recent examples of the latter include the Framework Convention on Tobacco Control and the International Health Regulations (2005). These experiences have enabled the Organization to identify which health issues require a formal negotiated agreement, and which are best approached through consensus building. WHO participates in more than 80 global health partnerships and in numerous global, regional and national health networks. These partnerships and networks benefit from WHO's convening power and its technical expertise. The Organization continues to learn which are the best ways to participate in these partnerships, while maintaining its unique identity and mandate.

25. In response to increasing demands, the Organization will strive to build more effective alliances within the United Nations System and the broader development community. It will work to harmonize the health architecture at country level and will engage in the reform process aimed at creating an effective country team under a common United Nations lead. WHO will provide forums and engage in dialogue with the increasing number and type of entities involved

in health and development. WHO's governing bodies will continue to play their lead role, most important for the Organization's effectiveness and vitality.

26. Over the past 60 years, WHO has played a prominent role in launching, coordinating, and implementing public-health programmes and initiatives. Some examples are eradication of smallpox, the Expanded Programme on Immunization, the Action Programme on Essential Drugs, the Global Programme on AIDS, the Onchocerciasis Control Programme in west Africa, StopTB, efforts to eradicate poliomyelitis, to eliminate leprosy, and to control SARS and Avian Influenza. WHO has frequently been able to adapt or transform itself in order to meet the needs of specific public health programmes. Work during 2004-2005 revealed that an important challenge to improving the performance of health systems is the absence of international consensus about the way in which such systems should function and how they can be strengthened. This may impede efforts to mobilize the financial and technical support required for a concerted approach to strengthening health systems in countries in most need.

27. Many important determinants of health fall outside of the direct sphere of influence of the health sector. WHO is drawing from experience and developing capacity to work with sectors other than health in order to build their understanding of what can realistically be done to improve national health. WHO will do more to monitor global trends that are of significance to health in areas such as trade and agriculture, and will work with ministries of health to craft appropriate responses.

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

29. In order to accelerate the expansion of public-health interventions, WHO will work with governments and partners to move beyond pilot projects that gather evidence or test feasibility and to draw up realistic plans for building up services linked to sustainable financing. In health crises, WHO has to act rapidly in order to be an effective partner and ministries of health will require plans agreed to in advance.

30. WHO will be more systematic in its contacts with civil society and industry, including the international health-care and pharmaceutical industries, and more proactive in leading a dialogue on setting priorities and ethical standards for research as scientific advances continue.

31. The past years have seen many new initiatives in the area of management and administration. The challenge now lies in the need to consolidate and institutionalize already introduced changes and to complete reforms without compromising operational capability or staff confidence.

32. Although WHO has been successful in mobilizing resources, a key challenge has been to ensure alignment between the activities planned and the resources mobilized. Indeed, voluntary contributions were often earmarked for specific programmes. Also, internal mechanisms to channel resources to where they are most needed have been lacking. Despite improvements, more efforts will be required to avoid situations where funds sit idle or underutilized in one programme or location while they are acutely needed in another. This will require work by the contributors of voluntary funds as well as within the Organization.

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

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

III. WHO'S RESULTS-BASED MANAGEMENT FRAMEWORK

35. Until now, the biennial programme budget served as the strategic plan for WHO. The two-year time horizon of the programme budget, however, has been seen as limiting its value as a strategic planning document because it does not adequately reflect the more strategic nature of WHO's work. As of the biennium 2008-2009, a six-year medium-term strategic plan encompassing three biennial budget periods will form the framework for WHO's results-based management within the overall context of the General Programme of Work.

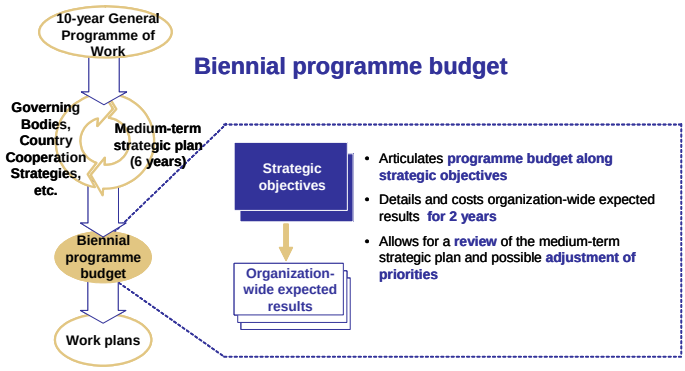
36. The Eleventh General Programme of Work, which covers the 10-year period 2006-2015, provides a long term perspective on the determinants of health and the measures required for improving health while setting forth a global health agenda. It charts the broad strategic framework and direction.

37. Flowing from the General Programme of Work is the draft Medium-term strategic plan 2008-2013. This plan will provide the strategic direction for the Organization for the six-year period, advancing the health agenda established in the Eleventh General Programme of Work by establishing a multibiennial framework to guide the preparation of biennial programme budgets and operational plans across each biennium.

38. The draft Medium-term strategic plan is organized around 16 crosscutting strategic objectives - to which WHO is committed to achieve - that provide a more strategic and flexible programme structure that reflects better the needs of countries and regions while facilitating more effective collaboration across all levels of the Organization.

39. The plan identifies the Organization-wide expected results for which the Secretariat will be accountable over the three bienniums 2008-2009, 2010-2011 and 2012- 2013. It specifies indicators, six-year targets and indications of the resources required for their achievement.

40. The Propose programme budget makes the Medium-term strategic plan operational, identifying the main issues to be addressed and specifying achievements expected in the biennium. It provides for each of the Organization-wide results the targets for 2008-2009 and the resources required for their achievement.



41. The Proposed programme budget remains the basis for operational planning. During the operational planning phase, country and regional offices and headquarters will indicate their contribution to the Organization-wide expected results. These operational plans, also referred to as work plans, establish how commitments made by the Secretariat in the Organization's strategic plan and biennial budgets will be achieved through the delivery of specific products and services. In these work plans, time frames, and responsibility and accountability for delivering products and services are identified for each organizational entity and level, thus linking strategic objectives and Organization-wide expected results with the organizational structure.

IV. STRATEGIC DIRECTION FOR 2008-2013

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

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

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

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

46. The three levels of the Secretariat, and its close working relations with governments, enable it to gather health information and monitor trends over time and across countries, regions and the globe.

47. The core functions of WHO will guide the work of the Secretariat and provide a framework for assessing the coherence and quality of output at global, regional and country levels. The Eleventh General Programme of Work sets out the following **six core functions**:

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

48. The framework for WHO's activities for the period 2008-2013 is the General Programme of Work, specifically, the global health agenda and the core functions of the Organization. The work will focus on the five main areas set out below.

Providing support to countries in moving to universal coverage with effective public health interventions

49. The pressing need effectively to address the global burden of communicable diseases is reflected in the formulation of several WHO strategies for expanding interventions to reduce the burden of HIV, tuberculosis, malaria and vaccine-preventable diseases, and to make rapid progress in eradicating, eliminating or controlling diseases such as poliomyelitis, leprosy, dracunculiasis, onchocerciasis, schistosomiasis, and lymphatic filariasis. Implementation of the International Health Regulations (2005) will provide a framework for strengthening surveillance of, preparedness for and response to, communicable diseases.

50. Several strategies agreed by Member States will guide the work of the Organization in improving reproductive and child health and addressing noncommunicable diseases, such as cancer and cardiovascular disease. Interventions related to the health of mothers and children will be linked through a continuum of care throughout the life-cycle. Once poliomyelitis has been eradicated, WHO will increase its collaboration further with UNICEF, GAVI and other partners to implement a global immunization strategy.

51. Provision of support to Member States is carried out largely in collaboration with other organizations of the United Nations system and partners. In the above-mentioned areas it involves mostly high-level technical support - direct implementation by WHO, as for example, in the eradication of poliomyelitis, is rarely needed.

Strengthening global health security

52. WHO will continue to respond to health emergencies, crises and conflicts, including support for development of national emergency and preparedness plans, and plans for implementing transition and recovery actions after conflicts and disasters. Work will also expand to cover environmental emergencies and nutrition during emergency periods, control of communicable diseases during crises.

53. WHO work will be aligned with reform of humanitarian action within the United Nations system and in close partnership with other organizations of the system, nongovernmental organizations, and national institutions.

Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health

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

55. Strategies that take both population-based and behavioural approaches will be implemented to reduce risks to health - such as obesity, high blood pressure, harmful use of alcohol, and unsafe sex. WHO's Framework Convention on Tobacco Control will continue to guide the work to reduce tobacco consumption. WHO will also consolidate and expand its work on health promotion, nutrition, food safety, food security, and prevention of injury and violence.

Increasing institutional capacities to deliver health system functions under the strengthened governance of ministries of health

56. Universal coverage with effective public-health interventions is dependent on effective health-care systems. The world health report 2006 highlights the crisis in the global health workforce, and steps that countries and their partners need to take over the coming years if health commitments and targets such as those in the Millennium Development Goals are to be met.[1] WHO will also provide support to Member States in putting in place strategies to

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

strengthen other key national institutional capacities and systems such as sustainable financing, information, research, and essential medicines and technologies.

Strengthening WHO's leadership at the global and regional levels and supporting the work of governments at the country level

57. The Eleventh General Programme of Work emphasized the increased number of stakeholders working in health at both national and international levels and the need for WHO to respond flexibly and rapidly to this changing environment. Along with working more effectively in partnerships, WHO will use its convening power to stimulate action across sectors, while building the capacity of governments to take on this role nationally. It will take the lead role in shaping the global health archictecture, and participate in United Nations reforms at global, regional and country levels. To meet these challenges, WHO will continue to evolve as a learning organization and to strengthen its managerial capacity.

58. WHO activities in these five areas focuses on **16 strategic objectives**, reflecting the results-based management framework, and providing clear, measurable and budgeted expected results for the Organization over the period of the Medium-term strategic plan. They promote collaboration across disease-specific programmes by capturing the multiple linkages among the determinants of health and health outcomes, policies, systems and technologies. The strategic objectives are listed below.

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

59. Rapid changes in health needs and opportunities can be expected over the coming years. Flexibility and responsiveness are essential, and WHO will continue to monitor trends, and modify plans and expected results accordingly.

V. ENSURING EFFICIENT AND EFFECTIVE IMPLEMENTATION

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

61. A comprehensive managerial reform is under way to improve the management of the Organization, main thrust of which is set out in the strategic objective 16, namely, to develop and sustain WHO as a flexible, learning Organization, enabling it to carry out its mandate more efficiently and effectively. It is also captured in an Organization-wide guide, which is continuously under review to ensure that it effectively addresses the changing needs of the Organization[1]. Managerial reform is also a standing item on the agenda of the Programme, Budget and Administration Committee of the Executive Board[2]. The scope of these reforms spans the results-based management framework, the management of financial resources, the provision of effective operational support and the ensuring of robust accountability.

62. Like many large, complex, global organizations, WHO faces the challenge of working efficiently across different, but related, programme areas, and across countries, regions and headquarters. Organizational processes such as joint planning and peer reviews can facilitate this work, together with collaborative methods that promote inter-dependence, such as greater staff mobility and rotation across the Organization.

63. With 142 country offices, six regional offices and headquarters, WHO is a decentralized organization. Managing programmes efficiently and effectively in such an environment requires balancing the need to take an organization-wide approach and responsibility and to recognize regional specificities. Transparent governance mechanisms and common systems and approaches across the Organization will be increasingly adopted, linked to further devolution of decision-making and greater accountability. This trend will be facilitated by moving from managing through tight bureaucratic controls to a greater reliance on monitoring.

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

65. Efficient and effective implementation of the Organization's strategic objectives requires more strategical work with a wide range of partners in the public-health and development communities. In its daily technical work the Secretariat relies on a wide network of scientific experts from academic institutions, private- and public-sector research facilities and other centres of excellence, many of which are WHO collaborating centres. Such collaboration lies at the heart of much of the Organization's work as a technical agency charged with setting global norms and standards on a wide range of health issues.

66. WHO will work strategically with key partners, beyond drawing on this network of scientific expertise, in order to maximize its impact on global health. These partners can

[1] Increasing managerial effectiveness and efficiency: an organizational roadmap, April 2006.
[2] See, for example, document EBPBAC4/3.

complement the Organization's own competencies in areas such as operations or provide major resources for disbursement at country level. WHO participates in a substantial number of global health partnerships, through which it will exercise leadership on health issues while maintaining its independence on technical health matters.

67. WHO has a long history of working closely with sister organizations of the United Nations system such as FAO, UNICEF, UNEP, UNFPA, UNAIDS, and international financing institutions such as the World Bank. WHO will strengthen its links with other partners at country level in order to provide seamless support to governments requiring technical advice and seeking to build capacity. Improving the quality of WHO's support to countries includes its more active participation as a member of a single United Nations team, while maintaining close working relationship with ministries of health to ensure sector-wide support for health issues.

68. As a specialized agency within the United Nations system, WHO participates in interagency efforts to improve the overall functioning of the system and to increase its coherence. Significant gains are still to be made in both efficiency and effectiveness by working together more closely on specific management reforms. WHO can gain from participating actively in selective efforts to streamline administrative processes, leveraging the collective purchasing power of the system, and sharing experiences in management reform.

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

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

VI. EFFECTIVE FINANCING OF THE MEDIUM-TERM STRATEGIC PLAN

71. Effectively financing the objectives set out in the draft Medium-term strategic plan will require an overall budget of US$4 263 million over the next two years, and up to XX thousand million over the full six-year strategic planning period[1]. On the basis of expected expenditure in the biennium 2006-2007, the Proposed programme budget would increase by 17.2%. This increase is justified by the ambitious yet realistic targets to be achieved in response to the growing demands made on the Organization.

72. The increase is intended mainly for achieving the Millennium Development Goals for maternal and child health; increasing the focus on noncommunicable diseases; implementing the International Health Regulations (2005), and making health development sustainable through greater attention to the determinants of health and strengthening of the health systems that underpin any adequate response by the health sector. Effectively financing for results within this plan will require efficiently managing different sources of income, and ensuring resources are made available equitably across the Organization.

[1] The expected amount required for the last two bienniums of the Medium-term strategic plan is being calculated and will be included in the document to be submitted to the Executive Board at its 120th session (January 2007).

Sources of income and financial plan

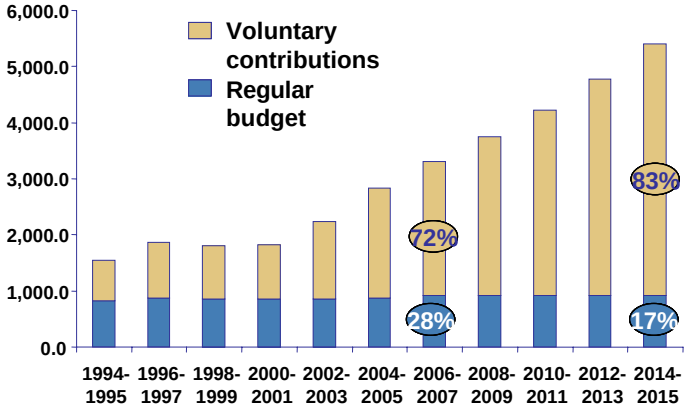
73. WHO's approach to managing its financial resources has evolved incrementally over time, partly to reflect the shifting trend whereby an increasing share of the Organization's resources come from voluntary contributions. Since 2000, WHO has adopted a results-based approach to determining resource requirements. It is now implementing an integrated budget comprising all sources of funding. WHO is further working with partners and donors better to align voluntary contributions with the programme budget. For the next six-year period, WHO aims to finance the medium-tern strategic plan through the following three sources of funds: assessed contributions and miscellaneous income, which together make up the regular budget; negotiated core voluntary contributions; and project-type voluntary contributions.

Assessed contribution and miscellaneous income

74. All Member States pay assessed contributions, the total amount of which had remained constant for many bienniums. Recognizing the increased demands on WHO, and the growing imbalance between voluntary contributions and the regular budget, the Health Assembly by resolution WHA58.4 approved a 4% increase in assessed contributions. Indeed, as a Member-State organization with global responsibility for normative technical work, it is imperative for its credibility and integrity that a significant portion of its budget should be financed through assessed contributions.

75. Over the past two years, demands on, and expectations of, WHO have further risen, as demonstrated by a 61% increase in expenditure of voluntary contributions as compared to the previous biennium. A regular budget amounting to US$1 000 million is thus proposed in order to maintain a reasonable balance between the two sources of funding. This represents a 9.3% increase compared to the biennium 2006-2007. Even at this level, assessed contribution would account for only 23% of the overall budget. The regular budget, as a percentage of the total programme budget, is expected to continue falling during the six-year period.

Balance between regular budget and voluntary contributions (US$ millions)



76. Miscellaneous income is derived from a number of sources, the most significant of which have been interest earnings on regular budget funds, collections of arrears of assessed contributions, and unspent regular budget funds at the end of a biennium. These three components are subject to significant fluctuation, notably interest earnings, which depends on both the speed of collection of assessed contributions and the prevailing market interest rate. The level of unspent regular budget funds at the end of a biennium depends on the quality and timing of programme implementation. Recent improvements in the planning process have tended to decrease the amount of such unspent funds and this trend is expected to continue.

The level of overall miscellaneous income is expected to remain at approximately US$30 million per biennium.

Negotiated core voluntary contributions

77. In the biennium 2004-2005, about 74% of the total income came from voluntary contributions. Less than a dozen different sources accounted for more than 75% of all voluntary contributions received, with the remaining 25% coming from more than 420 different sources. Most voluntary contributions are received for development work and humanitarian assistance and come mainly from bilateral and multilateral development agencies and private foundations. Although all these resources are welcomed and necessary to implement the programme budget, the form in which they are provided pose a challenge to ensuring proper alignment between the programme budget and implementation. Further, administering thousands of separate agreements requiring specific reporting significantly increases the transaction costs to the Organization.

78. Working with key partners and donors, WHO is moving towards having a larger share of core voluntary contributions either unearmarked or negotiated Organization-wide. This arrangement would make it possible to align resources more effectively across all levels of the Organization, meet critical funding gaps, and improve implementation of the programme budget. Currently, slightly less than 10% of voluntary contributions are considered as negotiated core voluntary contributions. WHO will seek to increase the share of core voluntary contributions to 30% of total resources by 2013. For the biennium 2008-2009, the aim is to double the level of core voluntary contributions from current expectations to roughly US$600 million, representing about 16% of total resources.

Project-type voluntary contributions

79. Currently the Organization is financed largely from voluntary contributions intended for a specific purpose, which is likely to continue over the next six years. For the biennium 2008-2009, after taking into account the regular budget and core voluntary contributions, about US$2 600 million will need to be raised. On the basis of past trends this is a realistic target. The high degree of specificity of much of the project funding, including approximately US$1 000 million related to partnerships within WHO or specific appeals, makes the financing of all WHO planned activities difficult to achieve in full. Such project funding includes partnerships housed within WHO but with a separate governance structure, response to emergencies and epidemic outbreaks, special disease eradication drives, and procurement on behalf of Member States.

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

Table 1. Proposed evolution in the financing of the programme budget during the period of the Medium-term strategic plan (US$ million)

Sources of income	Baseline, 2006-2007		Proposed programme budgets, 2008-2013			
	Programme budget 2006-2007	Expected expenditure 2006-2007	Proposed programme budget 2008-2009	Increase over expected expenditure 2006/2007 %	2010-2011	2012-2013
Assessed contributions	893	893	**970**	8.6		
Miscellaneous income	22	30	**30**	0.0		
Total regular budget	**915**	**923**	**1 000**	**8.6**		
Negotiated core	---	300	**600**	100.0		
Project-type specified	---	2 413	**2 663**	10.4		
Total voluntary contributions	2 398	2 713	**3 263**	20.3		
Total financing	**3 313**	**3 636**	**4 263**	**17.2**		

Proposed budget breakdown

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

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

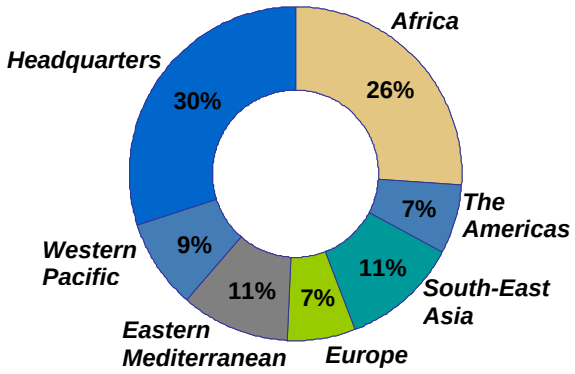
Location	Programme budget 2006-2007			Proposed programme budget 2008-2009		
Regional office:	Regular budget	Voluntary contribution	Total	Regular budget	Voluntary contribution	Total
Africa	203.6	745.8	949.5	222.5	966.0	1 188.5
The Americas	77.8	120.8	198.5	85.0	197.0	282.0
South-East Asia	99.3	258.0	357.2	108.4	387.6	496.0
Europe	58.2	242.4	200.6	63.6	213.4	277.0
Eastern Mediterranean	87.5	294.4	381.8	95.5	373.4	468.9
Western Pacific	76.5	156.4	232.9	83.6	267.7	351.3
Headquarters	312.5	680.4	993.0	341.4	858.0	1 199.4
Total	**915.3**	**2 398.1**	**3 313.4**	**1 000.0**	**3 263.0**	**4 263.0**

82. In continuation of the Organization's strategy to strengthen first-line support to countries with adequate back-up at regional and global levels, most of the budget will be spent in regions and countries. Resource distribution between regions reflect programme needs that follow a results-based approach, and are in line with indications from the validation mechanism for strategic resource allocation recently reviewed by the Executive Board[1]. Subsequent biennial programme budgets will reflect programmatic changes between regions, but should remain relatively similar over the six-year period. Table 3 below shows the shift from 2006-2007 to

[1] See document EB55-EB118/2006/REC/1, Summary record of the fourth meeting, section 4.

2008-2009, excluding the poliomyelitis eradication initiative and WHO's response to emergencies, so as to be comparable with the validation mechanism.

Table 3. Budget distribution between regional offices and headquarters budget split [a] (US$ million)



	Approved 2006-2007	% of total	Proposed 2008-2009	% of total
AFRO	768.9	26.5	986.7	26.0
AMRO	181.6	6.3	258.1	6.8
SEARO	290.7	10.0	432.0	11.4
EURO	188.2	6.5	250.9	6.6
EMRO	287.6	9.9	402.7	10.6
WPRO	222.7	7.7	327.2	8.6
HQ	962.7	33.2	1132.5	29.9
Total [a]	**2902.3**	**100.0**	**3790.1**	**100.0**

[a] Excludes the Global Poliomyelitis Eradication Initiative and WHO's response to emergencies, so as to make it comparable to the validation mechanism

83. Table 4 below shows the proposed budgets by strategic objective for the full period of the strategic plan. In line with the General Programme of Work, they have been grouped by the five main areas.

Table 4. Proposed biennial budgets 2006 to 2013
Breakdown by biennium and the five main areas (US$ million)

Area	Programme budget 2006-2007	Expected expenditure 2006-2007	Percentage of total	Proposed programme budget 2008-2009	Percentage of total	Increase over expected expenditure 2006-2007	2010-2011	2012-2013	Total Medium-term strategic plan
Public-health interventions	1 706	1 963	54.0	**2 130**	50.0	8.5			
Global health security	130	132	3.6	**220**	5.1	66.5			
Determinants of health	249	255	7.1	**488**	11.5	91.7			
Health systems	500	552	15.1	**644**	15.1	16.8			
Leadership and governance	728	735	20.2	**781**	18.3	6.3			
	3 313	**3 636**	**100.0**	**4 263**	**100.0**	**17.2**			

84. Resource requirements in the area of support to countries in moving to universal coverage with effective public-health interventions, which already represents the largest share of the Organization's finances, will increase in the biennium 2008-2009 by 8.5% compared to expected expenditures in 2006-2007, and will continue to increase over the period of the medium-term

strategic plan, albeit to a lesser extent than in other areas. This area will continue to represent the largest share of the Organization's budget.

85. Emergency response and preparedness and work related to strengthening of global health security will increase in 2008-2009 by 66.5% and will increase by xx% over the six-year period. However, resources in this area are in part difficult to plan, given the nature of the work.

86. Crucial work on health determinants, which have received insufficient attention and resources over the past years will increase in 2008-2009 by 91.7%, and is expected to increase by nearly xxx% over the six years. This growth, however, is from a relatively small base.

87. The shift in 2008-2009 towards dedicating a larger share of resources to the strengthening of health systems will continue, with an increase of 16.8%, and with a rise of xx% over the six years.

88. The strengthening of WHO's leadership, support to work of governments, which involves the work and management of the Organization, will continue to aim for greater economies of scale and efficiencies. The budget level will remain relatively stable, thus representing a relative decrease as a share of the total, from 20% to 18%. Savings will hinge on achieving a more efficient financing of the programme budget, as described above.

VII. STRATEGIC OBJECTIVES

STRATEGIC OBJECTIVE 1

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

Scope

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

Indicators and Targets

- The vaccine-preventable disease mortality rate reduced by two-thirds by 2013.
- Coverage of interventions targeted at the control, elimination or eradication of tropical diseases: 80% in 49 at-risk Member States by 2013.
- The proportion of countries achieving and maintaining certification of polio eradication and destruction or appropriate containment of all polioviruses to reach 100% by 2010.
- The number of countries complying with the core requirements of the International Health Regulations (2005) for surveillance, reporting, notification, verification and response to reach 192 by 2013.

Linkages with other strategic objectives

The work will be linked to that undertaken under the following strategic objectives:

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

ISSUES AND CHALLENGES

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

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

Epidemics can place sudden and intense demands on health systems. They expose existing weaknesses in health systems and, in addition to their impact on morbidity and mortality, can disrupt economic activity and development. The need for rapid response drains resources, staff, and supplies away from previously defined public health priorities and routine disease control activities, such as childhood immunization or HIV/AIDS, tuberculosis and malaria control. WHO has a primary role in preparedness, detection, risk assessment and communications and response to public health emergencies such as epidemics and pandemics. WHO has verified over 1000 epidemics of international concern over the last five years.

Under the revised International Health Regulations (2005), which will come into effect in 2007, WHO will have a binding legal obligation to strengthen its internal epidemic/public health alert and response capacity and to support Member States in the development and maintenance of minimum core capacities for the detection and assessment

of, and response to, public health risks and emergencies of which the majority are attributable to communicable diseases.

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

Lessons learnt show that:

- The prevention, control and surveillance of communicable diseases are all essential components in human security, including health security, economic development and trade.
- Public health emergencies in communicable diseases can cost billions of dollars, not only in direct health-related costs, but also in the impact epidemics can have on trade and finance.
- Not only is the prevention of communicable diseases one of the most cost-effective public health interventions, it can also yield positive economic returns, particularly among the most marginalized and economically disadvantaged population groups.
- The control of vaccine-preventable, epidemic-prone and tropical diseases has proved remarkably successful in narrowing gaps in equity by reaching hard-to-reach marginalized, poor, young populations and women, particularly mothers.
- These interventions are among the most effective components of health systems in many countries; they also provide a platform for disseminating other essential public health services.
- WHO should assume a leadership role in setting a global research agenda that will have an innovative and sustainable impact on disease control through the improvement, development and evaluation of new tools, interventions and strategies.

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

STRATEGIC APPROACHES

To achieve this objective, Member States will have to invest human, political and financial resources to ensure and expand equitable access to high quality and safe interventions for the prevention, early detection, diagnosis, treatment and control of communicable diseases among all populations. A key component in the financial and operational sustainability of communicable disease prevention and control will be the establishment and maintenance by Member States of effective coordination mechanisms with all partners and across all relevant sectors at the country level, and a willingness to work with the Secretariat in extending these coordination mechanisms to the regional and international spheres. Increased national involvement in research, through achievement of the objectives for investment in health research, research capacity strengthening and integration of research into the mainstream of national programmes and plans will be critical to improved access to, and use of, research findings. The International Health Regulations (2005) will require Member States to adopt the necessary legal, administrative, financial, technical and political provisions for the development, strengthening and maintenance of integrated surveillance systems at primary, intermediate and national levels and related activities, to enable them to detect, report on, and respond to public health risks and potential public health emergencies, and to generate information for evidence-based policy decisions on public health interventions.

In supporting Member States' efforts, the Secretariat will focus on:

- strengthening its leadership role, as well as its collaboration with global health stakeholders, partnerships and civil society, while working with Member States to articulate ethical and evidence-based policies. It should facilitate the expansion of community access to existing and new tools and strategies, including vaccines and medicines, that meet acceptable standards of quality, safety, efficacy and cost-effectiveness, while reducing disparities in access;
- strengthening its capacity to fulfil its obligations to provide technical assistance, build capacity and respond to Member States, in particular, in respect of commitments entered into through Health Assembly resolutions related to communicable diseases and the International Health Regulations. This includes facilitating national and international resource mobilization and advocacy efforts;
- maintaining and strengthening an effective international system for alert and response to epidemics and other public health emergencies with immediate technical support to affected state(s) and collective international action for containment and control;
- facilitating public health preparedness in collaboration with other United Nations agencies and partners, including private and civil society organizations as appropriate;
- providing Member States with tools, strategies and technical assistance to evaluate and strengthen monitoring and surveillance systems;
- coordinating integrated surveillance activities at global and regional levels to inform policy decisions and public health responses;

- shaping the research agenda on communicable diseases and stimulating and supporting the generation, translation and dissemination of valuable knowledge for use in the formulation of ethical and evidence-based policy options; and
- strengthening the capacity of Member States to undertake health research, especially on the development of tools and strategies for the prevention, early detection, diagnosis, treatment and control of communicable diseases.

ASSUMPTIONS, RISKS AND OPTION ANALYSIS

This strategic objective would be achieved under the following assumptions:

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

The following risks may adversely affect achievement of the strategic objective:

- increased pressure to divert resources away from communicable diseases and towards other aspects of health, and the fact that prevention and control of communicable diseases are not recognized and visibly maintained as a health priorities, particularly in the least developed countries. The prevention and control of communicable diseases will remain a priority on national and international health agendas provided that policy messages from the Secretariat and other international partners are harmonized;
- insufficient investment directed towards the International Health Regulations and the fragmented approach of governments towards their implementation;
- the inadequacy of private sector and unilateral efforts to secure funding to bridge the gap in investment in research, which were identified more than a decade ago; less than 10% of global health research resources are spent on health problems that affect 90% of the world's population. The promotion and coordination of policies and actions based on the premise of global public goods can maximize the value of the investment;
- the failure to complete interruption of polio transmission by the end of 2007, which will necessitate additional supplemental immunization activities and incur extra costs. The risks can be mitigated through the use of new tools and strategies to accelerate interruption of wild polio virus, as well as heightened advocacy and social mobilization efforts at all levels; and
- an influenza pandemic that could cause unprecedented morbidity and mortality, as well as grave economic harm. Advanced planning for appropriate detection and response strategies, including containment and control strategies and research into the development of vaccines and medicines, is key to minimizing the potentially disruptive impact of a pandemic.

ORGANIZATION-WIDE EXPECTED RESULTS	**1.** Policy and technical support provided to Member States to maximize equitable access of all people to vaccines of assured quality, including new immunization products and technologies, and to integrate other essential child health interventions with immunization.			
INDICATORS	**1.1** Number of developing countries that have reached at least 90% in national vaccination coverage and at least 80% in vaccination coverage in every administrative unit.	**1.2** Number of developing countries assisted to make decisions about appropriate changes and additions to the immunization schedule, including the introduction of new vaccines and/or new technologies.	**1.3** Number of essential child health interventions integrated with immunization for which guidelines on common programme management are available.	**1.4** Number of countries that have established either legislation or a specified national budget line to ensure sustainable financing of immunization.
BASELINE	39	25	1	166
TARGETS TO BE ACHIEVED IN 2009	90/165	60/165	5	180
TARGETS TO BE ACHIEVED IN 2013	140/165	117/165	9	192/192

RESOURCES (IN US$ 000)	
Costs 2008-2009	149 361
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*In welcoming the Global immunization vision and strategy, the Health Assembly made a commitment to provide policy and technical support to Member States in order to increase protection against more diseases by making immunization available to all eligible people, introducing new vaccines and technologies and linking immunization to the delivery of other health interventions and overall development of the health sector. More than 75% of the resources are for activities at regional and country levels.* ***What is new:*** *global health partnerships, such as the Global Alliance for Vaccines and Immunization and increasing resources to Member States to implement immunization programmes through initiatives such as the International Financing Facility for Immunization, increase the pressure on the Secretariat to provide policy and technical support to assist Member States implement evidence-based health system approaches to ensure that the resources are used in a financially sustainable way in the long term. The proposed increases in the Secretariat's budget may be rather low in the light of these increased expectations.*

ORGANIZATION-WIDE EXPECTED RESULTS	**2.** Effective coordination and provision of support to Member States to achieve certification of poliomyelitis eradication and destruction, or appropriate containment of polioviruses, leading to a simultaneous cessation of oral polio vaccination globally.			
INDICATORS	**2.1** Percentage of countries using oral polio vaccine concurring with an internationally agreed time-line and process for cessation of routine oral polio vaccine use.	**2.2** Percentage of final country reports or updates submitted to and reviewed by appropriate regional certification commissions.	**2.3** Number of facilities worldwide storing or handling poliovirus following global oral polio vaccine cessation.	**2.4** Number of least-developed countries that have initiated plans for ensuring transition of the acute flaccid paralysis surveillance infrastructure funded by WHO into national core capacity building in line with the International Health Regulations.
BASELINE	0	63%		0
TARGETS TO BE ACHIEVED IN 2009	100% of 135 countries	75% of 215 countries	n/a	20
TARGETS TO BE ACHIEVED IN 2013	100% of 135 countries	100% of 215 countries	<20	35

RESOURCES (IN US$ 000)	
Costs 2008-2009	251 654
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*Recent outbreaks of polio have delayed the polio eradication initiative. It is therefore expected that polio campaigns in some countries will continue through 2008 and that WHO will need to continue to provide technical assistance for polio campaigns, as well as the polio surveillance infrastructure.* ***What is new:*** *once transmission has been interrupted, there will be a reduction in WHO's costs, but activities related to global certification, oral polio vaccine cessation and containment will continue through 2013. During this time, the polio surveillance infrastructure in the least-developed countries - which is currently the primary early-warning system for detecting and responding to public health emergencies - will undergo a gradual transition to increase country capacity in line with International Health Regulation requirements.*

ORGANIZATION-WIDE EXPECTED RESULTS	**3.** Effective coordination and support provided to Member States to provide access for all populations to interventions for the prevention, control , elimination and eradication of neglected tropical diseases, including zoonotic diseases.			
INDICATORS	**3.1** Number of countries achieving guinea-worm eradication certification.	**3.2** Number of countries that have achieved elimination of leprosy at national and sub-national levels.	**3.3** Population at risk of lymphatic filariasis in endemic countries to be brought under mass drug administration or preventive chemotherapy.	**3.4** Coverage of at-risk school-age children in endemic countries with regular treatment against schistosomiasis and soil transmitted helminth infections.
BASELINE				
TARGETS TO BE ACHIEVED IN 2009	10	22	900 million	56%
TARGETS TO BE ACHIEVED IN 2013	20	24	1 200 million	75%

RESOURCES (IN US$ 000)	
Costs 2008-2009	152 288
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*Although cost-effective interventions are available and are being implemented, being able to demonstrate that the elimination of many neglected tropical diseases as public health problems can be achieved requires facilitation of intercountry control programmes by WHO, development of new and improved interventions to combat drug resistance and support from the private sector. Since controlling them can be shown to be highly cost-effective from a societal point of view, interventions in this area can be very effective in alleviating poverty.* ***What is new:*** *as we approach the goals of eliminating/eradicating guinea-worm and leprosy and halving the mortality rate for rabies, the Secretariat's efforts to reinforce its accomplishments and maintain momentum should be intensified, hence the need for increased resources in 2010-2013. The integrated approach to implementing health systems-based solutions for the control of tropical diseases requires a gradual, sustainable scaling up of WHO's support to Member States during 2008-2013.*

ORGANIZATION-WIDE EXPECTED RESULTS	**4.** Provision of policy and technical support to Member States to enhance their capacity to carry out surveillance and monitoring of all communicable diseases of public health importance.			
INDICATORS	**4.1** Percentage of countries with integrated surveillance of all communicable diseases of public health importance.	**4.2** Number of countries receiving technical assistance from WHO to adapt generic surveillance and communicable disease monitoring tools or protocols to specific country situations.	**4.3** Percentage of joint reporting forms on immunization surveillance and monitoring received on time at global level in accordance with established time-lines.	**4.4** Number of countries supported by WHO to establish a system at district level to record, analyse and evaluate the quality and safety of vaccine/drug/ intervention delivery.
BASELINE	30%	40 (in 2004-2005)		not currently monitored
TARGETS TO BE ACHIEVED IN 2009	50% of 192 countries	40		25% of 192 countries
TARGETS TO BE ACHIEVED IN 2013	75% of 192 countries	117	95% of 192 countries	75% of 192 countries

RESOURCES (IN US$ 000)	
Costs 2008-2009	71 832
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

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

ORGANIZATION-WIDE EXPECTED RESULTS	**5.** New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed and validated, and scientists from developing countries increasingly taking the lead in this research.			
INDICATORS	**5.1** Number of consensus reports published on global research needs and priorities for a disease or type of intervention.	**5.2** Number of new and improved tools (e.g. medicines, vaccines or diagnostics) receiving internationally recognized approval for use.	**5.3** Number of new and improved interventions and implementation strategies whose effectiveness has been determined and the evidence made available to appropriate institutions for policy decisions.	**5.4** Proportion of peer reviewed publications based on WHO supported research where the first author's institution is in a developing country.
BASELINE	3/biennium	1/biennium	2/biennium	48%
TARGETS TO BE ACHIEVED IN 2009	3	2	3	55%
TARGETS TO BE ACHIEVED IN 2013	6	6	8	60%

RESOURCES (IN US$ 000)	
Costs 2008-2009	74 166
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*Even though 85% of the global burden of disability and premature mortality affects the developing world, less than 4% of global research funding is devoted to the disorders that constitute the major burden of disease in developing countries.* ***What is new:*** *increases in funds for research, as well as the expanding role of public-private partnerships make it essential for the Secretariat to integrate, harmonize and define the global health research agenda and support countries to make evidence-based policy decisions.*

ORGANIZATION-WIDE EXPECTED RESULTS	**6.** Member States assisted to achieve the minimum core capacities required by the International Health Regulations for the establishment and strengthening of alert and response systems for use in epidemics and other public health emergencies of international concern.			
INDICATORS	**6.1** Number of countries that have completed the assessment of core capacities for surveillance and response, in line with their obligations under the International Health Regulations (2005).	**6.2** Number of countries supported by WHO to develop plans of action to meet minimum core capacity requirements for early warning and response in line with their obligations under the International Health Regulations.	**6.3** Number of countries whose national laboratory system is engaged in at least one internal or external quality-control programme for communicable diseases.	**6.4** Number of Member States participating in training programmes focusing on the strengthening of early warning systems, public health laboratories or outbreak response capacities.
BASELINE				
TARGETS TO BE ACHIEVED IN 2009	150	115	135	150
TARGETS TO BE ACHIEVED IN 2013	192	192	192	192

RESOURCES (IN US$ 000)	
Costs 2008-2009	80 848
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*Under the International Health Regulations (2005), all State Parties have made a commitment to assess their national core capacities for surveillance and response within two years of their entry into force in May 2007, and to develop and maintain the same core capacities for five years (with a two-year extension if needed) after that date. As defined in the Health Regulations, core capacities include surveillance and early warning for epidemic-prone diseases and essential diagnostic, response and communication capacities.* ***What is new:*** *during 2008-2009, WHO will need adequate internal technical and financial resources to support the national assessments and preparation of action plans. During 2010-2013, resources will be required mainly for implementation and the monitoring and evaluation of achievements.*

ORGANIZATION-WIDE EXPECTED RESULTS	**7.** Member States and the international community equipped to detect, assess, respond and cope with major epidemic and pandemic-prone diseases (e.g. influenza, meningitis, yellow fever, haemorrhagic fevers, plague and smallpox) through the development and implementation of effective prevention, detection, preparedness and intervention tools, methodologies, practices, networks and partnerships.		
INDICATORS	**7.1** Number of countries having national preparedness plans and standard operating procedures in place for major epidemic prone diseases (e.g. pandemic influenza).	**7.2** Number of international support mechanisms for diagnosis and mass intervention (e.g. international laboratory surveillance networks or ICG stockpiling mechanisms for meningitis, haemorrhagic fevers, plague, yellow fever, influenza, smallpox).	**7.3** Number of countries with basic capacity in place for safe isolation of infectious cases and safe laboratory handling of dangerous pathogens.
BASELINE			
TARGETS TO BE ACHIEVED IN 2009	135	10	100
TARGETS TO BE ACHIEVED IN 2013	192	18	192

RESOURCES (IN US$ 000)	
Costs 2008-2009	62 214
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*Strong disease and theme specific programmes and projects are vital for WHO to ensure that key threats are dealt with in a systematic fashion and that WHO maintains it's much needed global expertise in vital areas (e.g. influenza, smallpox, biosafety, deliberate epidemics, yellow fewer). The avian influenza crisis has highlighted the need for WHO to accelerate work with Member States to ensure that their ability to detect, assess, respond and cope with the threat of known epidemic-prone and emerging infectious diseases.* ***What is new:*** *the development of standard operating procedures and stockpiles of necessary medicines and vaccines are a critical component to mitigating the potential impact of these diseases. Maintaining and expanding existing networks and partnerships supporting Member States in the different aspects of preparedness and response to specific epidemic risks, and developing new ones where required, are essential elements of the WHO strategy. By the end of 2007, all Member States will have national preparedness plans devised, implemented and tested, and this will form a critical backbone to the response to a potential pandemic.*

ORGANIZATION-WIDE EXPECTED RESULTS	**8.** Coordinated regional and global capacity, rapidly available to Member States, for detection, verification, risk assessment and response to epidemics and other public health emergencies of international concern.			
INDICATORS	**8.1** Global event management system in place to support coordination of risk assessment, communications and field operations for headquarters, regional and country offices.	**8.2** Number of partner institutions participating in the global outbreak alert and response network and other relevant regional sub-networks.	**8.3** Proportion of requests for assistance from Member States for which WHO mobilizes comprehensive and coordinated international support to disease control efforts, investigation and characterization of events and sustained containment of outbreaks.	**8.4** Median time to verification of outbreaks of international importance, including laboratory confirmation of aetiology.
BASELINE				
TARGETS TO BE ACHIEVED IN 2009	1	200	100%	4 days
TARGETS TO BE ACHIEVED IN 2013	1	400	100%	2 days

RESOURCES (IN US$ 000)	
Costs 2008-2009	57 871
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*There is a continuing and increasing demand on WHO to operate an effective global system of epidemic intelligence gathering, verification, risk assessment, information management and rapid field response using innovative information technology, standard operating procedures and the resources of partners in the global outbreak alert and response network (GOARN) and other relevant regional networks. This service is now mandated and obligated according to the International Health Regulations (2005).* ***What is new:*** *a focus on strengthening WHO epidemic alert and response operations at country and regional level; while increasing standardization and coordination of operations across the Organization; an increasing level of accountability for decision making especially when these decisions affect travel and trade.*

STRATEGIC OBJECTIVE 2

To combat HIV/AIDS, malaria and tuberculosis.

Scope

Work under this Strategic Objective will focus on scaling-up and improving HIV/AIDS, TB and Malaria prevention, treatment, care and support interventions so as to achieve universal access, including among high-burden populations, women, infants, children, adolescents, poor and vulnerable groups; advancing related research; addressing key bottlenecks that are currently impeding intervention access, use and quality; and contributing to the broader strengthening of health systems.

Indicators and Targets

- HIV-related deaths averted annually in low- and middle-income countries due to antiretroviral therapy by 2013. (Baseline: 300,000 in 2005).
- Mother to Child HIV Transmission reduction: Target: 60% reduction in percentage of HIV-infected infants born to HIV-infected mothers down to 10% by 2013 (Baseline of 25% in 2005).
- HIV Prevalence Reduction among vulnerable populations: Target: All (136) countries with low-prevalence and concentrated HIV epidemics having have halted or reversed HIV prevalence among most at-risk populations (injecting drug users, sex workers and men who have sex with men) by 2013 (Baseline 0 countries in 2005).
- TB Incidence reduction: Target: Having halted and began to reverse the incidence of TB by 2013 (Baseline 1990 annual incidence increasing).
- TB Mortality reduction: Target 47% reduction by 2013 (Baseline 1990 figures).
- Malaria Mortality reduction in endemic countries: Target: 50% reduction by 2013 (Baseline 1.2 million deaths globally in 2002).
- Elimination of Malaria from countries where elimination is currently considered feasible by 2013: Target: 7 countries certified or enrolled in a WHO certification process for Malaria elimination countries by 2013 (Baseline: 0 countries in 2005).

Linkages with other strategic objectives

This work will also be linked with work undertaken in:

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

ISSUES AND CHALLENGES

HIV/AIDS, Tuberculosis and Malaria global pandemics claim more than six million lives annually and contribute heavily to national and individual poverty. Controlling HIV/AIDS, Tuberculosis and Malaria is crucial to achieving many of the MDGs and a successful fight against the three diseases will also have far-reaching impact on reducing poverty and child mortality; and improving maternal and newborn health; and other health outcomes; as well as

alleviating the burden on individuals, communities, nations and their health systems. Lessons learnt indicate that various strategic approaches are needed to combat the three diseases.

STRATEGIC APPROACHES

In this context, major impetus will be given to promoting the delivery and universal access of essential interventions for prevention, treatment, care and support to halt transmission and curtail morbidity and mortality from the three diseases. At the primary care level, these can be harmonized to maximize the effectiveness of a given patient encounter with the health system; and to optimize on the various entry points. Special emphasis will be placed on maximizing prevention; ensuring that the services are also tailored and delivered to the poor, vulnerable groups and hard-to-reach populations, including injecting drug users, sex workers and prisoners; addressing the needs of populations in conflict situations and humanitarian crises; ensuring relevance to sociocultural contexts; and encouraging use of evidence, norms and standards in policy and programme formulation.

Strengthening and supporting human resources and provider networks and enhancing public-private mix will be vital; including training and upgrading the skills of health professionals and community workers; widening the service provision networks and pool of providers; strengthening human resource management capacity; better engagement of non-governmental and private sector institutions; strengthening referral systems; tapping the potential of community health workers, persons living with the diseases and family members; and promoting strategies to retain health human resources.

Facilitating the availability and promoting proper use of quality, safe and affordable medicines, diagnostics, insecticides and health commodities; expanding quality-assured laboratory networks; and ensuring well functioning public and private supply chains will also be crucial.

Monitoring, evaluation, and surveillance systems for decision making, progress monitoring and accountability towards HIV, TB and Malaria targets will be enhanced, as well as improving effectiveness and efficiency of information systems (generation and use of age and sex disaggregated data); strengthening epidemiological and behavioural surveillance; strengthening data collection and analysis capacity (including financial tracking); assessing impact of interventions and trends of the three diseases in special population groups; refining indicators for key new interventions (such as the long-term impact of antiretroviral treatment for people with HIV/AIDS and resistance monitoring.

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

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

In supporting the efforts of Member States, WHO Secretariat will focus on:

- developing global HIV/AIDS, TB and malaria policies, strategies and standards;
- providing technical cooperation and coordination efforts to Member States for the implementation of policies, strategies and standards;
- facilitating availability and proper use of high quality medicines and commodities;
- measuring progress towards global and regional targets and assessing national programme and system performance, financing and impact;
- facilitating partnerships, advocacy and communications;
- supporting global, regional and subregional and intercountry initiatives aimed at prevention and control of HIV/AIDS, TB and Malaria;
- assisting Member States as appropriate to develop and implement mechanisms for resource mobilization and utilization; and
- fostering and supporting research and building research capacity in target countries.

ASSUMPTIONS, RISKS AND OPTION ANALYSIS

Enabling HIV, TB and Malaria programs to successfully scale up requires a consistent and strong national (all levels) capacity to develop evidence-based policies, analyse their effects, and adjust them as necessary. It also requires substantial increase in resources, reinforcing health systems and building institutional capacity to solve operational constraints. This strategic objective would be achieved under the following assumptions:

- HIV/AIDS, TB and Malaria will continue to be recognized as priority national and international health agendas;
- strengthening of national health systems will be accorded a higher profile, with the aim to attain universal access to essential health services and care;
- partnership mechanisms and involvement of stakeholders will be strengthened with the aim of attaining the agreed targets at national and regional levels; and synergy and coordination among the increasing number of actors in

HIV/AIDS, TB and Malaria will become a reality; and

- gender inequalities, discrimination and stigmatization currently fuelling the three diseases will be addressed as priority cross-cutting issues.

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

- difficulties in raising and sustaining the necessary resources - both for WHO and for Member States, as more and more competing priorities emerge;
- health gains achieved by WHO and Member States in HIV/AIDS, TB and Malaria may not be sustained in the least developed countries if the political and financial commitment is not increased; and
- difficulties in sustaining WHO leadership functions and interface within the array of actors, in the midst of growing number of actors and partnerships, increasing competition for resources and special coordination and harmonization challenges.

ORGANIZATION-WIDE EXPECTED RESULTS	**1.** Guidelines, policy, strategy and other tools developed for prevention, treatment and care for HIV/AIDS, Malaria and TB, including innovative approaches for increasing coverage of the interventions among the poor, hard to reach and vulnerable populations.			
INDICATORS	**1.1** Number of supported countries achieving the national intervention targets for HIV/AIDS.	**1.2** Number of supported countries achieving the national intervention targets for Malaria.	**1.3** Number of countries achieving the targets for detection and treatment of TB.	**1.4** Number of countries achieving prevention and control targets for sexually transmitted infections.
BASELINE				
TARGETS TO BE ACHIEVED IN 2009			XXX countries achieving TB case detection above 70% and treatment success rate at least 85%.	60% high burden countries having at least 70% of persons with sexually transmitted infections at health care facilities appropriately diagnosed, treated and counselled.
TARGETS TO BE ACHIEVED IN 2013		All endemic countries achieving 80% intervention targets.	All countries exceeding 70% case detection and 85% success rate.	All high burden countries having at least 90% of persons with sexually transmitted infections at health care facilities appropriately diagnosed, treated and counselled.

RESOURCES (IN US$ 000)	
Costs 2008-2009	124 000
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*WHO has a firm commitment to maximize access to HIV/AIDS, TB and Malaria interventions, as outlined in the various WHA Resolutions, the Global Health Sector for HIV/AIDS, the Global Plan to Stop TB; the Global Plan to Roll Back Malaria; articulation of WHO's Contribution to Universal Access HIV/AIDS Prevention, Treatment (and the need to advance work done under the 3by5 Initiative); and implementation of the Millennium development goals, and others. Most of the resources are for country and regional level activities*

ORGANIZATION-WIDE EXPECTED RESULTS	**2.** Policy and technical support provided to countries towards expanded delivery of prevention, treatment and care interventions for HIV/AIDS, Malaria and TB; including integrated training and service delivery; wider service provider networks; strengthened laboratory capacities and better linkages with other health services, such as reproductive health, maternal, newborn and child health, sexually transmitted infections, nutrition, drug dependence treatment services, respiratory care, neglected diseases and environmental health.			
INDICATORS	**2.1** Number of targeted countries that have developed integrated/coordinated policies on HIV/AIDS and tuberculosis.	**2.2** Number of targeted countries that have developed and implemented health workforce strategies and plans incorporating HIV/AIDS, malaria and tuberculosis needs.	**2.3** Number of countries monitoring access and quality of health services for HIV/AIDS, tuberculosis and malaria.	**2.4** Number of countries with appropriate human resources policies for HIV/AIDS, tuberculosis and malaria programmes.
BASELINE				
TARGETS TO BE ACHIEVED IN 2009				
TARGETS TO BE ACHIEVED IN 2013				

RESOURCES (IN US$ 000)	
Costs 2008-2009	256 000
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	

ORGANIZATION-WIDE EXPECTED RESULTS	**3.** Global guidance and technical support provided on policies and programmes to promote equitable access to essential medicines of assured quality for the prevention and treatment of HIV/AIDS, tuberculosis and malaria, and their rational use by prescribers and consumers; and uninterrupted supply diagnostics, safe blood and other essential commodities.			
INDICATORS	**3.1** Number of global norms and quality standards for HIV, tuberculosis and malaria medicines and diagnostics developed or updated.	**3.2** Number of priority medicines for HIV, tuberculosis and malaria assessed and pre-qualified for UN procurement.	**3.3** Number of countries with the supply of HIV, tuberculosis and malaria medicines integrated into national pharmaceutical systems.	**3.4** Cumulative number of patients treated with support from the Global TB Drug Facility.
BASELINE				
TARGETS TO BE ACHIEVED IN 2009				12 million
TARGETS TO BE ACHIEVED IN 2013			All targeted countries supported to increase access to affordable HIV/AIDS, tuberculosis and malaria essential medicines.	21 million

RESOURCES (IN US$ 000)	
Costs 2008-2009	85 100
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*HIV/AIDS, tuberculosis and malaria work depends significantly on medicines, diagnostics and other essential health technologies. Expanding access and ensuring the quality of these is a major priority from WHO, as evidenced by various WHA Resolutions. This is an increasing priority area for member states and there is enormous demand for WHO's support in this area. Most of the resources will be used for country and regional level activities.*

ORGANIZATION-WIDE EXPECTED RESULTS	**4.** Global, regional and national surveillance, evaluation and monitoring systems strengthened and expanded to monitor progress towards targets and resource allocations for HIV/AIDS, malaria and tuberculosis control along with monitoring the impact of control efforts and the evolution of drug resistance.		
INDICATORS	**4.1** Number of countries that regularly collect, analyse and report surveillance coverage, outcome and impact data using WHO's standardized methodologies, including appropriate age and sex dis-aggregation.	**4.2** Number of countries collaborating with WHO on annual surveillance, monitoring and financial allocation data for inclusion in the annual global reports on HIV/AIDS, malaria and tuberculosis control and the achievement of targets.	**4.3** Number of countries reporting on surveillance and monitoring of HIV, malaria and tuberculosis drug resistance.
BASELINE			
TARGETS TO BE ACHIEVED IN 2009			
TARGETS TO BE ACHIEVED IN 2013	All targeted countries tuberculosis: 211	All targeted countries.	

RESOURCES (IN US$ 000)	
Costs 2008-2009	124 000
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

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

ORGANIZATION-WIDE EXPECTED RESULTS	**5.** Political commitment sustained and mobilization of resources ensured through advocacy and nurturing of HIV/AIDS, malaria and tuberculosis partnerships at country, regional and global levels; support provided to countries as appropriate to develop/strengthen and implement mechanisms for resource mobilization and utilization and increase the absorption capacity of available resources; and engagement of communities and affected persons increased to maximize the reach and performance of HIV/AIDS, malaria and tuberculosis control.		
INDICATORS	**5.1** Number of functional partnerships for HIV/AIDS, malaria and tuberculosis control.	**5.2** Number of targeted countries that receive WHO support in accessing financial resources or increasing absorption of funds for HIV/ AIDS, tuberculosis and malaria.	**5.3** Number of countries that have involved communities, civil society organizations, private sector in planning, design, implementation and evaluation of HIV/AIDS, malaria and tuberculosis programmes.
BASELINE			
TARGETS TO BE ACHIEVED IN 2009	HIV: 30 (2007) tuberculosis: 43/87 target countries having functional partnerships malaria: 33/46 target countries; 30% of target countries.	Malaria: 30% of target countries requesting support are supported.	malaria: 10% target countries
TARGETS TO BE ACHIEVED IN 2013	HIV: 75 tuberculosis: 87 countries having functional partnerships malaria: 42/46 target countries.	All targeted countries requesting assistance to access funds from financing agencies supported tuberculosis: 75% of those eligible? HIV: 30? malaria: 50 of target countries	malaria: 30% of target countries

RESOURCES (IN US$ 000)	
Costs 2008-2009	35 000
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*Resources are required to ensure engagement and coordination with various partners for rapid scaling up of HIV, tuberculosis and malaria interventions, including advocacy activities, coordination and collaboration with key partnerships, networks and stakeholders such as UNAIDS, Stop TB and Rollback Malaria Partnerships, GFATM, PEPFAR, Global TB Drug Facility; Malaria Medicines and Supply Service; AIDS Medicines and Diagnostics Service, etc. They are also needed for promoting funding of HIV, tuberculosis and malaria aspects that remain severely under-funded such as laboratory capacity and human resources. The work cuts across all three levels of the Organization.*

ORGANIZATION-WIDE EXPECTED RESULTS	**6.** New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of HIV, tuberculosis and malaria developed and validated, with scientists from developing countries increasingly taking the lead in this research.		
INDICATORS	**6.1** Number of new and improved tools (e.g. drugs, vaccines, diagnostics) receiving internationally recognized approval for use in the HIV, tuberculosis or malaria fields.	**6.3** Number of new and improved interventions and implementation strategies for HIV, tuberculosis and malaria, for which effectiveness has been determined and evidence made available to appropriate institutions for policy decisions.	**6.3** Proportion of peer-reviewed publications arising from WHO supported research on HIV, tuberculosis or malaria and for which the first author's institution is based in a developing country.
BASELINE	1	3	48%
TARGETS TO BE ACHIEVED IN 2009	2	6	55%
TARGETS TO BE ACHIEVED IN 2013	4	10	63%

RESOURCES (IN US$ 000)	
Costs 2008-2009	87 000
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

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

STRATEGIC OBJECTIVE 3

Prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries.

Scope

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

Indicators and Targets

- Number of countries that score above xx on the WHO scale to prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries (scale to be developed; should include criteria that can be measured with little or no additional effort).

Linkages with other strategic objectives

The work will be linked to that undertaken under the following strategic objectives:

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

ISSUES AND CHALLENGES

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

The total number of deaths from these conditions represents 75% of the global mortality rate and the percentage is projected to increase. Over the period 2006-2015, deaths from communicable conditions, maternal and perinatal conditions and nutritional deficiencies are expected to decrease by 3%, while deaths from chronic noncommunicable conditions are expected to increase by 17%, neuro-psychiatric disorders by 14% and injuries by 12%. The major part of this increasing burden, affects low- and middle-income countries.

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

In this context, the major challenges are:

- to increase awareness of the magnitude of the problem and the potential that exists for prevention;
- to increase the political will to address the problem;
- to initiate appropriate multi-sectoral collaboration; and
- to generate the necessary resources in an environment of competing interests.

STRATEGIC APPROACHES

To achieve this objective, priority will need to be given to addressing chronic noncommunicable conditions, mental disorders, violence and injuries within national and international health and overall development agendas. A comprehensive public health approach that includes the fostering of multisectoral collaboration and innovation is essential. The Member States should develop coordinated but distinct responses to chronic, noncommunicable diseases, mental disorders, and violence and injury that are based on comprehensive and integrated action. Shifting the focus on to primary prevention, reorienting the emphasis towards prevention in health care and ensuring community participation are key factors for achieving successful outcomes in countries.

In supporting the efforts of the Member States, the Secretariat will focus on:

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

ASSUMPTIONS, RISKS AND OPTION ANALYSIS

This strategic objective would be achieved under the following assumptions:

- the existence of a high level of multisectoral cooperation between global and national stakeholders, and recognition that multisectoral action is more likely to be successful than individual actions;
- that countries recognize that integrated prevention and management of the conditions covered by this objective is more likely to be successful than focusing on individual conditions and disorders; and
- that progress will be jeopardized if countries continue to prioritize tertiary care in the allocation of resources instead of primary care and prevention.

The following risks may adversely affect achievement of the strategic objective:

- if the growing threat to health and development posed by chronic noncommunicable conditions, mental disorders, violence and injuries continues to be omitted from the high-level development agenda as set out in the Millennium Development Goals; and
- the emergence of new global threats, such as severe acute respiratory syndrome and avian influenza, which could further undermine the allocation of both priority and resources to conditions covered by this objective.

ORGANIZATION-WIDE EXPECTED RESULTS	**1.** Advocacy and support provided to increase political, financial and technical commitment in countries in order to address chronic noncommunicable conditions, mental and behavioural disorders, violence and injuries and disabilities.			
INDICATORS	**1.1** Number of targeted countries that have a focal point or unit for injuries and violence prevention with own budget in the health ministry.	**1.2** *The world health report* on disability and rehabilitation published and launched.[1]	**1.3** Number of targeted countries that have a unit for mental health with its own budget in the health ministry.	**1.4** Proportion of targeted countries that have a unit or department for chronic noncommunicable conditions with its own budget in the health ministry.
BASELINE				
TARGETS TO BE ACHIEVED IN 2009	120	Draft report	120	30%
TARGETS TO BE ACHIEVED IN 2013	192	Report published in 6 languages	192	85%

RESOURCES (IN US$ 000)	
Costs 2008-2009	24 200
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*The resources will be used to raise the profile of, and strengthen commitment for action for, chronic noncommunicable conditions, mental and behavioural disorders, violence and injuries and disabilities at global, regional and national levels. Resources will also be used to support the creation of units in national public health agencies to address chronic noncommunicable conditions, mental and behavioural disorders, violence and injuries and disabilities, and to support their initial activities. Finally, resources will be used for the development of global tools, reports, and campaigns that describe the situation and make recommendations for action.*

[1] See Resolution WHA58.23.

ORGANIZATION-WIDE EXPECTED RESULTS	**2.** Guidance and support provided to countries for the development and implementation of policies, strategies and regulations for chronic noncommunicable conditions, mental and behavioural disorders, violence and injuries and disabilities.				
INDICATORS	**2.1** Number of targeted countries that have and are implementing national plans to prevent unintentional injuries and violence.	**2.2** Number of targeted countries that have and are implementing national plans for disability and rehabilitation.	**2.3** Number of countries receiving and utilizing guidance on policies, strategies and regulations for mental, behavioural, neurological and psychoactive substance use disorders.	**2.4** Proportion of targeted countries that have and are implementing a nationally approved policy document for the prevention and control of chronic, noncommunicable conditions.	**2.5** Proportion of targeted countries that have and are implementing comprehensive national plans for the prevention of visual and hearing impairment.
BASELINE					
TARGETS TO BE ACHIEVED IN 2009	70	60	72	30%	30%
TARGETS TO BE ACHIEVED IN 2013	120	100	192	85%	85%

RESOURCES (IN US$ 000)	
Costs 2008-2009	29 900
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*National plans and policies are key to coordinated multisectoral responses to chronic noncommunicable conditions, mental and behavioural disorders, violence and injuries and disabilities. Only a minority of countries have developed such plans. The resources will be used to support regional and national processes that result in the development and initial implementation of such documents.*

ORGANIZATION-WIDE EXPECTED RESULTS	**3.** Improved capacity in countries to collect, analyse, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable conditions, mental and behavioural disorders, violence and injuries and disabilities.				
INDICATORS	**3.1** Number of targeted countries that have published a national compilation of data on the magnitude, causes and consequences of injuries and violence.	**3.2** Number of targeted countries that have published a national compilation of data on the prevalence and incidence of disabilities.	**3.3** Number of targeted countries establishing or substantially strengthening national or regional information systems on the magnitude, causes and consequences of mental, behavioural, neurological and psychoactive substance use disorders.	**3.4** Proportion of targeted countries with a national health reporting system and annual reports that include indicators of chronic, noncommunicable conditions.	**3.5** Proportion of targeted countries documenting the burden of visual and hearing impairment.
BASELINE					
TARGETS TO BE ACHIEVED IN 2009	70	90	36	30%	30%
TARGETS TO BE ACHIEVED IN 2013	120	140	72	85%	85%

RESOURCES (IN US$ 000)	
Costs 2008-2009	28 000
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

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

ORGANIZATION-WIDE EXPECTED RESULTS	**4.** Improved evidence compiled by WHO on the cost-effectiveness of interventions to address chronic noncommunicable conditions, mental and behavioral disorders, violence and injuries and disabilities.	
INDICATORS	**4.1** Evidence on the cost-effectiveness of widely available interventions for the management of depression, schizophrenia, epilepsy and substance use disorders prepared and made available.	**4.2** Evidence on the cost-effectiveness of a core package of interventions for chronic, noncommunicable conditions summarized and the global cost of implementation estimated.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	4 interventions	Core package completed
TARGETS TO BE ACHIEVED IN 2013	12 interventions	Expanded and desirable packages are completed, and overall approach is contextualized for country implementation.

RESOURCES (IN US$ 000)	
Costs 2008-2009	23 800
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*Resources will be used to support further research in low and middle income countries on cost effectiveness of interventions. This will include training and workshops to refine methodology, studies, and compilation of results at national, regional and global level, including through best practice documents and focused dissemination strategies. Resources will also be used to inform policy-makers at country level and to assist them with using this information for priority setting.*

ORGANIZATION-WIDE EXPECTED RESULTS	**5.** Guidance and support provided to countries for the preparation and implementation of multisectoral population-wide programmes to prevent mental and behavioural disorders, violence and injuries and hearing and visual impairment.		
INDICATORS	**5.1** Guidelines on multisectoral interventions to prevent violence and unintentional injuries published and widely disseminated.	**5.2** Guidance on the prevention and management of depression, schizophrenia, epilepsy and substance use disorders prepared and made available.	**5.3** Proportion of targeted countries implementing strategies recommended by WHO for population-wide prevention of hearing and visual impairment.
BASELINE			
TARGETS TO BE ACHIEVED IN 2009	12	Guidance on 2 disorders	30%
TARGETS TO BE ACHIEVED IN 2013	18	Guidance on 4 disorders	85%

RESOURCES (IN US$ 000)	
Costs 2008-2009	25 100
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	

ORGANIZATION-WIDE EXPECTED RESULTS	**6.** Guidance and support provided to countries to strengthen their health and social systems in order to prevent and manage chronic noncommunicable conditions, mental and behavioural disorders, violence and injuries and disabilities.			
INDICATORS	**6.1** Number of targeted countries that strengthened their health-care system response to unintentional injuries and violence using WHO guidelines.	**6.2** Number of countries that strengthened their rehabilitation services using the recommendations in *The world health report* on disability and rehabilitation.[1]	**6.3** Number of countries conducting a systematic assessment of their mental health systems using the WHO assessment instrument for mental health systems and thereafter utilizing the information to strengthen national mental health systems.	**6.4** Proportion of targeted countries implementing integrated primary health-care strategies recommended by WHO in the management of chronic, noncommunicable conditions.
BASELINE				
TARGETS TO BE ACHIEVED IN 2009	30	10	72	30%
TARGETS TO BE ACHIEVED IN 2013	70	80	144	85%

[1] See Resolution WHA58.23

	RESOURCES (IN US$ 000)
	Costs 2008-2009: 26 200
	Estimates 2010-2011: ~ 000
	Estimates 2012-2013: ~ 000
JUSTIFICATION	*Resources will be used for documents, training, workshops and direct support for the strengthening of health and rehabilitation services in low and middle income countries, to ensure that they improve ways in which they address chronic noncommunicable conditions, mental and behavioural disorders, violence and injuries and disabilities.*

STRATEGIC OBJECTIVE 4

To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, while improving sexual and reproductive health and promoting active and healthy ageing for all individuals, using a life-course approach and addressing equity gaps.

Scope

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

Indicators and Targets

- Proportion of births attended by skilled health personnel : At least 85%.
- Maternal mortality ratio: Less than 50 countries with maternal mortality ratio above 100 per 100,000 live births.
- HIV transmission rate from mother to child: by 2013, the proportion of infants infected with HIV will be reduced by 60% (from 30% to 12%).
- Under-five mortality rate: 154 countries will have met or are on track to meet Millennium Development Goal Target 5 [reduce by two thirds, between 1990 and 2015, the under-5 mortality rate].
- HIV prevalence among pregnant women aged 15-24 years: all countries with generalized HIV epidemics have achieved and maintained at least a 25% reduction in prevalence, compared to their 2000-2003 baseline.
- Unmet need for family planning: unmet need should be decreased by 75%.

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

Linkages with other strategic objectives

This work will be linked with the work undertaken in:

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

ISSUES AND CHALLENGES

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

Political will to make a difference in these areas is flagging and resources are insufficient. Those who are most affected, (e.g., poor women and children in developing countries), have limited influence on decision-makers and are often excluded from care. Some issues are politically and culturally sensitive and do not draw the attention that they should, given the burden placed on public health. Efforts to improve the quality of necessary health care and to

increase coverage are insufficient. Competing health priorities, vertical programme approaches and lack of coordination between governments and development partners result in programme fragmentation, missed opportunities and an inefficient use of the limited resources that are currently available. Lack of attention to gender inequality and gaps in health equity undermine ongoing efforts to decrease mortality and morbidity globally. This pattern can be changed through the concerted action of all involved.

Technical knowledge and programme experience indicate that effective interventions exist for most of the health problems covered by this strategic objective and that basic interventions are feasible and affordable even in resource-constrained settings. There is general agreement that what is required is action towards reaching universal access to, and coverage by, key interventions (ref: WHA 58.31). To this end, adopting a life-course approach that recognizes the influence of early life events and of inter-generational factors on future health outcomes will serve to bridge gaps and build synergies between programme areas while also providing effective support to ensure active and healthy ageing (ref: WHA 58.16).

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

STRATEGIC APPROACHES

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

Integration and harmonization must be achieved at the service delivery level. A continuum of care must be ensured that runs through the life course and spans the home, the community and different levels of the health system. This needs to occur within the broader framework of strengthening health systems to ensure adequate and equitable financing and delivery of quality health-support services, with marginalized and underserved groups receiving priority attention. Of particular relevance to this strategic objective is the need to address the crisis in human resources for health.

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

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

To this end, Member States and partners must commit resources and prioritize national action through intensified advocacy and the mobilization of all partners around one concrete plan at the country level.

In supporting the efforts of the Member States, the WHO Secretariat will focus on various actions, within a human rights and gender-responsive framework:

- providing technical guidance for the formulation and implementation of effective, evidence-based policies and interventions, aiming for universal access to care, with due attention to gender inequality and gaps in health equity ;
- supporting countries to build their capacity for service delivery, with particular attention paid to the strengthening of human resources for health, and the provision and rational use of essential medicines, safe blood, health technologies and commodities;
- aligning the technical content of programmes and developing synergies between programme areas (including nutrition, HIV, tuberculosis and malaria), addressing the specific needs of female and male children, adolescents, adults and older individuals, while ensuring a continuum of care from the home to the first-level health facility and referral facilities throughout the life stages;
- supporting the necessary research and development of technologies and interventions while providing the necessary evidence on determinants and causes as well as on the effectiveness of the programmes;
- supporting countries to monitor their health situation by age and sex, and assess progress towards internationally-agreed goals and targets relevant to this objective, monitoring and evaluating programmes to ensure optimal coverage with effective services; and
- working through partnerships to mobilize political leadership and resources for improving the sexual and reproductive, maternal, newborn, child and adolescent health of both sexes while working towards healthy ageing.

The WHO Secretariat will, over the coming years, intensify its technical support to countries accordingly. To this end, the work plan and budget assume that most growth and most resources will be applied at the country level, with support from the regional offices.

ASSUMPTIONS, RISKS AND OPTION ANALYSIS

This strategic objective is formulated according to the following assumptions:

- overall strengthening of health systems will occur, including the development and maintenance of a suitable infrastructure, a reliable supply of essential drugs and commodities, functional referral systems and a competent and well-motivated health workforce;
- international and national actions will be undertaken for dealing with the crisis affecting human resources for health;
- key processes will be pursued such as the improved harmonization of the work of UN agencies at the country level and the integration of health issues in national planning and implementation instruments, for instance, poverty reduction strategy papers and medium-term expenditure frameworks; and
- potential for raising new resources for WHO's work in these areas will be materialized, as there is considerable political interest in making progress towards the Millennium Development Goals; this will likely increase with the support of global partnerships and initiatives, including the Partnership on Maternal, Newborn and Child Health, as we approach 2015.

The following risks have been identified that may adversely affect the achievement of this strategic objective:

- threats posed by the continued spread of the AIDS pandemic and setbacks in malaria control; and
- in some countries, increasing poverty, natural crises, political instability and food insecurity may lead to the reversal of direction in some indicators.

ORGANIZATION-WIDE EXPECTED RESULTS	**1.** Support to Member States to develop a comprehensive policy, plan and strategy for scaling up towards universal access to effective interventions in collaboration with other programmes, paying attention to gender inequality and gaps in health equity, providing a continuum of care throughout the life course, integrating service delivery across different levels of the health system and strengthening coordination with civil society and the private sector.		
INDICATORS	**1.1** Number of countries that have an integrated policy on universal access to effective interventions for improving maternal, newborn and child health.	**1.2** Number of countries that have a policy on universal access to sexual and reproductive health.	**1.3** Number of countries that have a policy on the promotion of active and healthy ageing.
BASELINE			
TARGETS TO BE ACHIEVED IN 2009	20	30	25
TARGETS TO BE ACHIEVED IN 2013	100	80	40

RESOURCES (IN US$ 000)	
Costs 2008-2009	27 025
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION

This will require:

- Advocacy and coordination of effective international efforts and the strengthening of collaboration with partners (e.g., Maternal Newborn and Child Health Partnership).

- Promotion of key initiatives and strategies such as the Global Reproductive Health Strategy and the Global Strategy for the Prevention and Control of Sexually-Transmitted Infections: 2006-2015; the Integrated Management of Pregnancy and Childbirth Strategy, the Integrated Management of Childhood Illness, the Global Strategy for Child and Adolescent Health and Development, the Global Strategy on Infant and Young Child Feeding, and the Child Health Policy Initiative.

- Promotion of national policies and laws that conform to international human rights norms and standards and that will help close the equity gap.

- Health system strengthening, with particular attention paid to specific requirements for strengthening human resources for health, the provision and rational use of essential medicines, safe blood, health technologies and commodities.

- Strengthened linkages between maternal and child health services and other programmes (including nutrition, HIV TB and malaria).

- Support to health management systems to monitor progress towards national targets and benchmarks relevant to MDG 4 and 5 and sexual and reproductive health goals.

ORGANIZATION-WIDE EXPECTED RESULTS	**2.** National research capacity strengthened as necessary and new evidence, products, technologies, interventions and delivery approaches of global and/or national relevance available to improve maternal, newborn, child and adolescent health, to promote active and healthy ageing, and to improve sexual and reproductive health.		
INDICATORS	**2.1** Number of new research centres strengthened through comprehensive institutional development and support.	**2.2** Number of completed studies on priority issues in the relevant field of health.	**2.3** Number of new or updated systematic reviews on best practices, policies and standards of care.
BASELINE			
TARGETS TO BE ACHIEVED IN 2009	10	50	25
TARGETS TO BE ACHIEVED IN 2013	30	150	75

RESOURCES (IN US$ 000)	
Costs 2008-2009	49 025
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*This will require:* *- Greater focus on country-led identification of needs to be addressed through research and of opportunities for strengthening national research capacity.* *- Improved prioritization of research, in close consultation with national research partners and other stakeholders.* *- Support for use of research findings to inform policies and programmes.*

ORGANIZATION-WIDE EXPECTED RESULTS	**3.** Guidelines, approaches and tools for improving maternal care in use at the country level, including technical support provided to Member States for intensified action to ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods, particularly for poor and disadvantaged populations, with progress monitored.	
INDICATORS	**3.1** Number of countries with at least 50% of target districts implementing strategies to ensure skilled care for every birth.	**3.2** Number of countries adapting and utilizing IMPAC policy, technical and managerial norms and guidelines.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	20	20
TARGETS TO BE ACHIEVED IN 2013	75	75

RESOURCES (IN US$ 000)	
Costs 2008-2009	70 025
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*This will require:* *- Focus on strengthening human resources capacity and on providing a supportive environment to ensure skilled care for every birth.* *- Focus on ensuring a continuum of care between communities and facilities, and referral care at all times.* *- Attention paid to marginalized populations and communities in order to enhance their participation in developing approaches to improve access to essential health services and referral care.* *- Monitoring and auditing systems to identify maternal deaths and detect failures of the system to address needs, especially those of marginalised and underserved populations.*

ORGANIZATION-WIDE EXPECTED RESULTS	**4.** Guidelines, approaches and tools for improving neonatal survival and health in use at country level, with technical support provided to Member States for intensified action towards the achievement of universal coverage along with effective interventions and progress monitoring.	
INDICATORS	**4.1** Number of countries with at least 50% of target districts implementing strategies for neonatal survival and health.	**4.2** Number of countries that have adapted, and where 50% or more of target districts are implementing, the packages of IMPAC and IMCI interventions, which include the full newborn period.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	40	40
TARGETS TO BE ACHIEVED IN 2013	75	75

	RESOURCES (IN US$ 000)	
	Costs 2008-2009	68 025
	Estimates 2010-2011	~ 000
	Estimates 2012-2013	~ 000
JUSTIFICATION	*This will require:* *- A continuum of care between maternal, newborn and child health services and strengthened linkages between these and other programmes such as immunization, family planning, nutrition, HIV/AIDS, syphilis elimination and malaria control.* *- Community involvement and promotion of contact between mothers, their families and health workers, and a continuum of care between communities and health facilities.* *- Suitable facilities for maternal and newborn care at community and primary care levels, especially for low birth weight infants.* *- Monitoring systems to track trends in neonatal survival, disaggregated by sex, and that allow the detection of subpopulations at high risk.*	

ORGANIZATION-WIDE EXPECTED RESULTS	**5.** Guidelines, approaches and tools for improving child health and development in use at the country level, with technical support provided to Member States for intensified action towards the achievement of universal coverage of the population with effective interventions, along with the monitoring of progress, taking into consideration international and human rights norms and standards, notably those stipulated in the Convention of the Rights of the Child.	
INDICATORS	**5.1** Number of countries implementing strategies to increase coverage with child health and development interventions.	**5.2** Number of countries that have expanded geographic coverage of IMCI to more than 75% of target districts.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	40	30
TARGETS TO BE ACHIEVED IN 2013	60	60

	RESOURCES (IN US$ 000)	
	Costs 2008-2009	38 025
	Estimates 2010-2011	~ 000
	Estimates 2012-2013	~ 000
JUSTIFICATION	*This will require:* *- A continuum of care from mothers and newborns to children, and between different levels of the health system.* *- Capacity building at all levels.* *- Linkages with efforts to address underlying social, environmental and behavioural determinants of ill-health and poor nutrition.* *- Promotion of child development and healthy lifestyles.* *- Emphasis on building community capacity and involvement in support of IMCI.* *- Monitoring systems that track trends in child survival, disaggregated by age and sex, and that allow the detection of subpopulations at high risk.*	

ORGANIZATION-WIDE EXPECTED RESULTS	**6.** Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, along with the scaling up of a package of effective prevention, treatment and care interventions in accordance with established standards.
INDICATORS	**6.1** Number of countries with a functioning adolescent health and development programme[1].
BASELINE	
TARGETS TO BE ACHIEVED IN 2009	50
TARGETS TO BE ACHIEVED IN 2013	100

[1] Note: A country with "an adolescent health and development programme" is defined as a country that has officially established a programme focussing on the health of adolescents or young people. This can be a stand-alone programme or a clearly-demarcated component of a health issue-specific programme such as the HIV programme. To be identified as "functioning", the programme should have in place a) a national level plan of action, b) a budget for activities, and c) a record of activities that have been carried out during the past year.

	RESOURCES (IN US$ 000)	
	Costs 2008-2009	36 025
	Estimates 2010-2011	~ 000
	Estimates 2012-2013	~ 000
JUSTIFICATION	*This will require:* *- Capacity building at the country level to collect, analyse and disseminate the data necessary for programme implementation.* *- Building of the capacity of health services to respond to the priority health needs of adolescents and to increase their access to services, with the meaningful involvement of young people, the engagement of community structures and a focus on particularly vulnerable groups and settings.* *- A supportive policy environment that ensures that the health sector provides evidence concerning effective interventions and examples of good practice.* *- Monitoring systems that track trends in adolescent health and development, disaggregated by age and sex, and that allow the detection of subpopulations at high risk.*	

ORGANIZATION-WIDE EXPECTED RESULTS	**7.** Guidelines, approaches and tools available, with technical support provided to Member States for accelerated action towards implementing the Global Reproductive Health Strategy, with particular emphasis on ensuring equitable access to quality sexual and reproductive health services, particularly in areas of unmet need, and with respect for human rights as they relate to sexual and reproductive health.	
INDICATORS	**7.1** Number of countries implementing the Global Reproductive Health Strategy.	**7.2** Number of countries having reviewed their existing national laws, regulations or policies relating to sexual and reproductive health.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	30	8
TARGETS TO BE ACHIEVED IN 2013	80	15

	RESOURCES (IN US$ 000)	
	Costs 2008-2009	59 025
	Estimates 2010-2011	~ 000
	Estimates 2012-2013	~ 000
JUSTIFICATION	*This will require:* *- Capacity building at the country level to collect, analyse and disseminate the data necessary for programme implementation.* *- Strengthened linkages between sexual and reproductive health services and other health programmes such as HIV/AIDS and nutrition.* *- Monitoring and evaluation of sexual and reproductive health programmes within and outside the health system, along with the establishment of accountability mechanisms.*	

ORGANIZATION-WIDE EXPECTED RESULTS	**8.** Guidelines, approaches, tools, and technical assistance provided to Member States for increased advocacy for ageing and health to be considered as a public health issue, for the development and implementation of policies and programmes aiming at maintaining maximum functional capacity throughout the life course and for the training of health care providers in approaches that ensure healthy ageing.	
INDICATORS	**8.1** Number of countries that will have implemented community-based policies focused on strengthening primary health care capacity to deal with ageing issues.	**8.2** Number of countries which will have implemented multi-sectoral policies reflecting the WHO Active Ageing policy framework.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	10	15
TARGETS TO BE ACHIEVED IN 2013	20	25

	RESOURCES (IN US$ 000)	
	Costs 2008-2009	14 025
	Estimates 2010-2011	~ 000
	Estimates 2012-2013	~ 000

JUSTIFICATION	*This will require:* *- Building the capacity of health services to support active and healthy ageing as well as support for the establishment of age-friendly primary health care centres.* *- Ensuring the meaningful involvement of older persons in the national policy development and programme planning process, with an emphasis on their contribution to society.* *- Supporting multi-sectoral initiatives that carry forward the Active Ageing framework, such as "age-friendly cities".*

STRATEGIC OBJECTIVE 5

Reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.

Scope

The joint efforts of the Member States and the Secretariat regarding this strategic objective encompass the following aspects: health sector emergency preparedness, intersectoral action for risk and vulnerability reduction within the framework of the International Strategy on Disaster Reduction, response to the health needs (including nutrition as well as water and sanitation.) of emergencies and crises, needs assessment of affected populations, transition and recovery health actions in post-conflict and post-disaster situations, fulfilling the mandate of WHO within the framework of the Humanitarian Reform, global alert and response system for environmental and food safety Public Health Emergencies, threat-specific risk reduction along with preparedness and response programmes for environmental and food safety public health emergencies.

Indicators and Targets

- Crude daily mortality. Target: Mortality of populations affected by major emergencies maintained below 1/1 000/day during initial emergency response phase.
- Access to functioning health services. Target: 90% of affected populations reach levels of access similar to pre-emergency conditions, or better, within one year.
- Weight for height. Target: Less than 10% of the affected population below 80% weight for height measure.

Linkages with other strategic objectives

The work in this strategic objective will be linked with the work undertaken in:

- strategic objective 1: in relation to International Health Regulations and response to epidemic emergencies;
- strategic objective 3: in relation to gender violence, responding to psychosocial needs of affected populations , addressing the health needs of the disabled , mass casualty management and chronic disease care;
- strategic objective 4: in relation to response to the health needs of vulnerable populations, especially mothers and children in emergency situations;
- strategic objective 8: in relation to intersectoral action for preparedness and risk reduction, and to environmental, chemical and radiological emergencies; and
- strategic objective 9: in relation to nutrition in emergency situations.

ISSUES AND CHALLENGES

The main thrust of this objective is to contribute to human security by minimizing the health impact and addressing the health and nutrition needs of vulnerable populations affected by emergencies, disasters, conflicts and other humanitarian crises

Each year, one in five Member States experiences a crisis that endangers the health of its people. According to the United Nations International Strategy for Disaster Reduction (UN/ISDR), 2005 saw an 18% rise in natural disasters. A series of political and social crises resulted in almost 25 million internally displaced people and more than 9 million refugees worldwide.

In the health sector, emergencies can place sudden and intense demands on health systems. These emergencies expose existing weaknesses in these systems and can disrupt economic activity and development. In countries with weak health infrastructures, health emergency response has often disrupted routine health services and humanitarian programmes for months on end.

Experience has shown that recovering from the disastrous effects of major and complex emergencies and crises takes much longer than perceived by the international community; their impact on health services and on the health status of populations persists for years.

STRATEGIC APPROACHES

As part of the Humanitarian Reform, WHO has been asked to ensure the coordination, effectiveness and efficiency of health action in crises in the areas of preparedness, response and recovery. WHO leads the Health Cluster of the Interagency Standing Committee.

Health sector involvement in emergency and humanitarian action should be comprehensive. Improvement of response is needed in a wide range of areas; these include mass casualty management, water, sanitation and hygiene,

nutrition, communicable and noncommunicable diseases, maternal and new born health, mental health, pharmaceuticals, health technologies, health logistics, health information services and management of the health infrastructure.

Funding of health-related aspects of emergency preparedness and response is a major concern. In this regard it is critical to ensure that needs analysis and project formulation be well connected with larger processes both within the UN System and within WHO. This requires the development of partnerships and coordination that can bring along a greater flow of predictable funding especially for chronic complex emergencies.

In supporting the efforts of the Member States, the WHO secretariat will:

- actively support Member States in building their capacity in the field of emergency preparedness and response through multisectoral, multidisciplinary and all-hazard approaches;
- establish and maintain national and international operational capacity for rapid response and for leading coordinated action of multiple stakeholders in environmental and food safety public health emergencies, disasters, conflict and other crises;
- develop knowledge bases and competencies for preparing and responding to emergencies;
- develop partnerships and coordination mechanisms with governments, civil society as well as with networks of collaborating and other centres of excellence to ensure timely and effective interventions when needed;
- develop technical and operational capacities in support of countries in crises particularly in conducting health assessments, coordinating health action, filling in gaps, providing guidance and monitoring the performance of humanitarian action on the health and nutrition of affected populations; and
- leverage the vast array of skills across WHO in support of response to emergencies (mental health, nutrition, water and sanitation, food safety, medicines, violence and injury prevention, mass casualty management, communicable diseases, maternal and child health).

ASSUMPTIONS, RISKS AND OPTION ANALYSIS

This strategic objective would be achieved under the following assumptions:

- strong, well-designed and adequately funded national health systems exist. Investing in in-country response programmes is therefore crucial to the work of WHO in these fields. Health action in crises and effective response to health emergencies is an integral part of WHO's mandated work.

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

- a misconception that the work in emergency preparedness and response is an additional responsibility on top of the regular normative and developmental work of the Organizations;
- insufficient development of mechanisms, readiness and competencies across WHO for effective and expeditious work in emergency situations; and
- insufficient funding of the core functions necessary to conduct work in emergency preparedness and response to fulfil the mandate of leader of the IASC Health Cluster.

ORGANIZATION-WIDE EXPECTED RESULTS	**1.** Norms and standards developed, capacity built and technical support provided to Member States for the development and strengthening of national emergency preparedness plans and programmes.			
INDICATORS	**1.1** Proportion of countries with national emergency preparedness plans that address multiple hazards.	**1.2** Proportion of countries where comprehensive mass casualty management plans are put in place.	**1.3** Proportions of countries in humanitarian emergencies with norms, guidelines, and strategies for reducing impact of health emergencies in maternal, newborns and children developed.	**1.4** Number of countries developing and implementing programmes for reducing the vulnerability of health, water and sanitation infrastructures.
BASELINE				
TARGETS TO BE ACHIEVED IN 2009	60%	40%	80%	40
TARGETS TO BE ACHIEVED IN 2013	70%	55%	90%	60

RESOURCES (IN US$ 000)	
Costs 2008-2009	42 000
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*Level of effort will increase in the 2010-2011 and subsequently in the 2012-2013 period.*

ORGANIZATION-WIDE EXPECTED RESULTS	**2.** Norms and standards developed, capacity built and technical support provided to Member States for a timely response to disasters associated with natural hazards and to conflict-related crises.		
INDICATORS	**2.1** Proportion of emergencies where health and nutrition assessments and tracking exercises are implemented.	**2.2** Number of global and regional training programmes on health operations in emergency response.	**2.3** Proportion of emergencies for which interventions for maternal, newborn and child health is put in place.
BASELINE			
TARGETS TO BE ACHIEVED IN 2009	60&	16	75%
TARGETS TO BE ACHIEVED IN 2013	80%	20	85%

RESOURCES (IN US$ 000)	
Costs 2008-2009	62 000
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*Level of effort will increase in the 2010-2011 and subsequently in the 2012-2013 period.*

ORGANIZATION-WIDE EXPECTED RESULTS	**3.** Norms and standards developed, capacity built and technical support provided to Member States for assessing needs along with planning and implementing transition and recovery actions in post conflict and post disasters situations.		
INDICATORS	**3.1** Number of post-conflict and post-disaster needs assessments conducted that have included a gender-responsive health component.	**3.2** Number of Humanitarian Action Plans for Complex Emergencies and CAP formulation processes where strategic and operational components for health have been included.	**3.3** Number of needs assessment and technical support provided in the areas of maternal and newborn health, mental health or nutrition in countries in transition and recovery situations.
BASELINE			
TARGETS TO BE ACHIEVED IN 2009	6	20	15
TARGETS TO BE ACHIEVED IN 2013	8	25	20

RESOURCES (IN US$ 000)	
Costs 2008-2009	51 500
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*Level of effort will increase in the 2010-2011 and subsequently in the 2012-2013 period.*

ORGANIZATION-WIDE EXPECTED RESULTS	**4.** Coordinated technical support on communicable disease control in natural disaster and conflict situations provided to Member States.	
INDICATORS	**4.1** Proportion of emergency-affected countries where a comprehensive communicable disease risk assessment has been conducted and an epidemiological profile and toolkit developed and disseminated to partner agencies.	**4.2** Proportion of acute natural disaster or conflict situations for which a disease surveillance/early warning system and communicable disease control interventions have been implemented.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	100%	100%
TARGETS TO BE ACHIEVED IN 2013	100%	100%

RESOURCES (IN US$ 000)	
Costs 2008-2009	35 000
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*Level of effort will increase in the 2010-2011 and subsequently in the 2012-2013 period.*

ORGANIZATION-WIDE EXPECTED RESULTS	**5.** Support provided to Member States for strengthening national preparedness as well as alert and response mechanisms for food safety and environmental health emergencies.				
INDICATORS	**5.1** Number of expert networks in place for responding to food safety and environmental public health emergencies.	**5.2** Proportion of countries with national plans for addressing preparedness, alerts and response to chemical, radiological and environmental health emergencies.	**5.3** Number of Member States with Infosan and environmental health emergency focal points.	**5.4** Proportion of food safety and environmental health emergencies where intersectoral collaboration and assistance is put in place.	**5.5** Readiness and stockpiling of necessary items for ensuring a prompt response to chemical and radiological emergencies.
BASELINE					
TARGETS TO BE ACHIEVED IN 2009	20	60%	175	65%	50%
TARGETS TO BE ACHIEVED IN 2013	30	70%	100%	100%	100%

RESOURCES (IN US$ 000)	
Costs 2008-2009	15 500
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*Level of effort will increase in the 2010-2011 and subsequently in the 2012-2013 period.*

ORGANIZATION-WIDE EXPECTED RESULTS	**6.** Effective communications issued, partnerships formed and coordination developed with other UN agencies, governments, local and international NGOs ,academic institutions and professional associations at the country, regional and global levels.		
INDICATORS	**6.1** Health cluster at the global level periodically convened, with annual action plans in place.	**6.2** Number of emergency-related interagency mechanisms and working groups where WHO is actively involved.	**6.3** Proportion of disasters and crises covered with a comprehensive communication strategy.
BASELINE			
TARGETS TO BE ACHIEVED IN 2009	100%	16	100%
TARGETS TO BE ACHIEVED IN 2013	100%	20	100%

RESOURCES (IN US$ 000)	
Costs 2008-2009	13 500
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*Level of effort will increase in the 2010-2011 and subsequently in the 2012-2013 period.*

STRATEGIC OBJECTIVE 6

Promote health and development, prevent and reduce risk factors for health conditions associated with tobacco, alcohol, drugs and other psychoactive substance use, unhealthy diets, physical inactivity and unsafe sex.

Scope

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

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

Indicators and Targets

- A 10% reduction in the total tobacco use prevalence rate in half the Member States by 2013.
- A 10% increase in the number of Member States that have stabilized or reduced the level of harmful use of alcohol by 2013.
- 10% of Member States with a high-burden of adult obesity to stop the rise in prevalence by 2013.

Linkages with other strategic objectives

The work in this strategic objective will contribute to and benefit from work undertaken in:

- strategic objectives 3, 4, 7, 8 and 9: while these seek to address underlying determinants of poor health and strengthen service provision, this strategic objective seeks in particular, to create healthy environments to enable individuals to make healthy choices.

ISSUES AND CHALLENGES

The six major risk factors addressed in this strategic objective are responsible for more than 60% of the mortality and at least 50% of the morbidity burden worldwide. They affect predominantly poor populations in low- and middle-income countries. While emphasis has been placed on the treatment of the adverse effects of these risk factors, much less attention has been devoted to prevention and how to effectively modify the determinants.

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

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

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

[1] *The world health report* 2002

Despite the substantial global burden of poor health associated with the major risk factors, there is a continuing lack of awareness and political commitment to act decisively to promote health and prevent and reduce their occurrence. Significant additional investment in financial and human resources is urgently needed at all levels within WHO and Member States to strengthen capacities and national and global responses to the burden of death, disease and disability caused by these risk factors.

Lessons learnt:

- Risk factor reduction and prevention is an essential component of national social and economic development plans as it leads to improvements in population health and a reduction in inequalities between population groups.
- Traditional public health approaches are not sufficient to deal with the problems caused by these risk factors and creative ways of working across government agencies, civil society, the private sector and other partners are needed.
- Public health problems caused by these risk factors have the potential to overwhelm health-care systems and cause significant social and economic hardship for individuals, families and communities, especially in countries and groups least able to afford the health-care costs they engender.
- Health promotion programmes have been shown to be cost effective, for example, educational strategies to reduce salt in processed foods, and advertising bans and price increases in the case of tobacco control.
- Risk factor prevention is the most cost-effective approach that low- and middle-income countries can adopt to control adverse health and social outcomes attributable to these risk factors.
- Evidence based on multi-level research shows that empowering initiatives can lead to improved health outcomes and that empowerment is a viable public health strategy. The integration of empowering interventions for women into the economic, educational and political sectors, has proved to have had the greatest impact on the quality of life, autonomy and authority of women, and has led to policy changes and improved child and family health.

STRATEGIC APPROACHES

An integrated approach to health promotion and the prevention and reduction of major risk factors will enhance synergies, improve the overall efficiency of interventions and dismantle the current vertical approaches to risk-factor prevention.

In countries, the strengthening of institutions and national capacities for surveillance, prevention and reduction of the common risk factors and related health conditions are essential actions. Furthermore, strong leadership and stewardship by health ministries is necessary to ensure the effective participation of all sectors of society. Action at the multisectoral level is vital because the main determinants of the major risk factors lie outside the health sector.

Leadership and capacity in health promotion need to be significantly scaled up in line with increased needs and activities across all relevant health programmes, as well as the recommendations made at the Sixth Global Conference on Health Promotion, held in Bangkok in August 2005. Comprehensive approaches that use a combination of strategies to address policy issues and capacities at individual, household and community levels are needed to ensure lasting success.

In supporting Member States' efforts, the Secretariat will significantly enhance its presence in countries and focus on:

- providing global leadership, coordination, communication, collaboration and advocacy for health promotion to improve health, reduce health inequalities, control major risk factors and contribute to national development objectives;
- providing evidence-based ethical policies, strategies and technical guidance and support to countries for the development and maintenance of national systems for surveillance, monitoring and evaluation, giving priority to countries with the highest or increasing burdens;
- encouraging increased investment at all levels and building internal WHO capacity, especially in regional and country offices, in order to respond effectively to organizational and Member States' needs in health promotion and risk-factor prevention and reduction;
- supporting countries to build multisectoral national capacities in order to mainstream gender and equity perspectives and strengthen institutional knowledge and competence in relation to the major risk factors;
- supporting the establishment of multisectoral partnerships and alliances throughout Member States and building international collaboration for the generation and dissemination of research findings;
- leading effective action to address policy and structural barriers, strengthen household and community capacity and ensure access to education and information in order to promote safe sexual behaviours and manage the consequences of unsafe sexual behaviours and practices;
- providing direct technical assistance in the implementation of the WHO Framework Convention on Tobacco Control, in collaboration with the permanent secretariat of the Convention, as well as to non-Parties to enable them to strengthen their tobacco control policies and become Parties to the Convention.

ASSUMPTIONS, RISKS AND OPTION ANALYSIS

This strategic objective would be achieved under the following assumptions:

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

The following risks may adversely affect achievement of the strategic objective:

- working or interacting with the private sector presents risks associated with the competing interests of industries, including the tobacco, alcohol, sugar and processed food and non-alcoholic drinks industries, and requires that the rules of engagement are followed in all cases. Improvements in public health are of paramount importance;
- that health promotion and risk-factor prevention may be adversely affected by the low priority afforded to this area and hence the scarcity of resources allocated by WHO and countries. Continued advocacy for increased investment is essential in order to minimize this risk; and
- that integrated approaches to prevention and reduction may also compromise organizational and country capacity to provide specific disease and risk-factor expertise unless the critical mass of expertise is protected and the required level of resources obtained. Adequate resources for integrated approaches, as well as critical mass of expertise in major areas, must be maintained.

ORGANIZATION-WIDE EXPECTED RESULTS	**1.** Advice and support provided to countries to strengthen their health promotion capacity across all relevant programmes, and to establish effective multisectoral and multidisciplinary collaborations to promote health and prevent and reduce the occurrence of major risk factors.	
INDICATORS	**1.1** Number of countries supported to develop outcome oriented health promotion activities or strategies to expand the finance base of health promotion.	**1.2** Number of multisectoral mechanisms or networks strengthened for health promotion and major risk-factor prevention at national level.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	50	Global health promotion partnership set up.
TARGETS TO BE ACHIEVED IN 2013	100	Health promotion inter-agencies set up at the regional and country levels.

RESOURCES (IN US$ 000)	
Costs 2008-2009	41 900
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*The Seventh Global Conference on Health Promotion, to be held in Africa in 2009, will provide an opportunity to review progress and revise the overall global health promotion approach undertaken by WHO. During 2010-2013, the work will focus on establishing WHO leadership in health promotion and ensuring that mechanisms are in place at country level so that policies and strategies are kept up to date. In order to meet these expectations, a significant increase in resources will be required in 2008-2009, but the level will remain constant in 2010-2011 and 2012-2013 to ensure that developments in global, regional and national health promotion make an effective contribution to reducing the death and disease burden associated with these major risk factors.*

ORGANIZATION-WIDE EXPECTED RESULTS	**2.** Guidance and support provided to strengthen national systems for major risk factor surveillance by developing, validating and disseminating frameworks, tools and operating procedures to countries with a high or increasing burden of death and disability attributable to the major risk factors.	
INDICATORS	**2.1** Number of countries supported that have developed a functioning national surveillance system for, or regular reports on, major risk factors in adults.	**2.2** Number of countries supported that have developed a functioning national surveillance system for, or regular reports on, major risk factors in youth.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	20	20
TARGETS TO BE ACHIEVED IN 2013	30	30

	RESOURCES (IN US$ 000)	
	Costs 2008-2009	19 900
	Estimates 2010-2011	~ 000
	Estimates 2012-2013	~ 000
JUSTIFICATION	*Much of the work has already begun, but a substantial number of Member States have yet to implement reliable risk-factor and response surveillance systems and many will require assistance from WHO in the future. Furthermore, Member States that have completed surveys previously will require technical assistance with repeat surveys. Additional surveillance tools may be required. It is anticipated that the level of effort, and consequently of resources, required for development, modification, validation and dissemination of standards and operating procedures will increase significantly in 2008-2009 and remain at that level during the remaining two bienniums.*	

ORGANIZATION-WIDE EXPECTED RESULTS	**3.** Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to countries with a high and increasing burden to strengthen institutions in order to address/prevent public health problems associated with tobacco. Support also provided to the Conference of the Parties to the WHO Framework Convention on Tobacco Control for implementation of the provisions of the Convention and development of protocols and guidelines.			
INDICATORS	**3.1** Number of countries that have adopted legislation or its equivalent in relation to the following settings and articles: smoking bans in health-care and educational facilities, bans on direct and indirect advertising of tobacco products in national media and health warnings on tobacco products that meet the criteria set out in the WHO Framework Convention on Tobacco Control.	**3.2** Number of countries with comparable national tobacco use prevalence data disaggregated by age and sex.	**3.3** Number of countries that have established or reinforced a national coordinating mechanism or focal point for tobacco control.	**3.4** Number of guidelines agreed to and number of protocols adoped by the Conference of the Parties.
BASELINE				
TARGETS TO BE ACHIEVED IN 2009	30	35	40	2
TARGETS TO BE ACHIEVED IN 2013	100	70	130	5

	RESOURCES (IN US$ 000)	
	Costs 2008-2009	40 900
	Estimates 2010-2011	~ 000
	Estimates 2012-2013	~ 000
JUSTIFICATION	*Significant additional investment will be required to adequately address the broad implementation needs in accordance with the decisions taken by the Conference of the Parties in its capacity as an independent governing body. WHO will be working closely with the Conference of Parties and the permanent secretariat of the Convention to provide the necessary support to Parties as they develop comprehensive tobacco control policies and programmes and surveillance systems that will allow them to fulfil their obligations under the Convention. The increased work programme and the commensurate need for more resources was noted in Decision FCTC/COP1(12).*	

ORGANIZATION-WIDE EXPECTED RESULTS	**4.** Evidence-based and ethical policies, strategies, recommendations, standards, guidelines developed, and technical support provided to countries with a high and increasing burden to strengthen institutions in order to address/prevent public health problems associated with alcohol, drugs and other psychoactive substance use.	
INDICATORS	**4.1** Number of countries supported that have developed policies, plans and programmes for preventing public health problems caused by alcohol, drugs and other psychoactive substance use.	**4.2** Number of policies, strategies, recommendations, standards and guidelines developed according to WHO procedures to assist Member States in preventing and reducing public health problems caused by alcohol, drugs and other psychoactive substance use.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	50	15
TARGETS TO BE ACHIEVED IN 2013	100	25

	RESOURCES (IN US$ 000)	
	Costs 2008-2009	20 900
	Estimates 2010-2011	~ 000
	Estimates 2012-2013	~ 000
JUSTIFICATION	*Significant additional investment is urgently needed to ensure a credible global response commensurate with the burden of death and disease attributable to alcohol, drug and other psychoactive substance use. This includes capacity building and institutional strengthening at all levels of WHO, including collaborating centres, and especially in regional and country offices to enable the Organization to respond effectively to Member States' needs, and to support the implementation of relevant WHO resolutions. A comprehensive and integrated approach to the prevention and reduction of this group of risk factors will be encouraged, but a substantial increase in resource levels is required.*	

ORGANIZATION-WIDE EXPECTED RESULTS	**5.** Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed and technical support provided to countries with a high and increasing burden to strengthen institutions in order to address/prevent public health problems associated with unhealthy diets and physical inactivity.	
INDICATORS	**5.1** Number of countries supported that have developed and implemented policies, plans and programmes for improving diets and physical activity, including the Global strategy on diet, physical activity and health.	**5.2** Number of policies, strategies, recommendations, standards and guidelines provided to promote healthy diets and physical activity.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	50	15
TARGETS TO BE ACHIEVED IN 2013	150	30
	RESOURCES (IN US$ 000)	
	Costs 2008-2009	19 900
	Estimates 2010-2011	~ 000
	Estimates 2012-2013	~ 000
JUSTIFICATION	*WHO guidelines on interactions with external stakeholders will be revised and updated to better reflect the current environment, especially in relation to the food, alcoholic and non-alcoholic beverage industries to ensure that public health objectives are highlighted. The increase in resources expected in 2008-2009 is likely to remain at a similar level thereafter. WHO needs to strengthen its normative work on physical activity. Most of the work related to the revision of guidelines will involve consultations with Member States. Interactions also need to include international and national nongovernmental organizations and community groups.*	

ORGANIZATION-WIDE EXPECTED RESULTS	**6.** Evidence-based and ethical policies, strategies, interventions, recommendations, standards and guidelines developed, and technical support provided to countries to promote safe sex and strengthen institutions in order to address and manage social and individual consequences of unsafe sex.	
INDICATORS	**6.1** Availability of evidence on the determinants and consequences of unsafe sex to identify effective interventions and to develop guidelines accordingly.	**6.2** Number of countries supported that have initiated new or improved interventions at individual, family and community levels to promote safe sexual behaviours.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	Research implemented on determinants and consequences of unsafe sex in order to develop three evidence based guidelines for promoting safe sexual behaviours.	10 countries supported in developing evidence-based interventions and in assessing the implementation of interventions at individual, family and communities levels to promote safe sexual behaviours.
TARGETS TO BE ACHIEVED IN 2013	3 new or adapted guidelines validated and implemented in 10 countries with WHO technical support.	10 countries supported by WHO that have implemented successfully WHO guidelines and scaled up interventions to promote safe sexual behaviours.
	RESOURCES (IN US$ 000)	
	Costs 2008-2009	18 900
	Estimates 2010-2011	~ 000
	Estimates 2012-2013	~ 000
JUSTIFICATION	*Significant additional resources are required to continue and expand urgently needed actions to address unsafe sex, which is the second highest ranking cause of death and disability in high-mortality countries. The actions required range from generating relevant evidence to assisting countries to implement policies, strategies and interventions. Investments to achieve this expected result, will be helpful in endeavouring to reach the goals for other risky behaviours. In 2008-2009, WHO will increase the resources for generating and building an evidence base while strengthening its normative role.*	

STRATEGIC OBJECTIVE 7

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

Scope

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

Indicators and Targets

- Relevant knowledge available: Proportion of national health coverage or outcome (mortality/morbidity) data that is disaggregated by at least 3 determinants (sex, age, ethnicity, place of residence, and/or socioeconomic status) and available for explanatory research.
- Social and economic conditions favourable to health: Primary and secondary school enrolment of girls.
- Inter-sectoral collaboration: Policies and work plans of priority non-health sectors (e.g., agriculture, energy, education, finance, transport) which have incorporated health targets.
- Informed strategies: number of health-related policies, programmes and legislation that explicitly address and incorporate human rights and gender perspectives in their design and implementation.

Linkages with other strategic objectives

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

- strategic objectives 1-5: notwithstanding the technical complexities, it is firmly established that health outcomes are powerfully influenced by social and economic determinants, as well as by the availability and quality of clinical services;
- strategic objectives 6, 8 and 9: strategic objective 7 is primarily concerned with the underlying determinants and the structural factors (such as labour markets, the education system, gender inequality) that define people's different positions in social hierarchies, which affect intermediate determinants such as the environment, including food (strategic objectives 8 and 9) and individual factors such as behaviours, (strategic objective 6); and
- strategic objectives 10-14: health policies and systems need to include intersectoral action on health determinants. To take coherent action on health inequities also depends on the availability of appropriately disaggregated health data and the capacity to analyse and use such data to develop policies and services that respond to the needs of different social groups and address structural determinants.

ISSUES AND CHALLENGES

Health equity is an overarching goal endorsed by WHO Member States. In recent decades, health equity gaps between countries and among social groups within countries have widened, despite medical and technological progress. WHO and other health and development actors have defined tackling health inequities as a major priority and have pledged to support countries in more effective action to meet the health needs of vulnerable groups (WHR 2003, WHR 2004, WDR 2006). Meeting this goal will require attending to the social and economic factors that determine people's opportunities for health. An intersectoral approach, though often politically difficult, is indispensable for substantial progress in health equity. The Millennium Development Goals underscore the deeply interwoven nature of health and economic development processes, the need for coordination among multiple sectors to reach health goals and the importance of addressing poverty and gender inequality.(UN Millennium Project Final Report).

This situation raises challenges for Ministries of Health, which must work in innovative ways to foster intersectoral collaboration on the social and economic determinants of health even as they align key health sector-specific programmes to respond better to the needs of vulnerable populations. Effective means to promote health gains for vulnerable groups include the integration into health sector policies and programmes of equity-enhancing, pro-poor, gender-responsive, ethically sound approaches. Human rights offer a unifying conceptual framework for these strategies and standards by which to evaluate success.

The crucial challenges are first to develop sufficient expertise regarding the social and economic determinants of

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

STRATEGIC APPROACHES

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

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

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

Redressing the root causes of health inequities will need coordinated integration by both the WHO secretariat and Member States to ensure that gender equality-, poverty-, ethics- and human rights-based perspectives are incorporated into health guideline preparation, policy-making and programme-implementation. The WHO Secretariat will focus on:

- Providing technical and policy support to Member States to develop and maintain national systems for the collection and analysis of health-related data on a disaggregated basis, and to develop, implement and monitor health policies based on the whole-government approach to health.
- Ensuring that gender equality, pro-poor focus, ethics, and human rights are incorporated in the work of technical programmes and regional offices through developing common terminology, tools and advocacy materials; enlarging the knowledge base and implementation capacity; and ensuring coherent strategies.
- Using the recommendations of the Commission on Social Determinants of Health to support policy action on the underlying causes of health inequities such as social exclusion, lack of educational and work opportunities as well as inequalities based on gender, age, disability, or ethnicity.
- Partnering with other UN agencies and programmes, and when appropriate civil society and the private sector, to advance health as a human right and human rights as a tool for improving health and reducing inequities; to address macroeconomic factors relevant to health including international trade; and to support institutions that improve ethical decision-making on health-related policies, programmes, and regulations.

ASSUMPTIONS, RISKS AND OPTION ANALYSIS

The principal assumptions underlying this strategic objective are that:

- in many settings, Ministries of Health, provided with adequate information and political and technical backing, will be willing and able to take leadership in catalysing intersectoral partnerships for action on health determinants; and officials of other government departments will be willing and able to collaborate effectively in such intersectoral action on health determinants, with the result that a significant number of countries will move towards a "whole-government" approach to health;
- within WHO-across headquarters, regional and country offices-it will be possible to build sustained support for the incorporation of social determinants of health and gender equality and human rights considerations into the Organization's technical cooperation and policy dialogue with Member States; and
- in many countries, health programme designers and implementers will be willing and able to incorporate equity-enhancing, pro-poor, gender-responsive, and human rights-based strategies into their programmes despite technical and political complications.

The key risks for progress on this strategic objective centre on the potential non-fulfilment of any one or several of these enabling conditions. The previous history of intersectoral action for health is not indifferent: as a key component of the Alma-Ata platform, it was judged by many to be among the least successful aspects of the Health For All process in the 1980s and 1990s. On the other hand, examples of promising innovation in this area exist in

WHO, for example the Community-Based Initiatives in Eastern Mediterranean Regional Office. Further evaluation is required to assess the potential for scaling-up. The policy innovations under-way in the Commission on Social Determinants of Health (CSDH) partner countries and other work of the Commission may provide examples of good practice and generate a better understanding of how to address the political challenges connected with action on social determinants.

Getting integrated policies, plans and programmes adopted at the national level is made more difficult by the "responsibility gap". While social and economic determinants concern all of government as well as the public, no one actor is accountable for them. Success will depend on overcoming the insularity of the policymaking process and developing and maintaining effective partnerships that involve a wide range of stakeholders at the national, regional and global levels (including agencies within the UN System and other international partners and non-governmental organizations).

An adequate skills base in national governments, at WHO and among other global health partners will be important to long-term success. This skills base does not currently exist in the requisite proportions. Expertise will be needed across many programmes and agencies to ensure that the tools of human rights, ethics, economic-, gender- and poverty-analysis are widely and effectively deployed when WHO develops normative guidance as well as when Member States make policies and implement programmes.

Currently, the issues grouped under strategic objective 7 are handled by small, isolated teams who 'market' them in an essentially ad hoc manner to those Member States, global health partners and other units within the Organization that have shown particular interest. Some promising country-level and regional initiatives exist but the knowledge emerging from these experiences needs to be systematized, adequately evaluated and disseminated.

The existence of strategic objective 7 attests that WHO has elected to give a high profile to the challenges of health equity and the social determinants of health in the years ahead and to seek a more coherent, systematic organizational approach to interwoven issues of equity, determinants, pro-poor approaches, gender, ethics and human rights. The importance for global public health of health equity and of the social and economic determinants of health is increasingly perceived. WHO's decision to raise the profile of these issues comes at a moment when scientific understanding of the health effects of social conditions has made rapid advances; calls for action on health equity, gender equality and human rights have arisen from many quarters and the Millennium Development Goals (MDGs) have once again spurred widespread recognition of the need for coordinated action across sectors to reach health and development targets. Thus, the efforts gathered under strategic objective 7 offer an opportunity for WHO to provide improved service to Member States. Nonetheless, care must be taken to integrate these topics across the organization lest they become isolated and marginalized. Moreover, some particular issues (e.g., gender) may receive low priority when a wider range of social determinants becomes the focus of attention.

ORGANIZATION-WIDE EXPECTED RESULTS	**1.** Significance of social and economic determinants of health recognized across the Organization and incorporated into WHO normative work and technical collaboration with Member States and other partners.		
INDICATORS	**1.1** Number of countries having implemented key policy recommendations of the Commission on the Social Determinants of Health.	**1.2** Number of countries whose WHO Country Cooperation Strategy documents (CCS) include strategies for action on the social and economic determinants of health.	**1.3** Number of WHO Regions with a regional strategy for action on the social and economic determinants of health.
BASELINE	0	0	0
TARGETS TO BE ACHIEVED IN 2009	12	14	5
TARGETS TO BE ACHIEVED IN 2013	42	28	6

RESOURCES (IN US$ 000)	
Costs 2008-2009	21 220
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*Though essential for achieving lasting health improvements across populations, the underlying determinants of health have received relatively little attention at WHO, necessitating a substantial increase from baseline. During 2008-09, the CSDH's work will be completed; implementation in countries and within units at HQ and in ROs and COs will begin. During 2010-2011, the level of effort will remain steady; the CSDH-associated expenses will be replaced by greater spending at country level. In 2012-2013, accelerating work at country-level will result in an ~10% increase.*

ORGANIZATION-WIDE EXPECTED RESULTS	**2.** Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels to address social and economic determinants of health and to encourage poverty-reduction and sustainable development.		
INDICATORS	**2.1** Number of countries whose health policies target the social and economic determinants of health on an intersectoral basis.	**2.2** Number of sub-regional, regional and global forums organized (alone or with other international organizations) for policymakers, programme-implementers and civil society on intersectoral actions to address the social and economic determinants of health and achieve the Millennium Development Goals.	**2.3** Number of tools developed and disseminated for assessing the impact of non-health sectors on health and health equity.
BASELINE	2	1	0
TARGETS TO BE ACHIEVED IN 2009	10	2	1
TARGETS TO BE ACHIEVED IN 2013	38	6	3

RESOURCES (IN US$ 000)	
Costs 2008-2009	14 920
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*Work across sectors both at the global and the local level is essential for addressing the social and economic determinants of health; this requires a very modest increase in WHO activity for 2008-2009 and 2010-2011. In 2012-2013, activity both in technical units and ROs and COs will increase.*

ORGANIZATION-WIDE EXPECTED RESULTS	**3.** Social and economic data relevant to health collected, collated and analysed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).		
INDICATORS	**3.1** Number of countries having health data of sufficient quality to assess and track health equity among key population groups.	**3.2** Number of countries with at least one national policy on health equity that incorporates an analysis of disaggregated data.	**3.3** Number of countries with at least one national programme on health equity that uses disaggregated data.
BASELINE	39	0 identified	0 identified
TARGETS TO BE ACHIEVED IN 2009	45	27	27
TARGETS TO BE ACHIEVED IN 2013	55	55	55

RESOURCES (IN US$ 000)	
Costs 2008-2009	10 520
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*Explanatory research on social and economic determinants and on health equity depends on increasing the availability of data that has been collected and reported on a disaggregated basis; this is recognized as essential for indicators across all Strategic Objectives will require considerable support from WHO, which will increase over the time period to enable countries to reach the targets.*

ORGANIZATION-WIDE EXPECTED RESULTS	**4.** Ethics- and rights-based approaches to health promoted within WHO and at the national and international levels.	
INDICATORS	**4.1** Number of tools and guidance documents developed for Member States and other stake-holders on how to use human rights to advance health and to reduce health gaps.	**4.2** Number of tools and guidance documents developed for Member States and other stake-holders on how to use ethical analysis to improve health policies.
BASELINE	20	8
TARGETS TO BE ACHIEVED IN 2009	28	12
TARGETS TO BE ACHIEVED IN 2013	45	20

RESOURCES (IN US$ 000)	
Costs 2008-2009	8 320
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

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

ORGANIZATION-WIDE EXPECTED RESULTS	**5.** Gender-analysis and responsive actions incorporated into WHO's normative work and support to countries towards the development of gender-sensitive policies and programmes in Member States.	
INDICATORS	**5.1** Number of publications that contribute to building evidence on the impact of gender on health and on effective strategies to address this.	**5.2** Number of tools and guidance documents developed for Member States on how to use gender analysis in health.
BASELINE	50	20
TARGETS TO BE ACHIEVED IN 2009	56	25
TARGETS TO BE ACHIEVED IN 2013	63	28

RESOURCES (IN US$ 000)	
Costs 2008-2009	11 819
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*The increased support for gender-related activities across WHO in 2008-2009 reflects commitment to the goal of mainstreaming this work across the Organization. In the subsequent biennia, the growth is accounted for by increased staff and activities in the regional and country offices.*

STRATEGIC OBJECTIVE 8

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

Scope

This strategic objective is aimed at addressing and reducing a broad range of traditional, modern and emerging health and environmental risks. Its purpose is to encourage strong health sector leadership for primary prevention of disease through environmental management as well as support strategic direction and guidance to mobilize non-health sector actors about how their policies and investments can lead to win-win development strategies that also benefit health.

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

Indicators and Targets

- Global reduction in environmental risks with major health impacts, including an increase in the proportion of the urban and rural population with access to improved water sources and improved sanitation and a decline in the proportion of the population using solid fuels, along with an increase in the proportion of the population with access to healthy household energy.
- A shift in key sectors of the economy (e.g. energy, agriculture, transport) and development initiatives (e.g. poverty reductions strategies) towards policies and investments that consider and diminish environmental risks to health.
- Increase in resources in the health sector dedicated to the primary prevention of disease through management of environmental risks to health.
- Reduction in the occupational risks to health faced by the global workforce
- Reduction in key environmental and occupational health risks in human settlements.

Linkages with other strategic objectives

-

ISSUES AND CHALLENGES

It is estimated that approximately one quarter of the global disease burden as well as one-third of that burden in developing countries could be reduced using environmental health interventions and strategies already available today.

At the same time, the limited data that does exist indicates that only about 2% of the typical national health budget is currently invested in preventive health strategies. Clearly, health institutions face both a fundamental challenge and opportunity – a challenge in controlling health costs and an opportunity to do so through more effective environmental health strategies and interventions.

Given the trends of rapid changes in lifestyles and urbanization, production and energy consumption along with pressures on climate and ecosystems, there could be even greater future consequences for public health and health costs, both short and long term, if the health sector fails to address environmental risks emerging right now. These emerging challenges may range from the global spread of new infections to new or more widespread forms of exposure to physical, chemical, radiation or psychosocial health hazards. Finally, for effective health sector action to take place, risks need to be reduced in the sectors and the settings where they occur – from homes, schools, workplaces and cities in sectors such as energy, transport, industry and agriculture. To address the root economic and developmental driving forces affecting environmental health risks, it is essential that health be at the centre of inter-sectoral actions. A range of actions is thus required both in the health sector itself and across sectors.

Within the health sector, there is an urgent need to equip health systems with new knowledge about the epidemiological impacts of key environmental risks as well as new knowledge and tools for primary interventions. Increasingly, health policymakers are called upon to interact in economic development and policy forums where decisions have profound long-term impacts on pollution, biodiversity, ecosystems -- and thus on environmental

health. Health professionals, often trained in treatment of the individual, thus need to be better equipped with skills and methods for monitoring and synthesizing health and environmental data; proactively guiding strategies for public awareness, protection and prevention; and responding to emergencies.

While health sector actors cannot implement development policies on their own, they can provide the epidemiological evidence along with the tools, methods or guidance for assessing the health impacts of development and for designing healthier policies or strategies. Concurrently, non-health sectors must be sensitized to health risks and thus informed and empowered to act. To achieve this, integrated assessment and cross-sectoral policy development should be supported to bring health and non-health sector actors together at the same table.

The mandate for WHO action on these issues and challenges is firmly anchored in WHO's constitution and in the history of public health practice and achievements. In the framework of UN reform, WHO has an opportunity to play a more visible global leadership role in public health and the environment, linking health explicitly to goals of sustainable development.

Integral to this challenge is the understanding that improved environmental health policy and investments will almost always yield some of the greatest benefits among the populations of the world with the poorest health and the greatest need. These include the poor and children. It is the health of children, in particular, which is most impacted by environmental risks, requiring a special focus on that population.

Addressing environmental health risks can also yield many gender and equity-related co-benefits in terms of time-savings for women fetching fuel or improved attendance rates for girls in school. But benefits and gains also will also be enjoyed by developed countries and stronger socio-economic groups in terms of stronger public health systems, lower health costs overall, reduced levels of conflict over environmental resources and fewer environmental crises.

STRATEGIC APPROACHES

Achieving this strategic objective will require the health sector to provide health leadership on international environment and sectoral policies; advocate and establish partnerships for coordinated multi-sectoral actions and integrated policies reducing health risks from the environment; and promote development frameworks and strategies that benefit health.

Management of public health risks requires intensifying institutional and technical capacities for assessing environmental and occupational health risks as well as for evaluating the impacts of policies. Preparedness for, and response to, environmental emergencies and disasters as well as to emerging threats deserves to be paid particular attention in health sector development.

Applying environmental health interventions as integral to good public health policy and effective preventive health strategies will be critical for scaling up primary prevention, as will strengthening the capacity of environmental health to act as a "prevention arm" within the health sector, identifying and responding to inequities in environmental health risks and outcomes from gender, age, ethnicity and social circumstance.

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

In supporting the efforts of the Member States, The WHO secretariat will:

- promote global environmental health partnerships;
- articulate policy positions to influence international trends in sectoral policies;
- bring together knowledge and provide guidance on assessment and management of environmental and occupational health risks, anticipating emerging issues;
- contribute to strengthening the capacity to set and implement health and environment policies, including through development of norms and standards;
- monitor and assess environmental health risks;
- support primary prevention through environmental health risks reduction, while monitoring its impact;
- support environmental health assessment and management in emergencies, conflicts and disasters, focusing on prevention, preparedness, response and planning for post-emergency reconstruction; and
- facilitate and promote the development, sharing and use of knowledge, research and innovation, while enhancing education about emerging environmental risks and equitable solutions among different stakeholders.

ASSUMPTIONS, RISKS AND OPTION ANALYSIS

This strategic objective would be achieved under the following assumptions:

- Health sector actors become increasingly cognizant of the mounting burden of disease from environmental health risks in light of new and emerging evidence.
- Actors influencing decisions in sectors of the economy (sector policy makers, banks, civil society organizations) with the greatest impact on public health will increasingly consider health as a key issue and the health costs and

benefits of their actions as central to their decision making.

- Development actors (banks, cooperation agencies, foundations, recipient countries) will increasingly realize the major contribution that the reduction of environmental health risks makes to the achievement of a number of the Millennium Development Goals (MDGs).
- The current favourable climate is maintained, in the context of UN system reform , for WHO to assume a more visible global leadership role in public health and the environment, linking health more explicitly to goals of environmental sustainability, economic development and humanitarian response.

As environmental health risks depend primarily on actions from other sectors, risk reduction depends on intervention beyond the direct control of the health sector. Health sector actions have therefore to influence those agendas and include enough leverage points to be able to achieve the desired changes.

In that context, risks that may adversely affect the achievement of this strategic objective include:

- Expectations from other sectors for quick results and impact in addressing environmental health risks may exceed the capacity of the health sector to provide support for their actions. This can be overcome by selecting realistically achievable aims (low-hanging fruit first).
- Lack of access to knowledge concerning the best options for sector interventions that address occupational and environmental health issues. This can be overcome by health agencies' investment in analysis and documentation concerning the most effective and economically cost-beneficial interventions.
- Weak or transient commitment by development and/or environmental actors and global leaders to addressing environmental health issues. Thiscan be overcome by investments in partnerships, outreach and more strategic global communications of environmental health issues, e.g., flagship global environmental health and outlook reports.
- The current weakness of health systems in addressing the range of occupational and environmental health risks and their root causes. This can be overcome by creating global and regional forums and focused initiatives whereby health and the environment are given a high profile and there is a push for action in partnerships; by outreach/communications targeted to health sector interests and needs; and by strengthening the skills and functions of the health systems themselves to integrate health and environmental issues into "traditional" health sector agendas.

ORGANIZATION-WIDE EXPECTED RESULTS	**1.** Evidence-based assessments, norms and guidance on priority environmental health risks (e.g., air quality, chemical substances, EMF, radon, drinking water, waste water reuse,) developed and updated; technical support to international environmental agreements and for monitoring MDG.			
INDICATORS	**1.1** Number of risk assessment/environ mental burden of disease (EBD) assessments conducted or updated.	**1.2** Number of new norms, standards and good practice guidance developed or updated.	**1.3** Key MDG related environmental hazards monitored by WHO.	**1.4** Number of international environmental agreements annually supported by WHO, including SAICM, Rotterdam and Stockholm conventions.
BASELINE				
TARGETS TO BE ACHIEVED IN 2009	5-10 risk assessments/ EBD per year.	5-10 new norms, standards, guidance produced or updated per year.	At least 2 MDG indicators monitored/reported each year.	4 international environmental agreements provided with WHO technical support.
TARGETS TO BE ACHIEVED IN 2013				

RESOURCES (IN US$ 000)	
Costs 2008-2009	35 900
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*There is a solid experience in risk assessment, burden of disease, norms and guidance and servicing of environmental agreements in the secretariat that needs to be expanded to provide further added-value through: harmonization of risk assessment for all types of hazard; provision or risk assessment for WHO guidelines and for FAO/WHO programmes on pesticide specifications as well as for chemicals risk assessment in food for the Codex Alimentarius Commission including on food additives (JECFA) and pesticide residues (JMPR); developing an interactive library of risks assessment, norms and BOD, expanding on the existing INCHEM and other databases; providing global monitoring and reporting of environment MDGs linked to health; providing health inputs to the new international approach to international management of Chemicals (SAICM) and enhancing health sector inputs into environment conventions (Stockholm, Rotterdam)*

ORGANIZATION-WIDE	**2.** Technical support and guidance provided to countries for the implementation of primary

EXPECTED RESULTS	prevention interventions that reduce environmental health risks; enhance safety; and promote public health, including in specific settings and among vulnerable population groups (e.g. children, elderly).			
INDICATORS	**2.1** Number of global or regional initiatives for primary prevention of EH risks in specific settings: workplaces, homes, schools, human settlements and health care settings effectively implemented in targeted countries with WHO technical and logistic support.	**2.2** Number of global or regional initiatives launched or maintained to prevent occupational and environmentally-related diseases (e.g. cancers from UV, asbestos, arsenic or radon; poisoning by pesticides or fluoride;) , implemented with WHO technical and logistics support in targeted regions or countries.	**2.3** Number of studies evaluating the costs and benefits of primary prevention interventions in specific settings conducted and disseminated.	**2.4** Number of target countries using WHO guidance to prevent and mitigate emerging OEH risks, promote OEH equity and protect vulnerable populations.
BASELINE				
TARGETS TO BE ACHIEVED IN 2009	Global strategies to address EH risks in at least 3 settings established with country support actions in at 20 locations.	3 Global or regional intervention initiatives, per year, started or maintained, with support from WHO.	5-10 cost benefit studies of primary prevention interventions in specific settings disseminated.	5-10 countries taking action to prevent OEH risks, promote OEH equity and protect vulnerable populations using WHO guidance. Collaborative research activities in support of children's environmental health developed in at least one region.
TARGETS TO BE ACHIEVED IN 2013				

RESOURCES (IN US$ 000)	
Costs 2008-2009	23 900
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*Following the very positive experience associated with addressing OEH risks in specific settings and in close connection with local actors, there is a strong demand for the secretariat to revitalize and extend its support to developing and implementing primary prevention interventions in specific settings and to reducing major OEH risks. New global initiatives are therefore planned to support interventions addressing OEH risks and promoting health in workplace, school, municipality, home and health care setting environments, as well as to document and inform about costs and benefits of different OEH interventions.*

ORGANIZATION-WIDE EXPECTED RESULTS	**3.** Technical assistance and support to countries for strengthening occupational and environmental health policy- making, planning of preventive interventions, service delivery and surveillance.	
INDICATORS	**3.1** Number of high priority countries receiving technical and logistical support for developing and implementing policies for strengthening the delivery of occupational and environmental health services and surveillance.	**3.2** Number of organizations implementing WHO-led initiatives to reduce occupational risks, e.g. among workers in the informal economy; to implement global occupational health strategy or to eliminate silicosis.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	5-10 countries receiving advice for strengthening occupational and environmental health services. 5 countries receiving advice to strengthen OEH surveillance.	10-15 organizations implementing WHO led initiatives to reduce occupational risks.
TARGETS TO BE ACHIEVED IN 2013		

RESOURCES (IN US$ 000)	
Costs 2008-2009	26 800
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*The health systems' ability to address occupational and environmental health risks is very limited and out of step with the great potential for delivering primary prevention of disease through better working and living environments. OWER 4 will address this neglected area and will strengthen the health sector's ability to plan and deliver quality occupational and environmental health services as well as the scaling up of OEH interventions and surveillance through a better evidence base, logistical and technical support, the engagement of a range of organizations in delivering initiatives to reduce OEH risks and to promote health, including among workers in the informal economy.*

ORGANIZATION-WIDE EXPECTED RESULTS	**4.** Guidance, tools, and initiatives supporting the health sector to influence policies in priority sectors (e.g. energy, transport, agriculture); assessing health impacts; costs and benefits of policy alternatives in those sectors; and harnessing non-health sector investments to improve health, environment and safety.			
INDICATORS	**4.1** Number of initiatives to develop and implement 'healthy sector' policies at the global and national levels using technical and logistical support from WHO.	**4.2** Number of sector-specific guidance tools for assessment of health impacts; assessment of economic costs and benefits; and promotion of health and safety guidance produced and promoted in target countries.	**4.3** Establishment of networks and partnerships to drive change in specific sectors or settings, (e.g., urban network), including an outreach and communications strategy.	**4.4** Capacity-building and institution strengthening for the health and non-health sectors at the regional and national levels for improving the OEH performance of at least 3 economic sector policies.
BASELINE				
TARGETS TO BE ACHIEVED IN 2009	Initiatives for 'healthy sector' policies implemented globally for at least 2 sectors, national initiatives in at least 10 countries.	At least 3 sectors for which tools and guidance for estimating health impacts (HIA), costs and benefits (CBA) of policies and projects are produced.	Networks established for two sectors, with communications strategy implemented.	10 Regional or national events conducted with WHO technical support.
TARGETS TO BE ACHIEVED IN 2013				

RESOURCES (IN US$ 000)	
Costs 2008-2009	26 600
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*There is a gap in the health sector's ability to influence other sector policies to promote OEH and a lack of tools, knowledge and skills to engage with other sectors.* ***New activities:*** *This OWER will build on the existing institutional experience with HIA, CBA and EH in other sectors to develop and provide access to a substantial knowledge base on the OEH impacts of sector policies, the costs and benefits of sector interventions for OEH and the experience with implementing sector change. The OWER will include the development of global initiatives through networks, partnerships, communities of practice and strategic communication, aiming to change the policy-making culture in the targeted sectors to consider and include the prevention of OEH risks as their aims. The OWER will provide technical support, institution strengthening skills-building and backstopping to countries to enhance the ability of the health sector to lead change in other sectors. It will also facilitate benchmarking and evaluation of performance and policy change towards the adoption of healthy sector policies*

ORGANIZATION-WIDE EXPECTED RESULTS	**5.** Enhance Health Sector leadership to support a healthier environment and influence public policies in all sectors so as to address the root causes of environmental threats to health. Including by responding to emerging and re-emerging environmental health concerns from development, evolving technologies, global environmental change as well as consumption and production patterns.			
INDICATORS	**5.1** Observatory addressing key emerging and re-emerging occupational and environmental health concerns in development implemented.	**5.2** Outreach and communications strategy for influencing occupational and environmental issues globally and in partnerships implemented.	**5.3** Global Health and Environment Outlook report on trends and scenarios along with key development issues and their health impacts, issued every two years.	**5.4** Regular engagement of global and regional policymakers and stakeholders in high-level health and environment forums.
BASELINE				

TARGETS TO BE ACHIEVED IN 2009	Observatory established.	5-10% increase in citations in mass media of WHO or partners on priority OEH issues addressed by SO8.	First bi-annual Global Environmental Health Outlook published.	Convening of at least 1 global and 1 regional forum for environmental health.
TARGETS TO BE ACHIEVED IN 2013				

RESOURCES (IN US$ 000)	
Costs 2008-2009	19 100
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION

Although environmental and occupational health risks are directly linked to consumption and production patterns as well as to policies in different sectors in the economy, there is presently no authoritative overview about the trends in these patterns and policies and about what they mean for risks to health, now and in the future. This leads to short term thinking and responses to EH risks and impedes adequate prevention and response.

This new set of products by the secretariat will put in place a global, multi-year outreach and communication strategy; produce strategic analysis; issue high impact publications (including a global OEH outlook report); provide knowledge management solutions; and engage high level stakeholders and governments in the response to OEH issues (Global and regional EH fora), as well as linking them with networks of practitioners. This OWER will build on existing economic and environmental analysis produced by relevant agencies, adding estimates and analysis of the potential impacts for Occupational and Environmental Health of those trends, monitoring the impacts of policies, informing on good practice and making recommendations for action that improves equity in OEH.

STRATEGIC OBJECTIVE 9

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

Scope

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

Indicators and Targets

- The proportion of underweight children under five.
- The proportion of overweight and obese children and adolescents under 20 years of age.
- Under five mortality rates due to diarrhoea.

Linkages with other strategic objectives

The achievement of the strategic objective requires strong linkages and effective collaboration with other strategic objectives, in particular:

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

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 crisis situations and should be specifically addressed in the context of HIV/AIDS epidemics.

About 800 million people are under-nourished and about 170 million infants and young children are underweight. Each year, more than five million children die from under-nutrition and a further 1.8 million from food and waterborne diarrhoeal diseases. Billions of people are affected by foodborne and zoonotic diseases many of which are fatal or lead to severe sequelae, or micronutrient deficiencies (so-called hidden hunger) especially of iron, vitamin A, iodine and zinc. Under-nutrition 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 billion 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 froms 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 this strategic objective, all the necessary financial, human and political resources will be required to build, promote and implement an intersectoral, science-based, comprehensive, integrated and action-oriented nutrition, food safety and food security agenda at global, regional and country levels,

in both stable and emergency situations. Such an agenda should address the whole spectrum of nutrition, food safety and food security issues related to the attainment of the Millennium Development Goals and other nutrition and food safety related international commitments, including the prevention of foodborne, zoonotic and diet-related chronic diseases and micronutrient malnutrition.

Despite declining prevalence rates of underweight children in most regions, the decline is not sharp enough for the Millennium Development Goal target for child malnutrition to be achieved by 2015. Furthermore, in Africa the rates continue to rise. The link between poverty, hunger and child under-nutrition is a loose one, so that increased wealth does not automatically lead to the alleviation of hunger and child under-nutrition. Hence, direct programme investment is necessary to reduce child under-nutrition. Successful efforts to alleviate most forms of malnutrition will ensure that benefits are heavily concentrated among the poor. Unless more progress is made in eliminating hunger and malnutrition, many of the other Millennium Development Goals will be very difficult to achieve. There are critical interactions between under-nutrition 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 under-nutrition 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 under-nutrition targets set out in the first Millennium Development Goal, achievement of all of the other Goals will be compromised.

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

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

STRATEGIC APPROACHES

To achieve this strategic objective, food safety and food security must play a central role in national development policies, as well as in agricultural development and animal and food production processes, with special emphasis on the most biologically and socially vulnerable populations. Key actions should include developing and implementing ethically and culturally acceptable essential interventions; scaling up access to those interventions; building synergies and strengthening linkages between programmes and avoiding duplication at service delivery level; and promoting improved 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: the 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 to improve the availability of healthier foods; and the 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.

In supporting Member States' efforts, the Secretariat will focus on eight broad approaches.

- To build partnerships, alliances and effective interactions with agencies within the United Nations System in the context of the reform process; establish an unprecedented collaboration between the different agencies to promote the integration of nutrition, food safety and food security programmes at country level and mainstream them into national development policies; and strengthen the participation of WHO´s country offices in joint planning and programming processes at national level.
- To maximize WHO's convening role in order to strengthen its normative function in an inclusive way and imbue all the relevant partners with a degree of ownership of its norms to ensure their dissemination and use; and increase investment in normative functions to fill existing 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.
- To effectively communicate the need for integrated policies and a single agenda whose aim is to improve nutrition and food safety and 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.
- To strengthen global linkages between policy-makers in the fields of health, agricultural development, water resources, trade and the environment, to ensure that nutrition, food safety and food security interventions are planned and executed in an integrated manner with the involvement of all stakeholders, so as to make sustainable health gains.
- To promote policy development through broad-based alliances in inclusive processes at all levels to achieve sustainable and effective policy implementation; increase technical support to Member States to strengthen their national capabilities in identifying problems and best policy options; implement the requisite nutrition, food safety

and food security interventions, including in relevant intersectoral actions; and monitor progress and assess impacts.

- To enhance WHO's presence at regional and country level and its nutrition and food safety capacity in order to provide the requisite support to Member States.
- To enhance institutional and human capacity and develop leadership in nutrition and food safety; and build and maintain an interactive network of practitioners at global, regional and local levels.
- To work with national governments to develop national food control systems and provide tools to aid this process; and support national and regional control programmes for zoonotic and non-zoonotic foodborne diseases to ensure sustainable food production development.

ASSUMPTIONS, RISKS AND OPTION ANALYSIS

This strategic objective would be achieved on the basis of the following assumptions:

- that access to safe food and adequate nutrition 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 both 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	**1.** Partnerships and alliances formed, leadership built and coordination and networking developed with all stakeholders at country, regional and global levels, to promote advocacy and communication, stimulate intersectoral actions, increase investment in nutrition, food safety and food security interventions, and develop and support a research agenda.	
INDICATORS	**1.1** Number of selected low-income developing countries that have institutionalized and functional coordination mechanisms to promote intersectoral approaches and actions in the area of food safety, food security and nutrition.	**1.2** Number of targeted low-income developing 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 funding mechanism for supporting nutrition and food safety activities.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	30	30
TARGETS TO BE ACHIEVED IN 2013	50	50

RESOURCES (IN US$ 000)	
Costs 2008-2009	24 000
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 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 2008-2009 biennium. The expected result establishes the basic requirements for enhancing the building of efficient intersectoral national 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 United Nations agencies in the context of the reform process, and to develop and implement communication strategies. During the 2010-2011 and 2012-2013 bienniums, fewer resources are expected to be needed.*

ORGANIZATION-WIDE EXPECTED RESULTS	**2.** Norms - including references, requirements, research priorities, guidelines, training manuals and standards produced and disseminated to Member States to increase their capacity to assess and respond to all forms of malnutrition, zoonotic and non-zoonotic food-borne diseases, and to promote healthy dietary practices.	
INDICATORS	**2.1** Number of new nutrition and food safety standards, guidelines and training manuals produced and disseminated to countries and the international community.	**2.2** Number of new norms, standards, guidelines, tools and training materials for zoonotic and non-zoonotic foodborne diseases prevention and management.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	15	3
TARGETS TO BE ACHIEVED IN 2013	50	10

	RESOURCES (IN US$ 000)	
	Costs 2008-2009	15 000
	Estimates 2010-2011	~ 000
	Estimates 2012-2013	~ 000
JUSTIFICATION	*WHO's normative work on food and nutritional norms, standards and recommendations will continue in 2008-2009 to plug 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 United Nations agencies. Most of the resources will be applied at headquarters level as the expected result entails cooperation between WHO and the Codex Alimentarius bodies and activities for the provision of scientific advice, for example the Joint FAO/WHO Expert Committee on Food Additives, The Joint FAO/WHO Meeting on Pesticide Residues and the Joint FAO/WHO expert meeting 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 for the 2010-2011 and 2012-2013 bienniums are expected to remain the same since the normative work is a continuing process.*	

ORGANIZATION-WIDE EXPECTED RESULTS	**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 increased, in stable as well as humanitarian crisis situations.	
INDICATORS	**3.1** Number of countries that have adopted and implemented the WHO Child Growth Standards.	**3.2** Number of countries that have nationally representative surveillance data on major forms of malnutrition.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	50	100
TARGETS TO BE ACHIEVED IN 2013	100	150

	RESOURCES (IN US$ 000)	
	Costs 2008-2009	13 400
	Estimates 2010-2011	~ 000
	Estimates 2012-2013	~ 000
JUSTIFICATION	*Most resources will be applied 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 field missions from headquarters and the regional offices to countries to assist in the assessment of their responses. There is a close link between this expected result and the previous one as monitoring, surveillance and the assessment of responses provide the support needed for the work of including nutrition, food safety and food security issues in sector-wide approaches, Poverty Reduction Strategy Papers and/or development policies, plans and budgets. During the 2010-2011 and 2012-2013 bienniums the resources required are expected to be the same since monitoring and evaluation are continuing processes.*	

ORGANIZATION-WIDE EXPECTED RESULTS	**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 as well as humanitarian crisis situations.				
INDICATORS	**4.1** Number of selected countries receiving WHO support that have developed and implemented at least 3 high-priority actions recommended by the Global Strategy for Infant and Young Child Feeding.	**4.2** Number of selected countries receiving WHO support that have developed and implemented strategies to prevent and control micronutrient malnutrition.	**4.3** Number of selected countries receiving WHO support that have developed and implemented strategies to promote healthy dietary practices to prevent diet-related chronic diseases.	**4.4** Number of selected low-income developing countries receiving WHO support that have included nutrition in their comprehensive responses to HIV/AIDS and other epidemics.	**4.5** Number of selected countries receiving WHO support that have strengthened national preparedness and response to nutritional emergencies.
BASELINE					
TARGETS TO BE ACHIEVED IN 2009	30	30	30	35	15
TARGETS TO BE ACHIEVED IN 2013	50	50	50	50	40

	RESOURCES (IN US$ 000) Costs 2008-2009: 29 900 Estimates 2010-2011: ~ 000 Estimates 2012-2013: ~ 000
JUSTIFICATION	*Most resources will be applied at regional and country levels. WHO´s presence in nutrition and food safety in these levels of the organization will also be substantially enhanced.. In 2008-2009 resources will be used to adequately staff regional, subregional and country offices and to support the effective implementation of nutrition interventions according to countries´ needs and demands. During the 2010-2011 and 2012-2013 bienniums, the amount of resources required is expected to be slightly reduced. The enhancement of countries' programmes could lead to a reduction in the demand for direct technical support.*

ORGANIZATION-WIDE EXPECTED RESULTS	**5.** Zoonotic and non-zoonotic foodborne diseases surveillance, prevention and control systems strengthened and food hazard monitoring and evaluation programmes established and integrated into existing national surveillance systems with results being disseminated to all key players.	
INDICATORS	**5.1** Number of countries that have established/ strengthened intersectoral collaboration for the prevention, control and surveillance of foodborne zoonotic diseases.	**5.2** Number of countries that have initiated/ strengthened programmes for the surveillance and control of at least one major foodborne zoonotic disease.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	20	50
TARGETS TO BE ACHIEVED IN 2013	40	70
	RESOURCES (IN US$ 000) Costs 2008-2009: 20 400 Estimates 2010-2011: ~ 000 Estimates 2012-2013: ~ 000	
JUSTIFICATION	*Most resources will be used at regional and country levels. The resources required for 2008-2009 will be used to further develop Global Salm-Surv network related activities in building national and regional capacities in surveillance, prevention and control of foodborne and zoonotic diseases. This expected result and the second one are linked as the monitoring and surveillance of responses are essential support activities in the building of efficient food safety systems. During the 2010-2011 and 2012-2013 bienniums the resources required are expected to be the same since surveillance and control of foodborne and zoonotic diseases are continuing processes.*	

ORGANIZATION-WIDE EXPECTED RESULTS	**6.** Capacity built and support provided to countries, including their participation in international standard-setting 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	**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.	**6.2** Number of selected countries receiving support from WHO that have built national systems for food safety and foodborne zoonoses emergencies with international links.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	90	0
TARGETS TO BE ACHIEVED IN 2013	110	50
	RESOURCES (IN US$ 000) Costs 2008-2009: 24 000 Estimates 2010-2011: ~ 000 Estimates 2012-2013: ~ 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 are expected to be able to support themselves. The resources for building systems are expected to remain the same in keeping with the anticipated level of need.*	

STRATEGIC OBJECTIVE 10

To improve the organization, management and delivery of health services.

Scope

The work to be undertaken as part of this strategic objective will enhance the way health systems perform in response to population's needs and demands. It is underpinned by the principles of Primary Health Care and Health for All, and a concern to reduce inequity in access and exclusion from the benefits of health care.

It seeks to equitably expand access across the range of services needed to improve health outcomes and respond to legitimate demand for care, by matching service response to needs and demand, by increasing organizational and managerial capacities of institutions and provider networks, and by strengthening informed demand; and covers the organization and management of all population-based and personal health services - individual providers, facilities and provider networks; public, private and voluntary; at all levels, from those within the community to tertiary hospitals and specialized services.

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

Indicators and Targets

The ultimate measure of successful health services is better health outcomes, as reflected in the achievement of other objectives. Overall progress against this strategic objective will be assessed by the number of countries that can demonstrate progress against five key dimensions of performance:

- expanding coverage;
- reducing exclusion and disparities in access;
- increasing the productivity and efficiency of health services;
- improving responsiveness to meeting legitimate expectations; and
- increasing conformity with service, quality, and safety standards.

Linkages with other strategic objectives

The work in this strategic objective is linked with several other strategic objectives:

- it underpins success in all strategic objectives concerned with the achievement of specific health outcomes, primarily strategic objectives 1-4. These objectives deal directly with service delivery through the development and implementation of specific interventions;
- it translates achievements under strategic objective 7 - particularly in relation to equity, pro-poor health policies and progressive realization of the right to health - into service delivery;
- it complements the work under strategic objective 5 which deals with the specific circumstances of service delivery in fragile states;
- it depends on progress under strategic objective 13 and 14, and particularly on progress in strategic objective 11 which deals with evidence, information and the governing of the health system; and
- it connects to strategic objective 15 on providing leadership, strengthening governance and encouraging partnerships and collaboration in engagement with countries to fulfil WHO's mandate.

ISSUES AND CHALLENGES

In too many countries, people do not get care when they need it either because, (i) services do 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 deprives individuals or groups from access to the services they need; and/or (iv) providers fail to adapt to the population's care seeking behaviour.

While funds are often directed to the achievement of disease specific health outcomes, many interventions are delivered by the same - often limited - group of health workers and facilities. The way services are organized and

managed affects access; determines the extent to which service coverage is genuinely pro-poor or equitable; and influences the achievements of improved health outcomes.

Many services are delivered in unstable and changing conditions. In countries with some form of decentralization, roles and relations between the centre and other levels are shifting. Central Ministries of Health may be moving to commissioning of services and facilities from both 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. Second, it is important to take into account the full 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 to address concerns about quality, effectiveness and cost, and to make the most of any potential contribution to meeting public health goals. Third, there is a growing need to ensure that services are 'close-to-client', and avoid unnecessary duplication and fragmentation.

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

STRATEGIC APPROACHES

Achieving this objective will require that Member states set up mechanisms, procedures and incentives that encourage all stakeholders - including public and non-public providers and provider organizations - to work together to improve service delivery and eliminate exclusion from access to care. Member States are to undertake major efforts in improving their organizational and managerial practices, in putting into place mechanisms to ensure synergies between public and non public providers, in embedding disease specific programmes within general health services, and in focusing on obtaining observable improvements in their performance in terms of service delivery.

In supporting the efforts of Member States, the WHO Secretariat will focus on:

- Maintaining a country specific approach, and 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 service strengthening takes place, including to the potential of empowering families and communities to take better advantage of health services, promotive, preventive and curative.
- Facilitating mechanisms for learning from the experience of others, as well as disseminating best practice; in the absence of a single universal model for service delivery, WHO has a key role to facilitate such learning and exchange, particularly in relation to innovative models to expand access and improve quality of health services.
- Fostering engagement between non-state and public providers, to promote greater mutual understanding and so 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 assisting the Member Sates 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.

ASSUMPTIONS, RISKS AND OPTION ANALYSIS

Success in strengthening service delivery assumes basic economic, social and political stability. However, it is important to recognize that 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.

A large proportion 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, the bulk of service delivery, as noted above, 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 focus will concentrate exclusively on primary or first contact care at the expense of failing to deal with inequities and inefficiencies in the hospital sector.

ORGANIZATION-WIDE EXPECTED RESULTS	**1.** Service delivery policies and their implementation in Member States increasingly reflect standards, best practices and equity principles endorsed by or developed with support from WHO.
INDICATORS	Proportion of countries that demonstrate progress in improving performance of health services in the following key areas: - expanded coverage and access; - reduced exclusion; - increased productivity and efficiency; - improved responsiveness; and - increased conformity with service, quality, and safety standards.
BASELINE	
TARGETS TO BE ACHIEVED IN 2009	Increase by 10% from baseline.
TARGETS TO BE ACHIEVED IN 2013	Increase by 25%.
	RESOURCES (IN US$ 000) Costs 2008-2009: 45 000 Estimates 2010-2011: ~ 000 Estimates 2012-2013: ~ 000
JUSTIFICATION	*The increase in resources required is due to the following: increased emphasis in the General Programme of Work on health systems; and as WHO's capacity increases particularly at country and regional levels, it is foreseen that the level of support will significantly increase. The levelling off in 2012-2013 is because of the overall expectation that the potential growth of WHO budget is limited.*

ORGANIZATION-WIDE EXPECTED RESULTS	**2.** Organizational and managerial capacities of service delivery institutions and networks in Member States are strengthened with a view of improving service delivery performance.
INDICATORS	Proportion of countries that demonstrate progress in identifying and meeting the organizational and managerial capacity shortfalls in their institutions and networks.
BASELINE	
TARGETS TO BE ACHIEVED IN 2009	Increase by 10% from baseline.
TARGETS TO BE ACHIEVED IN 2013	Increase by 25%.
	RESOURCES (IN US$ 000) Costs 2008-2009: 32 000 Estimates 2010-2011: ~ 000 Estimates 2012-2013: ~ 000
JUSTIFICATION	*The increase in resources required is due to the following: increased emphasis in the General Programme of Work on health systems; and as WHO's capacity increases particularly at country and regional levels, it is foreseen that the level of support will significantly increase. The levelling off in 2012-2013 is because of the overall expectation that the potential growth of WHO budget is limited.*

ORGANIZATION-WIDE EXPECTED RESULTS	**3.** Mechanisms and regulatory systems are in place in Member States to ensure collaboration and synergies between public and non-public service delivery systems that lead to better overall performance in service delivery.
INDICATORS	Proportion of countries that show evidence of improved regulatory capacities.
BASELINE	
TARGETS TO BE ACHIEVED IN 2009	Increase by 10% from baseline.
TARGETS TO BE ACHIEVED IN 2013	Increase by 25%.
	RESOURCES (IN US$ 000) Costs 2008-2009: 25 000 Estimates 2010-2011: ~ 000 Estimates 2012-2013: ~ 000
JUSTIFICATION	*The increase in resources required is due to the following: increased emphasis in the General Programme of Work on health systems; and as WHO's capacity increases particularly at country and regional levels, it is foreseen that the level of support will significantly increase. The levelling off in 2012-2013 is because of the overall expectation that the potential growth of WHO budget is limited.*

<table>
<tr><td>ORGANIZATION-WIDE EXPECTED RESULTS</td><td colspan="2">4. Policy, structural and managerial changes in the health services architecture of Member States are implemented to ensure that disease-specific programmes are adequately embedded in general health services so as to enhance overall performance of health service delivery.</td></tr>
<tr><td>INDICATORS</td><td>1. Proportion of disease specific global partnerships that conform to best practice principles recommended by the High Level Forum and World Health Report 2006.</td><td>2. Proportion of countries that reduce inefficiencies due to programme fragmentation.</td></tr>
<tr><td>BASELINE</td><td></td><td></td></tr>
<tr><td>TARGETS TO BE ACHIEVED IN 2009</td><td>Increase by 50%.</td><td>Increase by 10%.</td></tr>
<tr><td>TARGETS TO BE ACHIEVED IN 2013</td><td>Increase by 100%.</td><td>Increase by 25%.</td></tr>
<tr><td></td><td colspan="2"><table>
<tr><th colspan="2">RESOURCES (IN US$ 000)</th></tr>
<tr><td>Costs 2008-2009</td><td>42 000</td></tr>
<tr><td>Estimates 2010-2011</td><td>~ 000</td></tr>
<tr><td>Estimates 2012-2013</td><td>~ 000</td></tr>
</table></td></tr>
<tr><td>JUSTIFICATION</td><td colspan="2">The increase in resources required is due to the following: increased emphasis in the General Programme of Work on health systems; and as WHO's capacity increases particularly at country and regional levels, it is foreseen that the level of support will significantly increase. The levelling off in 2012-2013 is because of the overall expectation that the potential growth of WHO budget is limited.</td></tr>
</table>

STRATEGIC OBJECTIVE 11

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

Scope

The work to be undertaken as part of this strategic objective covers the responsibilities and processes of governing health systems, i.e. the leadership, governance and steering of these systems (or "stewardship", as it is referred to otherwise). It also covers the generation of system intelligence through research, production of information and evidence, and management of knowledge: these are critical to support policy-making and implementation processes.

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

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

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 from government 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 sector; and
- improved accountability and transparency arrangements.

Measurement strategies for these various dimensions of performance are under development. The focus will be on demonstrating progress within countries rather than on measuring countries against universal norms.

Significant progress in closing the knowledge-practice gap including reduction of the 10/90 funding gap for health research by 25% and increased equity in access to health knowledge and evidence

Increased availability and use of sound health statistics and evidence at global, regional and country levels: at least two-thirds of countries meeting internationally accepted standards for health information systems.

Linkages with other strategic objectives

The work under this strategic objective is closely linked with other strategic objectives:

- it underpins all strategic objectives concerned with the achievement of specific health outcomes, primarily strategic objectives 1-4;
- it complements the work under strategic objectives 5, which deals with the specific circumstances of building government and institutional capacity to organize health systems in fragile states;
- it also provides a platform for close collaboration with the evidence component of all health and disease-related strategic objectives, and
- it supports the equity-related strategic objective 7 and links with the other health systems strategic objectives 10 and 12-14.

ISSUES AND CHALLENGES

Lessons learnt show that to govern health systems on behalf of and in the best interest of citizens, requires vision, leadership, and policies that keep a balance between the multiple demands on health systems; above all it requires a complex set of institutional capacities that is only partially available. Many countries:

- Present inadequate capacities to formulate clear policy objectives and strategies that correspond to health system needs, are based on scientific evidence, and compatible with the cultural and social values of concerned societies.
- Experience difficulties in reconciling competing demands for limited resources across services and programmes,

and in making decisions about ways to organize them that maximize use of resources and ensure core public health functions are provided, despite limited evidence about 'what works' and sometimes in the face of earmarked external funds.

- Limited capacity of ministries of health to manage the increasing number of financing and implementation partners and networks that they have to deal with: public bodies (ministries of finance and planning, national legislatures, etc); international agencies; multilateral, bilateral and nongovernmental agencies; and various types of private enterprises and civil society organizations.
- Do not have adequate regulatory and legislative mechanisms to ensure socially responsible behaviour of all stakeholders, fair rules of game for all players, and implementation of strategies leading to the attainment of policy objectives.
- Lack mechanisms to ensure effective interaction with other sectors that influence social, economic and environmental determinants of health.
- Lack the mechanisms and information to ensure accountability and transparency.
- Have a limited capacity for delivering nationally-relevant research for health, including health systems research, for establishing and maintaining sound health information systems and translating research findings into policy and practice; experience difficulties in finding a balance between responding to international demand for health information and to their own needs for information and knowledge.

STRATEGIC APPROACHES

Achieving this objective will require that Member States set up structures and processes which involve a range of actors in defining how the health sector should operate and be managed. Ministries of health would review and develop enforceable regulations, standards and incentives that promote a 'level playing field' for all health system actors. They should also create mechanisms for better managing interactions with multiple partners. As governments decentralize so as to get closer to community concerns, efforts will be made to establish and promote effective accountability mechanisms to protect nationally agreed priorities.

Strengthening accountability would require the development of a culture of investing in and acting upon information and evidence as well as establishing functional (timely, reliable, relevant) health information systems. Building and sustaining the capacity for delivering nationally-relevant research for health, including health systems research, for establishing and maintaining sound health information systems and translating research findings into policy and practice, will be major conditions as well as e-Health platforms, 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.

In supporting the efforts of Member States, the WHO Secretariat will focus on:

- maintaining an approach to country support that is tailored to the political, cultural and social context in which governance strengthening takes place;
- contributing to strengthening the capacity of ministries of health to develop health sector policies that also fit with broader national development policies, and to allocate resources in line with policy objectives;
- assisting to build national information systems that can generate, analyze and use reliable information from population-based sources (surveys, vital registration), as well as clinical and administrative data sources, through collaboration with partners (e.g. UN, other agencies and the Health Metrics Network partnership);
- contributing to building national capacity to produce policy relevant research, and synthesizing country experience so as to provide evidence-based guidance, in collaboration with partners and the International Alliance for Health Policy and Systems Research;
- providing global guidance for resource allocation for health based on synthesis, analysis of country, regional and global data, including comprehensive databases; a key role will be played by international expert groups including the Advisory Committee for Health Research and Advisory Committee for Health Statistics and Evidence;
- facilitating exchange and dissemination of knowledge and experience within and between countries, and enhancing access to information and knowledge, and
- bridging the "know-do gap" in global health by synthesizing experience and disseminating best practice, fostering an environment that encourages the creation, sharing/translating, and effective application of knowledge to improve health; and helping to close the information divide between rich and poor countries, including international platforms such as the Global Observatory for e-Health.

ASSUMPTIONS, RISKS AND OPTION ANALYSIS

This strategic objective would be achieved under the following assumptions:

- a basic consensus agreement that the state has a responsibility for the health of the whole population;
- the ways external financing and implementation partners operate changes - including by operationalizing the principles in the Paris Declaration on Aid Effectiveness, so that they help reinforce rather than undermine national efforts to strengthen governance/stewardship;

- effective partnerships and involvement of stakeholders at national, regional and global levels are developed and maintained; of a particular importance are the international and regional agencies that invest in information, and a number of bilateral donors;
- progress on governance and strategic management of development in general, not just in the health sector; and
- countries and development partners are increasingly committed to using evidence for resource allocation.

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

- the lack of international and national investment in this area;
- inadequate coordination and harmonization between major international partners; and
- the preference for investing in short-term non-sustainable solutions.

ORGANIZATION-WIDE EXPECTED RESULTS	**1.** Improved country capacity and practices in national and local health sector policy making, regulation, strategic planning, implementation of reforms, intersectoral and inter-institutional coordination.	
INDICATORS	**1.1** Country capacity and practices in national and local health sector policy making, regulation, strategic planning, implementation of reforms and inter-institutional coordination.	**1.2** Proportion of countries with institutionalized health impact assessment.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	Increase by 10% from 2006 baseline.	Increase by 10% from 2006 level.
TARGETS TO BE ACHIEVED IN 2013	Increase by 25%.	Increase by 20%.

RESOURCES (IN US$ 000)	
Costs 2008-2009	21 787
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	

ORGANIZATION-WIDE EXPECTED RESULTS	**2.** Improved coordination of donor assistance at the global and country level to achieve national health system development targets and global health goals.	
INDICATORS	**2.1** Proportion of countries where the major donors to the health sector are harmonized and aligned with government systems.	**2.2** The proportion of health priorities which are not adequately funded.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	Increase by 20% from 2006.	Decrease by 15% from 2006 baseline.
TARGETS TO BE ACHIEVED IN 2013	Increase by 30%.	Decrease by 25%.

RESOURCES (IN US$ 000)	
Costs 2008-2009	4 387
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	

ORGANIZATION-WIDE EXPECTED RESULTS	**3.** Contribute to strengthened country health-information systems that provide and use quality and timely information for local health problems and programmes and for monitoring of major international goals.
INDICATORS	**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	
TARGETS TO BE ACHIEVED IN 2009	35%
TARGETS TO BE ACHIEVED IN 2013	66%

RESOURCES (IN US$ 000)	
Costs 2008-2009	49 686
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	

ORGANIZATION-WIDE EXPECTED RESULTS	**4.** Contribute to better knowledge and evidence for health decision-making, by consolidation and publication of existing evidence, facilitation of knowledge generation in priority areas and global leadership in research for health, including ensuring ethical conduct.		
INDICATORS	**4.1** Utilization and quality of organization-wide WHO database system of core health statistics and evidence that covers all high priority health issues.	**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 ICD.	**4.3** Effective research for health coordination and leadership mechanisms established and maintained at global and regional levels, including ACHR.
BASELINE			
TARGETS TO BE ACHIEVED IN 2009	Recent country health statistical profiles for 80% of Member States.	30	Relevant and ethical research practices (to be defined).
TARGETS TO BE ACHIEVED IN 2013	As in 2009	45	

RESOURCES (IN US$ 000)	
Costs 2008-2009	26 187
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	

ORGANIZATION-WIDE EXPECTED RESULTS	**5.** Strengthened national health research for health-systems development, within the context of regional and international research and engagement of civil society.	
INDICATORS	**5.1** Proportion of low and middle income countries in which national health-research systems meet internationally agreed minimum standards (to be defined).	**5.2** Countries complying with the Mexico Summit commitment to dedicate at least 2% of their health budget to research.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	25%	10% increase from baseline.
TARGETS TO BE ACHIEVED IN 2013	50%	25% increase.

RESOURCES (IN US$ 000)	
Costs 2008-2009	26 987
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	

ORGANIZATION-WIDE EXPECTED RESULTS	**6.** Knowledge management and e-health evidence, policies and strategies developed to strengthen health systems.		
INDICATORS	**6.1** Number of countries (MoH and SPHs) adopting KM strategies to bridge the know-do gap.	**6.2** Number of LMICs with access to essential scientific information and knowledge.	**6.3** Proportion of countries with Evidence-based eHealth frameworks and services.
BASELINE			
TARGETS TO BE ACHIEVED IN 2009	30	90	30%
TARGETS TO BE ACHIEVED IN 2013	70	120	75%

RESOURCES (IN US$ 000)	
Costs 2008-2009	32 286
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	

STRATEGIC OBJECTIVE 12

Ensure improved access, quality and use of medical products and technologies.

Scope

Medical products include medicines; vaccines; blood and blood products; cells and tissues of mostly human origin; biotechnology products; traditional medicines and medical devices. Technologies include diagnostic tests, and imaging, laboratory tests. The work undertaken under this strategic objective will focus on improving equitable access (as measured by availability, price and affordability) to essential medical products and technologies of assured quality (including safety, efficacy and cost-effectiveness), as well as their sound and cost-effective use. The sound use of products and technologies focuses on evidence-based selection; prescriber and patient information; appropriate diagnostic, clinical and surgical procedures; vaccination policies; supply systems, dispensing and injection safety; and blood transfusions. Information includes clinical guidelines, independent product information and ethical promotion.

Indicators and Targets

- Access to essential medical products and technologies as part of the fulfilment of the right to health, recognized in the constitution or in national legislation: 50 countries in 2013.
- Availability and median consumer price ratio of a basket of 30 key essential generic medicines in public, private and NGO sectors: (1) 80% availability of medicines in all sectors; and (2) median consumer price ratio of generic medicines less than 4 times the generic world market price
- Development stage of national regulatory capacity: t.b.d.
- Proportion of vaccines in use for childhood vaccination programmes that are of assured quality: 100% by 2013.
- Percentage of prescriptions in accordance with current national or institutional clinical guidelines: 70% by 2013.

Linkages with other strategic objectives

This strategic objective is strongly linked to the five health outcome-oriented objectives (strategic objectives 1-5), none of which can be achieved without vaccines, medicines and health technologies. With regard to access, work under this strategic objective will focus on "horizontal" issues such as comprehensive supply systems, pricing surveys and national pricing policies. On quality and regulatory support, all WHO work is covered by this strategic objective. Work on rational use will focus on general issues such as evidence-based selection of essential medicines, clinical guideline development, patient safety, adherence to long-term treatment and containing antimicrobial resistance.

Work under this strategic objective also contributes to health service delivery (strategic objective 10), good governance (strategic objective 7) and global public policy (strategic objective 15). Sustainable financing of products and technologies, on which access also depends, is covered in strategic objective 14.

ISSUES AND CHALLENGES

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

Medical products and technologies save lives, reduce suffering and improve health, but only if they are of good quality, safe, effective, available, affordable, acceptable and properly used by prescribers and patients. In many countries, however, not all these conditions are met. This is often due to a 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 donor pressures; and fragmented financing and supply strategies. A balance needs to be struck between short-term gain through special vertical systems and long-term development of comprehensive national policies and supply systems for medical products and technologies.

Lessons learnt show also that:

- 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 continue to remain untapped, leading to unnecessary disease, disability, death and economic waste;
- there is great potential for quality improvements and economic savings; for example, rational use programmes can

yield a three-fold economic return and prequalification a 200-fold return;

- the new global funding programmes insufficiently recognize the need for national capacity building in quality assurance, procurement and supply management, rational use and pharmaco-vigilance; without an increased effort in these areas a large proportion of the new supply funds may be wasted; and
- there is much more demand from Member States for product-and technology- related support than WHO is able to deliver.

STRATEGIC APPROACHES

Expanding access to essential medicines, vaccines and technologies of assured quality, and improving their use by health workers and consumers, has for many years been a priority area for the Member States and WHO. This long-term goal can best be achieved through the establishment and implementation of comprehensive national medicine policies.

Adequate supply of medical products and technologies of assured quality and their rational use, while depending largely on market forces, requires public investment, political will and capacity building within national institutions, including the national regulatory agencies.

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

Emphasis should be put on promoting a public health approach to innovation, and on adapting successful interventions from high-income countries to the needs and possibilities of low- and middle income countries.

In addition, monitoring access, safety, quality, effectiveness and use of products and technologies through independent assessments would be encouraged.

In supporting the efforts of the Member Sates, while combining its recognized technical leadership role and unique global normative functions with international advocacy, policy guidance and targeted country support, the WHO secretariat will focus on:

- developing policy guidance, nomenclatures and reference materials through WHO's Expert Committees, regional and global consultation processes, or through participation in other global or regional normative processes, with particular emphasis on equitable access and rational use of essential products and technologies (including paediatric formulations), 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 standards;
- promoting equitable access and rational use of quality products and technologies through technical and policy support to health authorities, professional networks, consumer organizations and other stakeholders, and facilitating needs assessments and capacity building;
- implementing directly quality programmes through WHO/UN prequalification programmes for priority vaccines, medicines and diagnostics;
- supporting countries to produce, use and export products of assured quality, safety and efficacy through strengthening of national regulatory authorities and an international programme to combat counterfeits;
- supporting countries in establishing and implementing programmes to promote good supply management, reliable procurement and rational use of products and technologies;
- supporting countries in establishing or strengthening systems for post-marketing surveillance, pharmaco-vigilance and prescription monitoring, and in communicating the outcomes to citizens and other stakeholders to promote patient safety;
- collating in global databases reports and information on significant events or global signals on product quality or safety, reviewing and disseminating them; and
- 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 which target the major disease burden in countries.

ASSUMPTIONS, RISKS AND OPTION ANALYSIS

It is assumed that expanding access to essential products and technologies of assured quality, and improving their use by health workers and consumers, will remain a priority area for Member States and therefore for WHO. It is also assumed that WHO will resist undue political and commercial pressure and will continue to fulfil its own constitutional and international treaty obligations with regard to the development of international pharmaceutical norms and standards, and will dedicate sufficient resources to this end, reversing the trend of the last decade.

Within national systems and within WHO there is a risk that medical product and technology related work might be split between different vertical programmes.

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 pharmaco-vigilance might result in wasting a large proportion of the new supply funds.

ORGANIZATION-WIDE EXPECTED RESULTS	**1.** Development and monitoring of comprehensive national policies on access, quality and use of essential medical products and technologies advocated and supported.			
INDICATORS	**1.1** Number of countries supported to develop and implement official national policies on access, quality and use of essential medical products and technologies.	**1.2** Number of countries supported to develop or strengthen comprehensive national procurement and supply systems.	**1.3** Number of countries supported to develop and implement national strategies on blood safety and infection control.	**1.4** Biennial global report on medicine prices, availability and affordability published.
BASELINE	62	20	46	Report in 2007
TARGETS TO BE ACHIEVED IN 2009	68	25	52	Report in 2009
TARGETS TO BE ACHIEVED IN 2013				

RESOURCES (IN US$ 000)	
Costs 2008-2009	36 314
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*Level of effort will remain relatively constraint over the three biennia.*

ORGANIZATION-WIDE EXPECTED RESULTS	**2.** International norms, standards and guidelines for the quality, safety, efficacy and cost-effectiveness of medical products and technologies developed and their national/regional implementation advocated and supported.			
INDICATORS	**2.1** Number of global quality standards, reference preparations and tools for effective regulation of medical products and technologies developed or updated.	**2.2** Number of International Non-proprietary Names for medical products assigned.	**2.3** Number of priority medicines, vaccines, diagnostics and equipment pre-qualified for UN procurement.	**2.4** Number of countries with their national regulatory authorities assessed and/or supported.
BASELINE	10 per year	110 per year	150 (cumulative)	20
TARGETS TO BE ACHIEVED IN 2009	20 additional	200 additional	200	25
TARGETS TO BE ACHIEVED IN 2013			400	

RESOURCES (IN US$ 000)	
Costs 2008-2009	64 537
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*It is anticipated that the resource requirements will increase by approximately 30% in order to respond to the full demands for prequalification of vaccines, priority medicines and diagnostics is to be met.*

ORGANIZATION-WIDE EXPECTED RESULTS	**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 WHO, regional and national programmes.	
INDICATORS	**3.1** Number of national or regional programmes to promote sound and cost-effective use of medical products and technologies promoted and supported.	**3.2** Number/percentage of countries with a national list of essential medicines and vaccines updated within the last five years and used for public procurement and/or reimbursement.
BASELINE	5	80
TARGETS TO BE ACHIEVED IN 2009	10	90
TARGETS TO BE ACHIEVED IN 2013		

	RESOURCES (IN US$ 000)	
	Costs 2008-2009	27 724
	Estimates 2010-2011	~ 000
	Estimates 2012-2013	~ 000
JUSTIFICATION	*Level of effort will remain relatively constraint over the three biennia.*	

STRATEGIC OBJECTIVE 13

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

Scope

The work under this strategic objective will address the stages of workforce development - entry, working life and exit, focusing on developing national workforce plans and strategies; enabling effective regulation of the educational system and job market towards an equitable distribution of health workers; achieving an appropriate mix of health workers responsive to population needs; and improving the management of the health workforce and the environment in which it works, including by providing financial and non-financial incentives, particularly for remote and underserved areas.

Indicators and Targets

- Density of the health workforce (disaggregated by country, gender and occupational classification where possible).
- Urban–rural distribution of health workers (disaggregated by country, gender and occupational classification where possible).

Linkages with other strategic objectives

The work will be linked to that undertaken under the following strategic objectives:

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

ISSUES AND CHALLENGES

There is a clear correlation between the density of health care providers and the attainment of high levels of coverage with essential health interventions, such as immunization and skilled attendance at delivery. The more health care providers workers per population, the higher the likelihood of infant, child and maternal survival.

Many countries have not attained the targets of intervention coverage for essential interventions set up by the Millennium Declaration. For example, the World health report 2006 identified 57 countries, 36 of them in sub-Saharan Africa, in which the density of health workers falls below the minimum threshold of 2.3/1000 population that is essential to achieve 80% skilled attendance at delivery. There is an estimated shortage of approximately 2.4 million health services providers in these countries; if management and support workers are included, the gap increases to approximately 4 million.

The reasons for these acute shortages are manifold. There is a limited production capacity in many developing countries due to years of underinvestment in health education institutions. There are also pull and push factors that make health workers leave their workplaces resulting in geographical imbalances within countries between rural and urban areas 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 already suffer from years of neglect, poorly managed health care reforms and economic stagnation.

Further problems of health workforce development include: skill mix and gender imbalances; a mismatch between educational output and health needs of the population; poor working conditions; a poor knowledge base; and lack of coordination between sectors.

These problems in health workforce development, particularly migration, are not new, but they have become acute in recent years because of accelerating trends in ageing of the population, changes in the epidemiological profile and globalization. Efforts to address theses challenges have been limited in scope and not widely promoted. Recent advocacy efforts have given the health workforce crisis more prominence on the international health agenda. Unless we are able to overcome the current workforce crisis, neither priority disease initiatives nor health systems strengthening will succeed.

STRATEGIC APPROACHES

As the human resources crisis has achieved a global dimension, it is necessary that a global response should be

provided by WHO and its partners.

Strategic approaches for Member States:

- Achievement of the strategic objective will require an available workforce, in the right places, in the right numbers and with the right skills to respond to the health needs of the population, within the context of country's own health systems.
- To do that it will be necessary to strengthen advocacy for health workforce improvement at global, regional and national levels with partnerships created and promoted at all levels. Health workforce information systems are required as is the development of evidence-based comprehensive national workforce policies and strategic health workforce plans which are systematically implemented, monitored and evaluated. Evidence-based best practices on development, education and management of health workers need to be collated and disseminated. Similarly there will need to be adequate funding for the health workforce which will require discussions and negotiations with finance ministries, labour and education ministries, and international development counterparts.
- In addition it will be necessary to expand capacity and improve quality of educational and training institutions; ensure appropriate skill mix and equitable geographical distribution of the health workforce through effective deployment and retention, by means of context-specific incentives.

In supporting Member states efforts, the Secretariat will develop and share the knowledge (data, information, and evidence) needed to change current practices, so that health workforce challenges are addressed and the overall performance of the health workforce continuously improves. Specifically, the Secretariat will focus on:

- providing response to countries in HRH crisis;
- facilitating agreements with other agencies on more effective financing mechanisms for health workforce development, and management of internal and international migration;
- supporting the development of national health workforce leadership at central and peripheral levels to mobilize resources for the health workforce and to formulate, implement, monitor and evaluate health workforce policies and plans responsive to health needs;
- strengthening national educational systems, including schools and universities, to support the production of all types of health workers, with appropriate skills and competencies;
- strengthening the knowledge base through 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, to generate information for evidence-based policy-making, monitoring and evaluation; and
- collaborating on setting norms and standards for the health workforce, including the development of internationally agreed-upon definitions, classification systems and indicators.

ASSUMPTIONS, RISKS AND OPTION ANALYSIS

This strategic objective would be achieved under the following assumptions:

- 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 supporting health workforce development will continue to actively engage all stakeholders, including civil society, professional associations and the private sector.

The following risks may adversely affect the achievement of the strategic objective:

- financing of health workforce development will remain at low levels;
- the issue of human resources development will continue to be neglected;
- countries in crisis will remain unable to take the lead in managing their response to crisis by themselves;
- active recruitment by developed countries, leading to uncontrolled migration will continue; and
- market forces will continue to be too strong in favour of out migration and brain-drain.

ORGANIZATION-WIDE EXPECTED RESULTS	**1.** Strengthened country capacity to lead the process of health workforce development.				
INDICATORS	**1.1** Number of countries with evidence-based policieis, plans and strategies for strengthening the health workforce in the areas of production, distribution, retention and	**1.2** Number of countries with strengthened planning and development capacities in MoH and allied national institutions for HRH development.	**1.3** Number of coutnries with strengthened national institutions for the increased production of different types of health workers.	**1.4** Number of countries with effective accreditation mechanisms for health educaiton institutions.	**1.5** Number of countries with bilateral agreements and other effective mechanisms for the management of migration.

	productivity.				
BASELINE	Baselines to be determined after completion of assessment in 2007.	Baselines to be determined after completion of assessment in 2007.	Baselines to be determined after completion of assessment in 2007.	Baselines to be determined after completion of assessment in 2007.	Baselines to be determined after completion of assessment in 2007.
TARGETS TO BE ACHIEVED IN 2009	30% more countries.	30% more countries.	30% more countries.	30% more countries.	30% more countries.
TARGETS TO BE ACHIEVED IN 2013	50% more countries than in 2009.	50% more countries than in 2009.	50% more countries than in 2009.	50% more countries than in 2009.	50% more countries than in 2009.

RESOURCES (IN US$ 000)	
Costs 2008-2009	26 488
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*There is strong evidence that availability of skilled health workers contributes to improved health outcomes, such as maternal, infant and child survival. This should be reflected in increased capacity of countries to take the leadership in advocating for the health workforce, in creating and maintaining the political commitment and the enabling environment necessary to formulate national policies and plans, and pursue their implementation, in order to reduce the shortages and address the maldistribution of health workers. Strengthened capacity of WHO at all levels is required in order to support health workforce development in countries.*

ORGANIZATION-WIDE EXPECTED RESULTS	**2.** Strengthened information and knowledge base on health workforce development at national, regional and global levels.			
INDICATORS	**2.1** Number of countries with well maintained and regularly updated databases for health workforce development.	**2.2** Number of countries providing quality data for the global health atlas at least once a year.	**2.3** Regional observatories established to assess and monitor health workforce situations in countries.	**2.4** Comprehensive and coherent research programmes established to inform HRH policy development and implementation.
BASELINE	Baselines to be determined after completion of assessment in 2007.	Global atlas on the health workforce.	Two regional observatories established by the end of 2007.	Baselines to be determined after completion of assessment in 2007.
TARGETS TO BE ACHIEVED IN 2009	30% more countries.	Global atlas updated at least once year.	Two further regional observatories established.	30% more programmes.
TARGETS TO BE ACHIEVED IN 2013	50% more countries than in 2009.	Global atlas updated at least once a year.	Regional observatories established in all six regions.	50% more programmes than in 2009.

RESOURCES (IN US$ 000)	
Costs 2008-2009	20 188
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*The knowledge base in human resources for health development is weak and uneven overall, compared to other domains of health systems research, such as health financing or health sector reform. Areas such as assessment, planning, production, regulation and management of health workforce need to be better understood. Common technical frameworks are necessary for comparable situation analysis, as well as to identify trends. Data and information must be collected and analysed to monitor global and regional health workforce situation and trends. Research needs to be supported and further stimulated to expand the knowledge base and to identify and promote best practices in health workforce development.*

ORGANIZATION-WIDE EXPECTED RESULTS	**3.** Technical support provided to countries in crisis to reduce their shortages by addressing the production, distribution and skill mix of their health workforce.		
INDICATORS	**3.1** Common technical frameworks and their accompanying tools and guidelines for the assessment, production, regulation and management of health workforce (including retention, performance and productivity), developed and used.	**3.2** Tools and guidelines for integrating HRH across priority programmes.	**3.3** Norms and standards updated, 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 HRH across priority programmes.	Norms and standards established for nursing and midwifery and other health professions.
TARGETS TO BE ACHIEVED IN 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 IN 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 (IN US$ 000)	
Costs 2008-2009	56 588
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*Performance of health workers is defined as 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 headquarters, regions and countries; representatives of other sectors; civil society; professional associations; bilateral donors; and other relevant stakeholders.*

ORGANIZATION-WIDE EXPECTED RESULTS	**4.** Strengthened networking and partnerships at global, regional, and country level, to strengthen the institutional infrastructure in countries with HRH crisis.		
INDICATORS	**4.1** Partnerships and alliances established at global, regional and interregional level to strengthen advocacy and resource mobilization for national health workforce development.	**4.2** Network of WHO Collaborating Centres and various communities of practice for health workforce development created and expanded.	**4.3** Twinning and exchange programmes established between developed and developing countries.
BASELINE	One global alliance and one interregional alliance established.	55 WHO Collaborating Centres, 39 of which relate to nursing and midwifery.	Baselines to be determined after completion of assessment in 2007.
TARGETS TO BE ACHIEVED IN 2009	Further interregional alliances established.	33 more WHO Collaborating Centres on HRH development, nursing and midwifery, HRH research etc to be designated by 2009.	30% more programmes.
TARGETS TO BE ACHIEVED IN 2013	Interregional alliances established that include all regions.	A total of 100 WHO Collaborating Centres on human resources designated by 2013.	50% more programmes established.

RESOURCES (IN US$ 000)	
Costs 2008-2009	14 588
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*The issues of health workforce development cannot be dealt with in isolation. Dialogue between stakeholders and working across sectors are required in order to analyse human resources constraints and identify and implement effective solutions for health workforce development. This is particularly relevant in light of the recent WHA resolutions WHA59.23 and WHA59.27, which require strong national institutions in order to implement the request for rapid scaling up of the production of the workforce and the more extensive engagement of nursing and midwifery in national policy formulation and implementation. By an adequate institutional infrastructure is understood the existence and functionality of a set of key institutions, such as medical schools, nursing and midwifery schools, public health schools, as well as professional associations and regulatory bodies.*

STRATEGIC OBJECTIVE 14

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

Scope

This strategic objective reflects the guiding principles described in Resolution WHA 58.33, "Sustainable health financing, universal coverage and social health insurance". The work will focus on: increasing funding for health from domestic and external sources in poor countries; increasing the predictability of funding; ensuring new external resources contribute to the development of sustainable domestic financial institutions; developing financial risk pooling mechanisms to reduce the extent of financial catastrophe and impoverishment; reducing financial barriers to prevention, promotion, treatment, rehabilitation and intersectoral health actions; ensuring efficient and equitable use of available health resources, including the appropriate mix of public and non-state providers and funding sources, and the appropriate mix of inputs including medicines; improving availability and use of key information on inputs, processes, outputs and outcomes of health financing systems; development of tools for monitoring and evaluating the performance of financing systems and ensuring transparency in revenue generation and use.

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 utilization of needed services is maintained or increased).
- Reduction in the number of countries that have high shares of out-of-pocket spending in total health spending.
- Increased equity and efficiency in the use of health resources.

Linkages with other strategic objectives

The work will be linked with work undertaken by all other Strategic Objectives, by ensuring that there are adequate funds available for improving health in Member States in all key areas, by minimizing financial barriers to using needed services and by encouraging use of the most efficient and equitable interventions to provide the best levels of health possible with the available 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, non-personal and intersectoral - so the major concern is to ensure adequate and equitable resource mobilization for health. Increased external flows 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 to health are used efficiently and that they are distributed equitably, yet rural/urban and gender disparities in access to services remain. In many countries, health financing relies heavily on out-of-pocket payments, placing large, sometimes catastrophic financial burdens on households who can be pushed into poverty, or further into poverty, as a result.

Responses require ensuring that more funds are available in poor countries, that they are available in a predictable manner and that resources are used equitably and efficiently. This sometimes requires quite complex adjustments to the way that funds for health are raised, pooled to spread risks and used to purchase and provide services. While countries will choose the mix of private and public providers and funders appropriate in their own settings, strong government stewardship is required and ministries of health sometimes require support to advocate for intersectoral activities designed to improve health.

Policy development 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, which 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 synthesized in a way that makes the experience readily available to policy-makers in a form they can use. The challenge is to develop ways of obtaining key information, to use this knowledge as an input to the policy debate about ways to improve health systems and to build capacity to obtain and use this information where necessary.

STRATEGIC APPROACHES

The approach taken to achieve the objective will follow the broad principles outlined Resolution WHA 58.33 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. This 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 funding for health-related activities from other sectors. Additional domestic financing will be mediated through a mix of state and non-state agents and institutions requiring effective government stewardship. Countries will also work with the international community to improve the predictability of external flows.

Reducing reliance on out-of-pocket payments where they are high by improving the effectiveness of prepayment mechanisms will require active assessment of the feasibility, effectiveness and equity of reforms to existing financing arrangements and/or the introduction of new arrangements.

Improving the efficiency of resource use by focusing on questions such as the appropriate mix of activities to fund and inputs to purchase requires assessing the mix of: prevention, promotion, treatment, rehabilitation and intersectoral action; capital versus recurrent expenditures; different types of recurrent expenditures such as human resources and medicines. It also includes considering whether high-cost, low-impact interventions are being funded at the expense of low-cost, high-impact alternatives as well as considering 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 improved access to needed services (personal, non-personal, intersectoral) and that paying for care does not result in financial catastrophe or impoverishment, promote transparency and accountability in health financing systems, and improve information generation and use - many countries do not know the extent of financial catastrophe associated with out-of-pocket payments or the extent to which the burden of funding 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.

In supporting Member States efforts, the Secretariat will focus on:

- Advocating for more and predictable funds for health globally, regionally and nationally and participation in partnerships that further this aim.
- Supporting ministries of health to put health higher on the domestic agenda and, as appropriate, to advocate for more funds from ministries of finance and external sources as well as advocating for health-related activities from other sectors.
- Supporting countries to develop and sustain high levels of accountability and transparency in the use of funds, and to develop their stewardship functions relating to financial management.
- Developing evidence and options and providing technical support by developing prepayment institutions and mechanisms 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 development about 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 action. Working to reduce waste and inefficiency and to improve equity in resource use.
- Providing technical support and evidence for policy development on ways to improve equity in resource use - including identifying groups suffering financial catastrophe and impoverishment because of health payments along with identifying methods that can be used to protect them.
- Sharing of country experiences with different types of financing, pooling and purchasing/ provision arrangements in different settings along with the factors associated with success in sustaining progress on key policy objectives.
- Providing and disseminating norms, standards and tools relevant to the above.
- Providing and disseminating information necessary for the development, operation and monitoring of fair, adequate and sustainable health financing systems.
- Capacity building at the country level and in WHO where needed.

ASSUMPTIONS, RISKS AND OPTION ANALYSIS

Achieving this strategic objective requires developing and maintaining effective partnerships and involving

stakeholders at the 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 remain committed to the goal of achieving universal coverage and that sufficient funds are available to undertake an ambitious, expanded work plan in support of those countries.

Possible risks are:

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

ORGANIZATION-WIDE EXPECTED RESULTS	**1.** Ethical and evidence-based policy and technical support provided to Member States to improve the performance of health system financing systems in terms of financial protection, equity in finance and use of services as well as efficiency of resource use.	
INDICATORS	**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; and improvement of the efficiency and equity of resource use.	**1.2** Key information on revenue raising, pooling and purchasing/provision to guide policy formulation and implementation developed and disseminated, and their use supported.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	36	6 technical briefs for policy makers documenting best practices produced and supported in countries.
TARGETS TO BE ACHIEVED IN 2013	90	15

RESOURCES (IN US$ 000)	
Costs 2008-2009	32 495
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 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 this increasing demand, a significant increase in funding is required for 2008-9 with modest increases subsequently.*

ORGANIZATION-WIDE EXPECTED RESULTS	**2.** International, regional and national advocacy, information and technical support designed to mobilize additional and predictable funding for health.		
INDICATORS	**2.1** WHO presence and leadership in international, regional and national partnerships to increase funding for health in poor countries.	**2.2** WHO support to countries in the design and/or monitoring of PRSPs, Sector-wide approaches, MTEFs and other long term financing developments in countries.	**2.3** Evidence collated and disseminated on best practices for the coordination of external financial assistance at the global, regional and national levels to increase levels and to improve the predictability of external assistance, and their use supported.
BASELINE			
TARGETS TO BE ACHIEVED IN 2009	4 active global and/or regional partnerships on financing options in which WHO is a "member".	16	3 technical briefs for policy makers produced and supported with discussion papers.
TARGETS TO BE ACHIEVED IN 2013	8	40	8

RESOURCES (IN US$ 000)	
Costs 2008-2009	10 795
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*WHO has contributed to international and national efforts to raise additional funding for health in poor countries and for vulnerable groups everywhere. It is important to build momentum internationally and to actively support countries to build health into country economic plans such as medium term expenditure frameworks (MTEFs). This requires strengthening capacity of country offices as well as other levels of WHO.*

ORGANIZATION-WIDE EXPECTED RESULTS	**3.** Measurement tools developed to analyse transparency and accountability in health financing systems, and technical support provided to support their use where needed.
INDICATORS	**3.1** Number of countries provided with technical support for utilizing WHO tools to track and evaluate the use of funds, to estimate future financial needs and to manage and monitor the funds that are available.
BASELINE	
TARGETS TO BE ACHIEVED IN 2009	20
TARGETS TO BE ACHIEVED IN 2013	50
	RESOURCES (IN US$ 000) Costs 2008-2009: 15 995 Estimates 2010-2011: ~ 000 Estimates 2012-2013: ~ 000
JUSTIFICATION	*WHO is the only agency providing estimates of health expenditures for all of our 192 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/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 build in WHO and in Member States to use them. This requires an initial increase in funding, followed by more modest increases after 2008 to enable more countries to be supported.*

ORGANIZATION-WIDE EXPECTED RESULTS	**4.** Norms and standards developed for resource tracking, estimating the economic consequences of illness, costs and effects of interventions, financial catastrophe and impoverishment, and their implementation promoted, supported and monitored.
INDICATORS	**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	
TARGETS TO BE ACHIEVED IN 2009	Tools available to countries for resource tracking, additionality, costing, economic burden, financial catastrophe and impoverishment. Framework on financing policy development. Tools and framework disseminated and supported.
TARGETS TO BE ACHIEVED IN 2013	Tools and frameworks modified, updated and disseminated as necessary.
	RESOURCES (IN US$ 000) Costs 2008-2009: 7 295 Estimates 2010-2011: ~ 000 Estimates 2012-2013: ~ 000
JUSTIFICATION	*The WHO secretariat is continually asked 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. The capacity in WHO to meet these demands needs to be expanded substantially as well as the ability to support policy-makers seeking to use the resulting norms and standards.*

ORGANIZATION-WIDE EXPECTED RESULTS	**5.** Steps taken to build capacity in health financial policy development, production, interpretation and the use of information.
INDICATORS	**5.1** Number of countries supported to build capacity in the development of health financing policies and strategies, and in the collection and use of financial information such as health expenditures costs, financial catastrophe and impoverishment, cost-effectiveness, budgeting.
BASELINE	
TARGETS TO BE ACHIEVED IN 2009	
TARGETS TO BE ACHIEVED IN 2013	80

	RESOURCES (IN US$ 000)	
	Costs 2008-2009	17 995
	Estimates 2010-2011	~ 000
	Estimates 2012-2013	~ 000
JUSTIFICATION	*There are limited skills in many countries in financial and economic planning and management for health, and many country offices of WHO do not have staff with expertise in this area. The demands from Member States for support have increased rapidly, and an increase in funding for 2008-2009 is required to meet the need to build capacity.*	

ORGANIZATION-WIDE EXPECTED RESULTS	**6.** Steps taken to stimulate the generation, translation and dissemination of valuable knowledge and to shape the research agenda.	
INDICATORS	**6.1** Key information and knowledge on health expenditures, financing, efficiency and equity to guide policy development and implementation validated and disseminated.	
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	Annual updates of health expenditure for 192 Member States and research conducted on the extend of catastrophic expenditure and impoverishment for 90 countries in which households are most at risk.	
TARGETS TO BE ACHIEVED IN 2013	Annual updates of health expenditure for 192 Member States and extent of catastrophic expenditure and impoverishment updated and new estimates for 20 countries.	
	RESOURCES (IN US$ 000)	
	Costs 2008-2009	8 095
	Estimates 2010-2011	~ 000
	Estimates 2012-2013	~ 000
JUSTIFICATION	*The secretariat has supported Member States with key information - on health expenditures, the effectiveness and costs of key interventions, and the extent of financial catastrophe and impoverishment relating to out-of-pocket payments, for example. Considerable additional work needs to be done to ensure this key information is disseminated to the policy-makers who could use it, at the time they need it. Moreover, this work continues to identify many gaps in knowledge and unanswered questions that are critical to policy, but the links between this and the researchers who could provide the answers need to be strengthened. This requires an increase in funding throughout the period covered by the medium term strategic plan.*	

STRATEGIC OBJECTIVE 15

Provide leadership, strengthen governance and foster partnership and collaboration in engagement with countries, to fulfil the mandate of WHO in advancing the global health agenda as articulated in the 11th General Programme of Work.

Scope

This strategic objective facilitates the work of WHO in all other Strategic Objectives. Responding to priorities in the 11th General Programme of Work, it recognizes that the context for international health has changed significantly. The scope of this objective covers three broad, complementary areas: leadership and governance of the Organization; WHO's support for, presence in, and engagement with individual member states; and the Organization's role in bringing the collective energy and experience of member states and other actors to bear on health issues of global and regional importance.

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

Indicators and Targets

- Number of countries implementing health related resolutions and agreements approved by the World Health Assembly.
- Number of countries which 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.
- Qualitative improvements in the global health architecture: progress towards a common health agenda among the full range of health partners, including more coherent and more predictable financing for health.

Linkages with other strategic objectives

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ISSUES AND CHALLENGES

For the more inward-looking dimension of this objective, i.e. the leadership and governance of the Organization, issues and challenges relate to the relationship between the World Health Assembly and the Secretariat, through the Director-General, as well as that of the Regional Committees with their respective regions through the Regional Directors, which demands an effective servicing of their needs, as well as responsive and transparent implementation of their decisions. Within the Secretariat, more robust mechanisms are needed to ensure clear lines of authority, responsibility and accountability, especially in a context where resources and decisions on the use of these resources are increasingly decentralized closer to where programmes are implemented.

At all levels, the Organization's capabilities must be strengthened to cope with the ever growing demand for information on health. The Organization must be equipped to communicate internally and externally in a timely and consistent way at HQ, region and country levels - both proactively, and in times of crises - to articulate its leadership in health, to provide essential health information and to ensure visibility.

There is a need for strong political will, good governance and leadership at the country level. Indeed, the state has 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 civil service reform and macroeconomic policy, which can have a major impact on the delivery of health services. The Secretariat, for its part, must do more to ensure it focuses its support around clearly articulated country strategies, that these are reflected and coherent with WHO's Medium-Term Plans and Programme Budgets, and to match the Organization's presence to the needs and level of development of the country concerned in order to provide optimal support.

At the global level, mechanisms such as the World Health Assembly could be further strengthened to allow stakeholders to tackle global health issues in a transparent and effective way. WHO must ensure that national health policy-makers and advisers are fully involved in all international forums where issues affecting health status are being discussed. 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 players in public health, outside government and intergovernmental bodies, whether they be activists, academic or private sector

lobbyists, need to have forums to contribute in a transparent way to global and national debates on health-related policies. They are also central to ensuring good governance and accountability.

Lessons learnt show also that:

- In an environment with an increasing number of sectors, actors and partners, WHO's role and comparative advantage needs to be well understood and indeed recognized; this is the case on most countries today, and across the majority of programmatic areas; it will be critical to maintain this advantage if WHO is to successfully implement the ambitious strategic objectives set out in this medium-term strategic plan, and hence contribute to reaching the health-related Millennium Development Goals.
- The increasing number of sectors, actors and partners involved in health work has also led to gaps in accountability and lack of synergy in the coordination of actions to improve health. 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.
- The expectations on the UN as a whole is increasing as is the need to be more clear on how it adds value; this is a challenge for WHO as it is for its partner UN agencies; of particular importance is the relations at country level where many changes are taking place as international agencies align their work with national health policies and programmes, and harmonize their efforts so as to reduce the overall management burden. Within this context, WHO needs to continue to play a proactive role with the United Nations system, as well as develop innovative mechanisms for managing or participating in global partnerships. The aim is to make the overall 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, the strategic approaches are as follows:

Leading, directing and coordinating the work of WHO in relation to the global health agenda. Providing leadership and direction to the work of WHO; strengthening the governance mechanism of the Organization through stronger engagement of Member States and effective secretariat support; effectively communicating the work and knowledge of WHO to member states, other partners, stakeholders and the general public.

Engaging with countries to advance the global health agenda, contribute to the national strategies and priorities, and bring country realities and perspectives into global policies and priorities. Orienting and coordinating the different organizational levels of WHO on the basis of an effective country presence that reflects national needs and priorities; promoting multi-sectoral approaches for advancing the global health agenda; developing institutional capacities at the national level for leadership and governance; building national capacity for health development planning; facilitating technical cooperation among developing and developed countries.

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 other international agencies, including UN organizations; actively engaging in the UN Reform dialogue; promoting the development of effective partnerships for health; reaching out to other stakeholders in health; and acting as a convener of relevance stakeholders on health issues of global and regional importance.

ASSUMPTIONS, RISKS AND OPTION ANALYSIS

This strategic objective would be achieved under the following assumptions:

- commitment from all stakeholders to good governance and strong leadership will continue; resolutions and decisions of the governing bodies would be upheld and respected by Member States and the Secretariat;
- a relationship bound by trust between Member States and the Secretariat, which today is strong and recognized will be maintained;
- mechanisms to ensure greater accountability between what has been approved and decided, and what is actually being implemented will be strengthened in the context of the results based management framework; and
- changes in the external and internal environment that are likely to occur over the six year period of the Medium Term Strategic Plan, will not fundamentally alter the role and functions of WHO; should this happen, for example in the context of UN Reforms, WHO must have the ability to respond and adapt itself accordingly.

Regarding the risks that may affect the achievement of the strategic objective, the following are to be considered:

- adverse consequences of the UN reform process could be mitigated and opportunities increased if WHO takes initiatives and plays a proactive role in this process;
- similarly, recognizing the strong leadership role played by the Director-General in WHO, a change in leadership within the Secretariat could affect the agenda set forth in the Medium Term Strategic Plan; this is part of an Organization's normal evolution, however, and can be managed through the existing governance mechanisms; and
- as the number of partnerships grow, this may paradoxically 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; WHO will need to work to mitigate this.

ORGANIZATION-WIDE EXPECTED RESULTS	**1.** Effective leadership and direction of the Organization through the enhancement of governance, coherence, accountability and synergy of the work of WHO.			
INDICATORS	**1.1** Proportion of resolutions adopted that focus on policy and can be implemented at global, regional and national levels.	**1.2** Proportion of documents submitted to governing bodies within constitutional deadlines, in all official languages.	**1.3** Level of understanding by key stakeholders of WHO's role, priorities and key messages.	**1.4** Level of satisfaction of governing bodies, as evidenced by their reports, with the operation of the external and internal audit and oversight frameworks.
BASELINE				
TARGETS TO BE ACHIEVED IN 2009	40%	100%	10% increase over survey baseline.	Qualitative assessment.
TARGETS TO BE ACHIEVED IN 2013	50%	100%	25% increase over survey baseline.	Qualitative assessment.

RESOURCES (IN US$ 000)	
Costs 2008-2009	66 500
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	

ORGANIZATION-WIDE EXPECTED RESULTS	**2.** Effective WHO country presence to implement WHO Country Cooperation Strategies that are aligned with, Member States' national health and development agenda, and harmonized with the UN country team and other development partners.	
INDICATORS	**2.1** Number of countries actively using the CCS process as a basis for planning WHO's country work and for harmonizing WHO's cooperation with the UN Country Team members and other development partners.	**2.2** Proportion of countries where WHO country presence, including regional and global support, reflects the respective Country Cooperation Strategies.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	60	25%
TARGETS TO BE ACHIEVED IN 2013	135	80%

RESOURCES (IN US$ 000)	
Costs 2008-2009	98 700
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	

ORGANIZATION-WIDE EXPECTED RESULTS	**3.** A convening framework maintained for the ethical development and implementation of the normative aspects of health through agreements, treaties, laws, and policies.
INDICATORS	**5.1** Number of global meetings to promote strategies and interventions that serve the collective interest of Member States and advance the global health agenda.
BASELINE	
TARGETS TO BE ACHIEVED IN 2009	2
TARGETS TO BE ACHIEVED IN 2013	2

RESOURCES (IN US$ 000)	
Costs 2008-2009	13 600
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	

ORGANIZATION-WIDE EXPECTED RESULTS	**4.** Global health and development architecture effectively providing more sustained and predictable technical and financial resources for health, based on a common health agenda which responds to the health needs and priorities of Member States.			
INDICATORS	**4.1** Proportion of external aid flows to health supplied through flexible and long-term instruments.	**4.2** Proportion of health partnerships that WHO is engaged in and that work according to the Best Practice Principles for Global Health Partnerships.	**4.3** Proportion of trade agreements appropriately reflecting public health interests as outlined in WHO guidance.	**4.4** Proportion of countries where WHO is leading or actively engaged in health and development partnerships (formal and informal), including in the context of UN Reforms.
BASELINE				
TARGETS TO BE ACHIEVED IN 2009	Mechanism established (in partnership with OECD/DAC and World Bank) for systematically monitoring long-term commitments or aid to health, programmed through government, baseline data gathered, and target set for 2013.	Global Fund, GAVI and other major GHPs agree to adapt a set of indicators* from the Paris H&A declaration, establish a system of monitoring, gather baseline data set targets for 2013.	Qualitative assessment.	Qualitative assessment.
TARGETS TO BE ACHIEVED IN 2013	To be established 2009.	To be established 2009.	Qualitative assessment.	Qualitative assessment.

RESOURCES (IN US$ 000)	
Costs 2008-2009	14 900
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	

ORGANIZATION-WIDE EXPECTED RESULTS	**5.** 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	**5.1** 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.	**5.2** Average number of page views/monthly visits to WHO websites.	**5.3** Number of multilingual (non-English) pages available on web-sites.	**5.4** Number of WHO publications sold per biennium.
BASELINE				
TARGETS TO BE ACHIEVED IN 2009	Baseline plus 20%.	48 000 000/5 000 000	22 000	400 000
TARGETS TO BE ACHIEVED IN 2013	Baseline plus 50%.	80 000 000/7 000 000	40 000	500 000

RESOURCES (IN US$ 000)	
Costs 2008-2009	30 000
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	

STRATEGIC OBJECTIVE 16

Develop and sustain WHO as a flexible, learning Organization, enabling it to carry out its mandate more efficiently and effectively.

Scope

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

In addition, the strategic objective covers a broad institutional reform agenda that will ensure that the above functions are continuously strengthened and able to provide better, more efficient and cost-effective support to the rest of the Organization. This agenda is closely linked to broader reforms within the United Nations system at both a country and a global level.

Indicators and Targets

- Cost-effectiveness of operational support services (i.e., how much does it cost us today to deliver a certain function vs. the cost at the end of the period, everything else being equal, as a proxy measure of efficiency).
- Alignment of voluntary contributions with the Programme Budget (as a proxy measure of trust/effectiveness in the Organization).
- Effectiveness of managerial and administrative capacity at the country level (methodologies to measure this are under development as part of the process of measuring WHO's overall effectiveness at country level).

Linkages with other strategic objectives

This objective should not be considered in isolation from the other strategic objectives, as its scope reflects and is responsive to the needs of the Organization as a whole. In particular, this objective should be read in conjunction with its complementary objective: To provide leadership, strengthen governance and encourage partnership and collaboration in engaging with countries and to fulfil the mandate of WHO in advancing the global health agenda. While Strategic Objective 16 is more inward-looking, geared towards managerial and administrative issues, Strategic Objective 15 is more outward-looking, focusing on issues of WHO leadership and governance, and on its engagement with Member States and partners globally, regionally and in countries.

ISSUES AND CHALLENGES

As highlighted in the 11th General Programme of Work, continuous change is today the norm. The Organization must continue to evolve in a flexible and responsive manner to respond successfully to evolving global health challenges that in the future may be very different from today's.

The global public health architecture, within which WHO plays a key role, is increasingly complex. New players and partnerships continuously emerging. Moreover, harmonization efforts 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, it must also ensure that it's ways of working reflect this changing environment pro-actively.

Investments in health have increased substantially over the last 10 years. This has led to an increasing demand from countries for technical support from WHO. It has also impacted WHO's relations with major partners and contributors who are expecting increasing transparency and accountability both in terms of measurable results and

in the use of financial resources.

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

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

WHO's results-based management framework has been strengthened through the critical work done on the 11th General Programme of Work and the development of a Medium-Term Strategic Plan. More can be done, however, to ensure that the results-based management framework effectively builds on lessons learnt, better reflects country needs, and encourages greater collaboration throughout the Organization.

Management of financial resources is a challenge in an environment where more than 70% of the Organization's resources are voluntary contributions. Regular monitoring and reporting of the resource situation across the Organization has improved. More engagement internally with all technical programmes and externally with partners is required, however, to ensure better alignment of resources with the Programme Budget and to lower transaction costs.

Progress has been achieved in implementing far-reaching human resources reforms, including the streamlining of recruitment and classification procedures, the adoption of a global competency model for all staff, the establishment of a staff development fund and the roll-out of a leadership programme for all senior managers. Building on this, further efforts are needed to develop better human resource planning in WHO as well as 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 that allows the Organization to leverage its knowledge base better and to access timely information to support management decision-making is being implemented. It will be critical to ensure that such a system is continuously aligned and responsive to the changing needs of the Organization. Efforts undertaken to improve the quality of managerial and administrative service delivery throughout the Organization must be pursued.

Recognizing the decentralized nature of WHO's work across 142 country offices, 6 regional offices as well as headquarters, a key challenge throughout the Organization is the alignment between responsibility and authority, which is a prerequisite for robust accountability. Critical thinking is required to ensure that decision-making and implementation are being done at the right levels in the Organization to maximize efficiency and effectiveness, in line with the needs and demands of the Organization. Particular emphasis should be placed on strengthening the managerial capacity of WHO country offices.

STRATEGIC APPROACHES

To achieve the strategic objective and respond to the above challenges, a number of broad complementary approaches are required. Over the last two to three years significant efforts have been made in internal reforms to enhance WHO's administrative and managerial capabilities, efforts that are starting to show results. These approaches will be intensified during the next six years, and include moving from an Organization managed mainly through tight, overly bureaucratic controls, to post facto monitoring in support of greater delegation and accountability; shifting responsibility and decision making on the use of resources closer to where programmes are implemented; increasing managerial transparency and integrity; strengthening corporate governance and common Organization-wide systems, while recognizing regional specificities; and strengthening managerial and administrative capacities and competencies in all locations, in particular at country offices. Successfully implementing these strategic approaches will require active support from Member States through, for instance, efficient financing of the Organization's Programme Budget, including Voluntary Contributions.

More specifically, to assist the Organization to discharge its mandate more effectively and efficiently, the Secretariat will focus on five strategic approaches, organized along the operating model depicted in the scope:

- 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 comparative advantage 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 the mobilization of resources.
- Building a culture in WHO that embeds learning processes in the work of all staff, fosters ethical behaviour and integrity, rewards performance and facilitates mobility to ensure the effective and efficient staffing of the Organization.
- Strengthening operational support throughout the Organization by continuously seeking more cost-effective ways to provide administrative, information and managerial systems and services, including the optimization of the location from which such services can best be delivered; providing a safe and healthy working environment; managing through clearly defined service-level agreements.
- Providing frameworks and tools that will enable the implementation of robust accountability mechanisms

throughout the Organization while supporting collaboration and coordination across its different levels.

ASSUMPTIONS, RISKS AND OPTION ANALYSIS

A key assumption is that there is support both among Member States and within the Secretariat to continue and further accelerate the reforms that are being undertaken. Indeed, successfully improving managerial ways of working in a sustainable fashion requires strong leadership from senior management and a strong commitment from all staff throughout the Organization to ensure that strategies and policies are effectively translated into day-to-day practices and behaviour. Reaching out and communicating internally and externally will be critical to ensure that this objective remains relevant to the changing needs of the Organization.

It is also assumed that while changes in the external and internal environment are likely to occur over the six year period of the MTSP, these will not fundamentally alter the role and functions of WHO. Nonetheless, should this alteration occur, managerial reforms that are part of this strategic objective will shape WHO into a more flexible Organization able to adapt itself accordingly.

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. This, however, must not be done to the detriment of maintaining institutional knowledge, quality, appropriate controls and accountability. It must also be recognized that 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 a linear one due to economies of scale.

ORGANIZATION-WIDE EXPECTED RESULTS	**1.** The work of the Organization is guided by strategic and operational plans that build on lessons learnt; reflect country needs; are developed jointly across the Organization; and are effectively used to monitor performance and evaluate results.			
INDICATORS	**1.1** Proportion of approved workplans which incorporate lessons learnt from the previous biennium as identified in their PB assessment report and have been developed in a consultative process with the other levels of the Organization.	**1.2** Proportion of SO reports for the Mid-term Review and Programme Budget Assessment that have been peer reviewed and submitted in a timely fashion.	**1.3** Proportion of programmatic, thematic and country evaluations that comply with the Organization's Framework on Programme Evaluation.	**1.4** Proportion of managers trained and certified on WHO's accountability mechanisms.
BASELINE				
TARGETS TO BE ACHIEVED IN 2009	80%	80%	100%	90%
TARGETS TO BE ACHIEVED IN 2013	90%	90%	100%	95%

RESOURCES (IN US$ 000)	
Costs 2008-2009	35 000
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*There is a need to reinforce the overall results-based management framework, i.e. joint planning, quality assurance, peer reviews, etc. Despite the increase last biennium, more investment is required, esp. in regions and countries to ensure a more collaborative and integrated approach. Substantial efforts are required to ensure greater accountability of programmatic performance, as well as better governance of the planning and programme implementation process throughout the Organization. The main increase will target regions and countries.*

ORGANIZATION-WIDE EXPECTED RESULTS	**2.** Sound financial practices and efficient management of financial resources through continuous monitoring and mobilization of resources to ensure the alignment of resources with the Programme Budgets (as may be revised by the Director-General within his delegated authority).		
INDICATORS	**2.1** Implementation of International Public Sector Accounting Standards.	**2.2** Proportion of SOs with expenditure levels meeting Programme Budget targets.	**2.3** Proportion of voluntary contributions that are un-earmarked.
BASELINE			
TARGETS TO BE ACHIEVED IN 2009	International Public Sector Accounting Standards implemented.	80%	20%
TARGETS TO BE ACHIEVED IN 2013		100%	30%

	RESOURCES (IN US$ 000)	
	Costs 2008-2009	47 500
	Estimates 2010-2011	~ 000
	Estimates 2012-2013	~ 000
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.*	

ORGANIZATION-WIDE EXPECTED RESULTS	**3.** Human resource policies and practices in place to attract and retain top talent, promote learning and professional development, manage performance and foster ethical behaviour.		
INDICATORS	**3.1** Proportion of offices[1] with approved HR plans for a biennium.	**3.2** Number of staff assuming a new position or moving to a new location during a biennium.	**3.3** Proportion of e-PMDS users in compliance with PMDS cycle whose individual staff development objectives have been met.
BASELINE			
TARGETS TO BE ACHIEVED IN 2009	75%	300	75%
TARGETS TO BE ACHIEVED IN 2013	100%	400	95%

	RESOURCES (IN US$ 000)	
	Costs 2008-2009	33 009
	Estimates 2010-2011	~ 000
	Estimates 2012-2013	~ 000
JUSTIFICATION	*The proposed increase reflects the need to strengthen capacity at the regional level to support managers and staff better at regional and country levels. Significant efforts are required to strengthen the management of human resources further by putting in place new policies that reinforce staff mobility and rotation, performance management, etc.*	

ORGANIZATION-WIDE EXPECTED RESULTS	**4.** Information systems management strategies, policies and practices that ensure reliable, secure and cost-effective solutions while meeting the changing needs of the organization.		
INDICATORS	**4.1** Proportion of known proposals, projects, and applications tracked on a regular basis via global portfolio management processes.	**4.2** Number of IT disciplines[2] implemented Organization-wide according to best practice IT benchmarks (e.g., "IT Infrastructure Library").	**4.3** Proportion of offices using consistent real-time management information.
BASELINE			
TARGETS TO BE ACHIEVED IN 2009	80%	7	75%
TARGETS TO BE ACHIEVED IN 2013	95%	11	100%

	RESOURCES (IN US$ 000)	
	Costs 2008-2009	100 000
	Estimates 2010-2011	~ 000
	Estimates 2012-2013	~ 000
JUSTIFICATION	*Resources remain relatively stable in this area resulting from, on the one hand, a decrease in costs related to the implementation of the Global Management System, and on the other an increase in costs due to the fact that during the 08/09 biennium there will be an overlap between legacy IT systems and the new Global Management System requiring greater support.*	

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

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

ORGANIZATION-WIDE EXPECTED RESULTS	**5.** Managerial and administrative support services[1] necessary to the efficient functioning of the Organization provided in accordance with Service Level Agreements that emphasize quality and responsiveness.	
INDICATORS	**5.1** Proportion of services delivered according to criteria in Service Level Agreements.	**5.2** Proportion of procedures delivered according to criteria in emergency standard operating procedures.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	75%	75%
TARGETS TO BE ACHIEVED IN 2013	100%	100%

RESOURCES (IN US$ 000)	
Costs 2008-2009	168 000
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

JUSTIFICATION	*The overall workload is increasing throughout the Organization, and support services must reflect that. At the same time, on-going efforts to find more cost-effective ways of working will lead to some savings as well. On balance, however, and over the next Biennium, there is a need to increase the level of resources slightly here. (Note: further work is required over the next few months in the context of a global review of service delivery to refine the costing).*

ORGANIZATION-WIDE EXPECTED RESULTS	**6.** A physical working environment that is conducive to the well- being and safety of staff in all locations.	
INDICATORS	**6.1** Timely implementation of the Capital Master Plan, within the approved budget.	**6.2** Proportion of locations that have implemented policies and plans to improve staff health and safety in the workplace, including MOSS compliance.
BASELINE		
TARGETS TO BE ACHIEVED IN 2009	On target	75%
TARGETS TO BE ACHIEVED IN 2013	On target	95%

RESOURCES (IN US$ 000)	
Costs 2008-2009	174 000
Estimates 2010-2011	~ 000
Estimates 2012-2013	~ 000

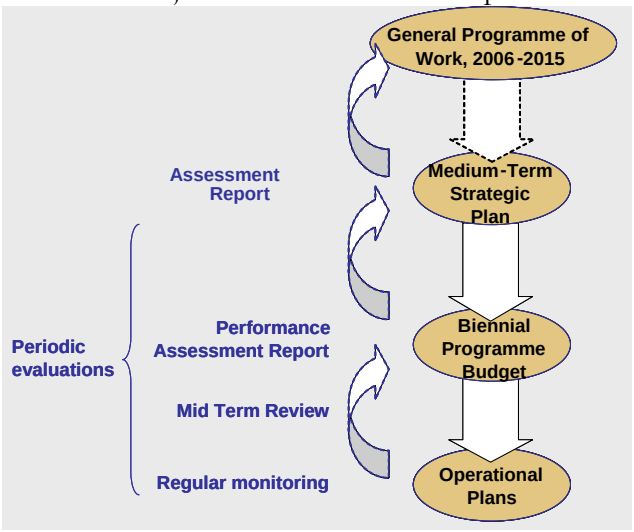
JUSTIFICATION	*The increase for this expected result is mainly due to increased security costs incurred in reaching Minimum Operating Safety Standards compliance. The overall resource requirement will be refined over the coming months as the Capital Master Plan is developed (due to be discussed at the EB119).*

[1] Includes services in the areas of Information Technology, Human Resources, Financial Resources, Logistics, and Language Services.

Monitoring and Evaluation of the Medium-term Strategic Plan and the Programme Budget

A number of instruments within WHO's results-based management framework serve to monitor, assess, evaluate and deal with potential performance issues related to the medium-term strategic plan and the associated Programme Budgets. The following paragraphs describe these different mechanisms, starting from operational plans and working up to the General Programme of Work.

Regular monitoring of programmatic and financial implementation on the basis of operational plans (work plans) occurs throughout the biennium, at least every six months. This serves to review and adjust where needed the implementation of specific activities in light of the programmatic and financial situation.



An organization-wide **Mid-term review** is carried out at the end of the first year of each biennium. This review focuses on assessing progress at each WHO office towards the achievement of the specific results for which each office is accountable. The mid-term review complements the un-audited financial report which is available at the same time.

The Programme Budget **Performance Assessment Report** undertaken at the end of the biennium complements the Audited Financial Report submitted at the same time. The Assessment Report provides an organization-wide summary of the programmatic performance of the Secretariat along with the broader lessons learnt from across the Organization

The Medium-term Strategic Plan is monitored through the Programme Budget Performance Assessment Reports. At the end of the six-year period, an **Assessment** will be undertaken to determine the extent to which the 16 strategic objectives in the Medium-term Strategic plan have been achieved. Data on the strategic objective indicators shall be collected to establish the degree to which the pre-defined targets have been reached. A detailed performance analysis will be provided, including a summary of the main achievements in the delivery of the strategic objectives; a discussion of the success factors and critical impediments, lessons learnt and how they can be applied by WHO in developing the subsequent strategic plan.

Another key component that helps close the loop of the results-based management framework is the periodic **Evaluation** of WHO programmes. These evaluations serve to assess critically the outcomes of WHO's work according to one of three perspectives: thematic, programmatic or country evaluations. About a dozen evaluations are performed each biennium.

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

The **General Programme of Work**, which provides the framework against which the Medium Term Strategic Plan is developed and implemented, will also be monitored. This will include in-depth assessment of the different priorities identified in the General Programme Of Work, as well as the monitoring of WHO's core functions to ensure their continued relevance, and to provide a mechanism for assuring the quality and influence of WHO's work.

Part II Draft Proposed Programme budget 2008-2009

ORIENTATION 2008-2009 BY STRATEGIC OBJECTIVES

STRATEGIC OBJECTIVE 1

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

ORGANIZATION-WIDE EXPECTED RESULTS	COST FOR 2008-2009
1. Policy and technical support provided to Member States to maximize equitable access of all people to vaccines of assured quality, including new immunization products and technologies, and to integrate other essential child health interventions with immunization.	149 361
2. Effective coordination and provision of support to Member States to achieve certification of poliomyelitis eradication and destruction, or appropriate containment of polioviruses, leading to a simultaneous cessation of oral polio vaccination globally.	251 654
3. Effective coordination and support provided to Member States to provide access for all populations to interventions for the prevention, control , elimination and eradication of neglected tropical diseases, including zoonotic diseases.	152 288
4. Provision of policy and technical support to Member States to enhance their capacity to carry out surveillance and monitoring of all communicable diseases of public health importance.	71 832
5. New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed and validated, and scientists from developing countries increasingly taking the lead in this research.	74 166
6. Member States assisted to achieve the minimum core capacities required by the International Health Regulations for the establishment and strengthening of alert and response systems for use in epidemics and other public health emergencies of international concern.	80 848
7. Member States and the international community equipped to detect, assess, respond and cope with major epidemic and pandemic-prone diseases (e.g. influenza, meningitis, yellow fever, haemorrhagic fevers, plague and smallpox) through the development and implementation of effective prevention, detection, preparedness and intervention tools, methodologies, practices, networks and partnerships.	62 214
8. Coordinated regional and global capacity, rapidly available to Member States, for detection, verification, risk assessment and response to epidemics and other public health emergencies of international concern.	57 871

RESOURCES BREAKDOWN

level at which allocated	COUNTRY	REGIONAL	HEADQUARTERS	TOTAL
Total 2008-2009				**900 234**
percentage by level				

STRATEGIC OBJECTIVE 2

To combat HIV/AIDS, malaria and tuberculosis.

ORGANIZATION-WIDE EXPECTED RESULTS	COST FOR 2008-2009
1. Guidelines, policy, strategy and other tools developed for prevention, treatment and care for HIV/AIDS, Malaria and TB, including innovative approaches for increasing coverage of the interventions among the poor, hard to reach and vulnerable populations.	124 000
2. Policy and technical support provided to countries towards expanded delivery of prevention, treatment and care interventions for HIV/AIDS, Malaria and TB; including integrated training and service delivery; wider service provider networks; strengthened laboratory capacities and better linkages with other health services, such as reproductive health, maternal, newborn and child health, sexually transmitted infections, nutrition, drug dependence treatment services, respiratory care, neglected diseases and environmental health.	256 000
3. Global guidance and technical support provided on policies and programmes to promote equitable access to essential medicines of assured quality for the prevention and treatment of HIV/AIDS, tuberculosis and malaria, and their rational use by prescribers and consumers; and uninterrupted supply diagnostics, safe blood and other essential commodities.	85 100
4. Global, regional and national surveillance, evaluation and monitoring systems strengthened and expanded to monitor progress towards targets and resource allocations for HIV/AIDS, malaria and tuberculosis control along with monitoring the impact of control efforts and the evolution of drug resistance.	124 000
5. Political commitment sustained and mobilization of resources ensured through advocacy and nurturing of HIV/AIDS, malaria and tuberculosis partnerships at country, regional and global levels; support provided to countries as appropriate to develop/strengthen and implement mechanisms for resource mobilization and utilization and increase the absorption capacity of available resources; and engagement of communities and affected persons increased to maximize the reach and performance of HIV/AIDS, malaria and tuberculosis control.	35 000
6. New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of HIV, tuberculosis and malaria developed and validated, with scientists from developing countries increasingly taking the lead in this research.	87 000

RESOURCES BREAKDOWN

level at which allocated	COUNTRY	REGIONAL	HEADQUARTERS	TOTAL
Total 2008-2009				**711 100**
percentage by level				

STRATEGIC OBJECTIVE 3

Prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries.

ORGANIZATION-WIDE EXPECTED RESULTS	COST FOR 2008-2009
1. Advocacy and support provided to increase political, financial and technical commitment in countries in order to address chronic noncommunicable conditions, mental and behavioural disorders, violence and injuries and disabilities.	24 200
2. Guidance and support provided to countries for the development and implementation of policies, strategies and regulations for chronic noncommunicable conditions, mental and behavioural disorders, violence and injuries and disabilities.	29 900
3. Improved capacity in countries to collect, analyse, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable conditions, mental and behavioural disorders, violence and injuries and disabilities.	28 000
4. Improved evidence compiled by WHO on the cost-effectiveness of interventions to address chronic noncommunicable conditions, mental and behavioral disorders, violence and injuries and disabilities.	23 800
5. Guidance and support provided to countries for the preparation and implementation of multisectoral population-wide programmes to prevent mental and behavioural disorders, violence and injuries and hearing and visual impairment.	25 100
6. Guidance and support provided to countries to strengthen their health and social systems in order to prevent and manage chronic noncommunicable conditions, mental and behavioural disorders, violence and injuries and disabilities.	26 200

RESOURCES BREAKDOWN

level at which allocated	COUNTRY	REGIONAL	HEADQUARTERS	TOTAL
Total 2008-2009				**157 200**
percentage by level				

STRATEGIC OBJECTIVE 4

To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, while improving sexual and reproductive health and promoting active and healthy ageing for all individuals, using a life-course approach and addressing equity gaps.

ORGANIZATION-WIDE EXPECTED RESULTS	COST FOR 2008-2009
1. Support to Member States to develop a comprehensive policy, plan and strategy for scaling up towards universal access to effective interventions in collaboration with other programmes, paying attention to gender inequality and gaps in health equity, providing a continuum of care throughout the life course, integrating service delivery across different levels of the health system and strengthening coordination with civil society and the private sector.	27 025
2. National research capacity strengthened as necessary and new evidence, products, technologies, interventions and delivery approaches of global and/or national relevance available to improve maternal, newborn, child and adolescent health, to promote active and healthy ageing, and to improve sexual and reproductive health.	49 025
3. Guidelines, approaches and tools for improving maternal care in use at the country level, including technical support provided to Member States for intensified action to ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods, particularly for poor and disadvantaged populations, with progress monitored.	70 025
4. Guidelines, approaches and tools for improving neonatal survival and health in use at country level, with technical support provided to Member States for intensified action towards the achievement of universal coverage along with effective interventions and progress monitoring.	68 025
5. Guidelines, approaches and tools for improving child health and development in use at the country level, with technical support provided to Member States for intensified action towards the achievement of universal coverage of the population with effective interventions, along with the monitoring of progress, taking into consideration international and human rights norms and standards, notably those stipulated in the Convention of the Rights of the Child.	38 025
6. Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, along with the scaling up of a package of effective prevention, treatment and care interventions in accordance with established standards.	36 025
7. Guidelines, approaches and tools available, with technical support provided to Member States for accelerated action towards implementing the Global Reproductive Health Strategy, with particular emphasis on ensuring equitable access to quality sexual and reproductive health services, particularly in areas of unmet need, and with respect for human rights as they relate to sexual and reproductive health.	59 025
8. Guidelines, approaches, tools, and technical assistance provided to Member States for increased advocacy for ageing and health to be considered as a public health issue, for the development and implementation of policies and programmes aiming at maintaining maximum functional capacity throughout the life course and for the training of health care providers in approaches that ensure healthy ageing.	14 025

RESOURCES BREAKDOWN

level at which allocated	COUNTRY	REGIONAL	HEADQUARTERS	**TOTAL**
Total 2008-2009				**361 200**
percentage by level				

STRATEGIC OBJECTIVE 5

Reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.

ORGANIZATION-WIDE EXPECTED RESULTS	COST FOR 2008-2009
1. Norms and standards developed, capacity built and technical support provided to Member States for the development and strengthening of national emergency preparedness plans and programmes.	42 000
2. Norms and standards developed, capacity built and technical support provided to Member States for a timely response to disasters associated with natural hazards and to conflict-related crises.	62 000
3. Norms and standards developed, capacity built and technical support provided to Member States for assessing needs along with planning and implementing transition and recovery actions in post conflict and post disasters situations.	51 500
4. Coordinated technical support on communicable disease control in natural disaster and conflict situations provided to Member States.	35 000
5. Support provided to Member States for strengthening national preparedness as well as alert and response mechanisms for food safety and environmental health emergencies.	15 500
6. Effective communications issued, partnerships formed and coordination developed with other UN agencies, governments, local and international NGOs ,academic institutions and professional associations at the country, regional and global levels.	13 500

RESOURCES BREAKDOWN

level at which allocated	COUNTRY	REGIONAL	HEADQUARTERS	TOTAL
Total 2008-2009				**219 500**
percentage by level				

STRATEGIC OBJECTIVE 6

Promote health and development, prevent and reduce risk factors for health conditions associated with tobacco, alcohol, drugs and other psychoactive substance use, unhealthy diets, physical inactivity and unsafe sex.

ORGANIZATION-WIDE EXPECTED RESULTS	COST FOR 2008-2009
1. Advice and support provided to countries to strengthen their health promotion capacity across all relevant programmes, and to establish effective multisectoral and multidisciplinary collaborations to promote health and prevent and reduce the occurrence of major risk factors.	41 900
2. Guidance and support provided to strengthen national systems for major risk factor surveillance by developing, validating and disseminating frameworks, tools and operating procedures to countries with a high or increasing burden of death and disability attributable to the major risk factors.	19 900
3. Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to countries with a high and increasing burden to strengthen institutions in order to address/prevent public health problems associated with tobacco. Support also provided to the Conference of the Parties to the WHO Framework Convention on Tobacco Control for implementation of the provisions of the Convention and development of protocols and guidelines.	40 900
4. Evidence-based and ethical policies, strategies, recommendations, standards, guidelines developed, and technical support provided to countries with a high and increasing burden to strengthen institutions in order to address/prevent public health problems associated with alcohol, drugs and other psychoactive substance use.	20 900
5. Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed and technical support provided to countries with a high and increasing burden to strengthen institutions in order to address/prevent public health problems associated with unhealthy diets and physical inactivity.	19 900
6. Evidence-based and ethical policies, strategies, interventions, recommendations, standards and guidelines developed, and technical support provided to countries to promote safe sex and strengthen institutions in order to address and manage social and individual consequences of unsafe sex.	18 900

RESOURCES BREAKDOWN

level at which allocated	COUNTRY	REGIONAL	HEADQUARTERS	TOTAL
Total 2008-2009				**162 400**
percentage by level				

STRATEGIC OBJECTIVE 7

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

ORGANIZATION-WIDE EXPECTED RESULTS	COST FOR 2008-2009
1. Significance of social and economic determinants of health recognized across the Organization and incorporated into WHO normative work and technical collaboration with Member States and other partners.	21 220
2. Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels to address social and economic determinants of health and to encourage poverty-reduction and sustainable development.	14 920
3. Social and economic data relevant to health collected, collated and analysed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).	10 520
4. Ethics- and rights-based approaches to health promoted within WHO and at the national and international levels.	8 320
5. Gender-analysis and responsive actions incorporated into WHO's normative work and support to countries towards the development of gender-sensitive policies and programmes in Member States.	11 819

RESOURCES BREAKDOWN

level at which allocated	COUNTRY	REGIONAL	HEADQUARTERS	TOTAL
Total 2008-2009				**66 799**
percentage by level				

STRATEGIC OBJECTIVE 8

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

ORGANIZATION-WIDE EXPECTED RESULTS	COST FOR 2008-2009
1. Evidence-based assessments, norms and guidance on priority environmental health risks (e.g., air quality, chemical substances, EMF, radon, drinking water, waste water reuse,) developed and updated; technical support to international environmental agreements and for monitoring MDG.	35 900
2. Technical support and guidance provided to countries for the implementation of primary prevention interventions that reduce environmental health risks; enhance safety; and promote public health, including in specific settings and among vulnerable population groups (e.g. children, elderly).	23 900
3. Technical assistance and support to countries for strengthening occupational and environmental health policy- making, planning of preventive interventions, service delivery and surveillance.	26 800
4. Guidance, tools, and initiatives supporting the health sector to influence policies in priority sectors (e.g. energy, transport, agriculture); assessing health impacts; costs and benefits of policy alternatives in those sectors; and harnessing non-health sector investments to improve health, environment and safety.	26 600
5. Enhance Health Sector leadership to support a healthier environment and influence public policies in all sectors so as to address the root causes of environmental threats to health. Including by responding to emerging and re-emerging environmental health concerns from development, evolving technologies, global environmental change as well as consumption and production patterns.	19 100

RESOURCES BREAKDOWN

level at which allocated	COUNTRY	REGIONAL	HEADQUARTERS	TOTAL
Total 2008-2009				**132 300**
percentage by level				

STRATEGIC OBJECTIVE 9

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

ORGANIZATION-WIDE EXPECTED RESULTS	COST FOR 2008-2009
1. Partnerships and alliances formed, leadership built and coordination and networking developed with all stakeholders at country, regional and global levels, to promote advocacy and communication, stimulate intersectoral actions, increase investment in nutrition, food safety and food security interventions, and develop and support a research agenda.	24 000
2. Norms - including references, requirements, research priorities, guidelines, training manuals and standards produced and disseminated to Member States to increase their capacity to assess and respond to all forms of malnutrition, zoonotic and non-zoonotic food-borne diseases, and to promote healthy dietary practices.	15 000
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 increased, in stable as well as humanitarian crisis situations.	13 400
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 as well as humanitarian crisis situations.	29 900
5. Zoonotic and non-zoonotic foodborne diseases surveillance, prevention and control systems strengthened and food hazard monitoring and evaluation programmes established and integrated into existing national surveillance systems with results being disseminated to all key players.	20 400
6. Capacity built and support provided to countries, including their participation in international standard-setting 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.	24 000

RESOURCES BREAKDOWN

level at which allocated	COUNTRY	REGIONAL	HEADQUARTERS	TOTAL
Total 2008-2009				**126 700**
percentage by level				

STRATEGIC OBJECTIVE 10

To improve the organization, management and delivery of health services.

ORGANIZATION-WIDE EXPECTED RESULTS	COST FOR 2008-2009
1. Service delivery policies and their implementation in Member States increasingly reflect standards, best practices and equity principles endorsed by or developed with support from WHO.	45 000
2. Organizational and managerial capacities of service delivery institutions and networks in Member States are strengthened with a view of improving service delivery performance.	32 000
3. Mechanisms and regulatory systems are in place in Member States to ensure collaboration and synergies between public and non-public service delivery systems that lead to better overall performance in service delivery.	25 000
4. Policy, structural and managerial changes in the health services architecture of Member States are implemented to ensure that disease-specific programmes are adequately embedded in general health services so as to enhance overall performance of health service delivery.	42 000

RESOURCES BREAKDOWN

level at which allocated	COUNTRY	REGIONAL	HEADQUARTERS	TOTAL
Total 2008-2009				**144 000**
percentage by level				

STRATEGIC OBJECTIVE 11

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

ORGANIZATION-WIDE EXPECTED RESULTS	COST FOR 2008-2009
1. Improved country capacity and practices in national and local health sector policy making, regulation, strategic planning, implementation of reforms, intersectoral and inter-institutional coordination.	21 787
2. Improved coordination of donor assistance at the global and country level to achieve national health system development targets and global health goals.	4 387
3. Contribute to strengthened country health-information systems that provide and use quality and timely information for local health problems and programmes and for monitoring of major international goals.	49 686
4. Contribute to better knowledge and evidence for health decision-making, by consolidation and publication of existing evidence, facilitation of knowledge generation in priority areas and global leadership in research for health, including ensuring ethical conduct.	26 187
5. Strengthened national health research for health-systems development, within the context of regional and international research and engagement of civil society.	26 987
6. Knowledge management and e-health evidence, policies and strategies developed to strengthen health systems.	32 286

RESOURCES BREAKDOWN

level at which allocated	COUNTRY	REGIONAL	HEADQUARTERS	TOTAL
Total 2008-2009				**161 320**
percentage by level				

STRATEGIC OBJECTIVE 12

Ensure improved access, quality and use of medical products and technologies.

ORGANIZATION-WIDE EXPECTED RESULTS	COST FOR 2008-2009
1. Development and monitoring of comprehensive national policies on access, quality and use of essential medical products and technologies advocated and supported.	36 314
2. International norms, standards and guidelines for the quality, safety, efficacy and cost-effectiveness of medical products and technologies developed and their national/regional implementation advocated and supported.	64 537
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 WHO, regional and national programmes.	27 724

RESOURCES BREAKDOWN

level at which allocated	COUNTRY	REGIONAL	HEADQUARTERS	TOTAL
Total 2008-2009				**128 575**
percentage by level				

STRATEGIC OBJECTIVE 13

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

ORGANIZATION-WIDE EXPECTED RESULTS	COST FOR 2008-2009
1. Strengthened country capacity to lead the process of health workforce development.	26 488
2. Strengthened information and knowledge base on health workforce development at national, regional and global levels.	20 188
3. Technical support provided to countries in crisis to reduce their shortages by addressing the production, distribution and skill mix of their health workforce.	56 588
4. Strengthened networking and partnerships at global, regional, and country level, to strengthen the institutional infrastructure in countries with HRH crisis.	14 588

RESOURCES BREAKDOWN

level at which allocated	COUNTRY	REGIONAL	HEADQUARTERS	TOTAL
Total 2008-2009				**117 852**
percentage by level				

STRATEGIC OBJECTIVE 14

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

ORGANIZATION-WIDE EXPECTED RESULTS	COST FOR 2008-2009
1. Ethical and evidence-based policy and technical support provided to Member States to improve the performance of health system financing systems in terms of financial protection, equity in finance and use of services as well as efficiency of resource use.	32 495
2. International, regional and national advocacy, information and technical support designed to mobilize additional and predictable funding for health.	10 795
3. Measurement tools developed to analyse transparency and accountability in health financing systems, and technical support provided to support their use where needed.	15 995
4. Norms and standards developed for resource tracking, estimating the economic consequences of illness, costs and effects of interventions, financial catastrophe and impoverishment, and their implementation promoted, supported and monitored.	7 295
5. Steps taken to build capacity in health financial policy development, production, interpretation and the use of information.	17 995
6. Steps taken to stimulate the generation, translation and dissemination of valuable knowledge and to shape the research agenda.	8 095

RESOURCES BREAKDOWN

level at which allocated	COUNTRY	REGIONAL	HEADQUARTERS	TOTAL
Total 2008-2009				**92 670**
percentage by level				

STRATEGIC OBJECTIVE 15

Provide leadership, strengthen governance and foster partnership and collaboration in engagement with countries, to fulfil the mandate of WHO in advancing the global health agenda as articulated in the 11th General Programme of Work.

ORGANIZATION-WIDE EXPECTED RESULTS	COST FOR 2008-2009
1. Effective leadership and direction of the Organization through the enhancement of governance, coherence, accountability and synergy of the work of WHO.	66 500
2. Effective WHO country presence to implement WHO Country Cooperation Strategies that are aligned with, Member States' national health and development agenda, and harmonized with the UN country team and other development partners.	98 700
3. A convening framework maintained for the ethical development and implementation of the normative aspects of health through agreements, treaties, laws, and policies	13 600
4. Global health and development architecture effectively providing more sustained and predictable technical and financial resources for health, based on a common health agenda which responds to the health needs and priorities of Member States.	14 900
5. 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.	30 000

RESOURCES BREAKDOWN

level at which allocated	COUNTRY	REGIONAL	HEADQUARTERS	TOTAL
Total 2008-2009				**223 700**
percentage by level				

STRATEGIC OBJECTIVE 16

Develop and sustain WHO as a flexible, learning Organization, enabling it to carry out its mandate more efficiently and effectively.

ORGANIZATION-WIDE EXPECTED RESULTS	COST FOR 2008-2009
1. The work of the Organization is guided by strategic and operational plans that build on lessons learnt; reflect country needs; are developed jointly across the Organization; and are effectively used to monitor performance and evaluate results.	35 000
2. Sound financial practices and efficient management of financial resources through continuous monitoring and mobilization of resources to ensure the alignment of resources with the Programme Budgets (as may be revised by the Director-General within his delegated authority).	47 500
3. Human resource policies and practices in place to attract and retain top talent, promote learning and professional development, manage performance and foster ethical behaviour.	33 009
4. Information systems management strategies, policies and practices that ensure reliable, secure and cost-effective solutions while meeting the changing needs of the organization.	100 000
5. Managerial and administrative support services necessary to the efficient functioning of the Organization provided in accordance with Service Level Agreements that emphasize quality and responsiveness.	168 000
6. A physical working environment that is conducive to the well-being and safety of staff in all locations.	174 000

RESOURCES BREAKDOWN

level at which allocated	COUNTRY	REGIONAL	HEADQUARTERS	TOTAL
Total 2008-2009				**557 509**
percentage by level				

Annex 1: Allocation by strategic

Strategic objective	Africa	The Americas	South-East Asia
1. To reduce the health, social and economic burden of communicable diseases.	317 064	32 800	135 100
2. To combat HIV/AIDS, malaria and tuberculosis.	243 400	48 800	81 300
3. Prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries.	18 200	10 000	18 000
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, while improving sexual and reproductive health and promoting active and healthy ageing for all individuals, using a life-course approach and addressing equity gaps.	115 000	27 700	51 100
5. Reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.	66 200	20 000	24 500
6. Promote health and development, prevent and reduce risk factors for health conditions associated with tobacco, alcohol, drugs and other psychoactive substance use, unhealthy diets, physical inactivity and unsafe sex.	26 000	14 000	13 000
7. Address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.	9 378	7 000	4 900
8. Promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.	19 000	12 300	14 000
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development.	38 500	14 700	14 100
10. To improve the organization, management and delivery of health services.	46 000	10 000	15 000
11. To strengthen leadership, governance and the evidence base of health systems.	32 030	10 800	16 100
12. Ensure improved access, quality and use of medical products and technologies.	22 867	9 000	12 700
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes.	34 952	10 000	17 100
14. To extend social protection through fair, adequate and sustainable financing.	29 100	7 400	7 000
15. Provide leadership, strengthen governance and foster partnership and collaboration in engagement with countries, to fulfil the mandate of WHO in advancing the global health agenda as articulated in the 11th General Programme of Work.	50 500	17 000	18 200
16. Develop and sustain WHO as a flexible, learning Organization, enabling it to carry out its mandate more efficiently and effectively.	120 260	30 500	53 900
TOTAL	**1 188 451**	**282 000**	**496 000**

objective and office, 2008-2009 (in US$ thousands)

Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
30 000	101 400	53 870	230 000	**900 234**
36 000	54 000	59 600	188 000	**711 100**
16 000	20 000	22 000	53 000	**157 200**
14 000	40 000	25 400	88 000	**361 200**
21 000	41 000	16 800	30 000	**219 500**
10 000	25 000	32 000	42 400	**162 400**
6 000	12 000	2 500	25 021	**66 799**
18 000	16 500	12 500	40 000	**132 300**
6 000	9 000	19 400	25 000	**126 700**
12 000	20 000	11 000	30 000	**144 000**
22 000	18 600	13 760	48 030	**161 320**
7 000	16 900	10 100	50 008	**128 575**
6 000	16 300	13 500	20 000	**117 852**
8 000	12 200	9 000	19 970	**92 670**
25 000	27 000	16 000	70 000	**223 700**
40 000	39 000	33 849	240 000	**557 509**
277 000	**468 900**	**351 279**	**1 199 429**	**4 263 059**

Annex 2: Allocation by strategic objective, organization-wide

Strategic objective 1: To reduce the health, social and economic burden of communicable diseases.			
Organization-wide expected result	**Africa**	**The Americas**	**South-East Asia**
Policy and technical support provided to Member States to maximize equitable access of all people to vaccines of assured quality, including new immunization products and technologies, and to integrate other essential child health interventions with immunization.			
Effective coordination and provision of support to Member States to achieve certification of poliomyelitis eradication and destruction, or appropriate containment of polioviruses, leading to a simultaneous cessation of oral polio vaccination globally.			
Effective coordination and support provided to Member States to provide access for all populations to interventions for the prevention, control , elimination and eradication of neglected tropical diseases, including zoonotic diseases.			
Provision of policy and technical support to Member States to enhance their capacity to carry out surveillance and monitoring of all communicable diseases of public health importance.			
New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed and validated, and scientists from developing countries increasingly taking the lead in this research.			
Member States assisted to achieve the minimum core capacities required by the International Health Regulations for the establishment and strengthening of alert and response systems for use in epidemics and other public health emergencies of international concern.			
Member States and the international community equipped to detect, assess, respond and cope with major epidemic and pandemic-prone diseases (e.g. influenza, meningitis, yellow fever, haemorrhagic fevers, plague and smallpox) through the development and implementation of effective prevention, detection, preparedness and intervention tools, methodologies, practices, networks and partnerships.			
Coordinated regional and global capacity, rapidly available to Member States, for detection, verification, risk assessment and response to epidemics and other public health emergencies of international concern.			
TOTAL			
Strategic objective 2: To combat HIV/AIDS, malaria and tuberculosis.			
Organization-wide expected result	**Africa**	**The Americas**	**South-East Asia**
Guidelines, policy, strategy and other tools developed for prevention, treatment and care for HIV/AIDS, Malaria and TB, including innovative approaches for increasing coverage of the interventions among the poor, hard to reach and vulnerable populations.			

expected result and office, 2008-2009 (in US$ thousands)

Europe	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**
Europe	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**

Annex 2: Allocation by strategic objective, organization-wide

Organization-wide expected result	Africa	The Americas	South-East Asia
Policy and technical support provided to countries towards expanded delivery of prevention, treatment and care interventions for HIV/AIDS, Malaria and TB; including integrated training and service delivery; wider service provider networks; strengthened laboratory capacities and better linkages with other health services, such as reproductive health, maternal, newborn and child health, sexually transmitted infections, nutrition, drug dependence treatment services, respiratory care, neglected diseases and environmental health.			
Global guidance and technical support provided on policies and programmes to promote equitable access to essential medicines of assured quality for the prevention and treatment of HIV/AIDS, tuberculosis and malaria, and their rational use by prescribers and consumers; and uninterrupted supply diagnostics, safe blood and other essential commodities.			
Global, regional and national surveillance, evaluation and monitoring systems strengthened and expanded to monitor progress towards targets and resource allocations for HIV/AIDS, malaria and tuberculosis control along with monitoring the impact of control efforts and the evolution of drug resistance.			
Political commitment sustained and mobilization of resources ensured through advocacy and nurturing of HIV/AIDS, malaria and tuberculosis partnerships at country, regional and global levels; support provided to countries as appropriate to develop/strengthen and implement mechanisms for resource mobilization and utilization and increase the absorption capacity of available resources; and engagement of communities and affected persons increased to maximize the reach and performance of HIV/AIDS, malaria and tuberculosis control.			
New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of HIV, tuberculosis and malaria developed and validated, with scientists from developing countries increasingly taking the lead in this research.			
TOTAL			
Strategic objective 3: Prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries.			
Organization-wide expected result	**Africa**	**The Americas**	**South-East Asia**
Advocacy and support provided to increase political, financial and technical commitment in countries in order to address chronic noncommunicable conditions, mental and behavioural disorders, violence and injuries and disabilities.			
Guidance and support provided to countries for the development and implementation of policies, strategies and regulations for chronic noncommunicable conditions, mental and behavioural disorders, violence and injuries and disabilities.			
Improved capacity in countries to collect, analyse, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable conditions, mental and behavioural disorders, violence and injuries and disabilities.			

expected result and office, 2008-2009 - continued (in US$ thousands)

Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL

Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL

Annex 2: Allocation by strategic objective, organization-wide

Organization-wide expected result	Africa	The Americas	South-East Asia
Improved evidence compiled by WHO on the cost-effectiveness of interventions to address chronic noncommunicable conditions, mental and behavioral disorders, violence and injuries and disabilities.			
Guidance and support provided to countries for the preparation and implementation of multisectoral population-wide programmes to prevent mental and behavioural disorders, violence and injuries and hearing and visual impairment.			
Guidance and support provided to countries to strengthen their health and social systems in order to prevent and manage chronic noncommunicable conditions, mental and behavioural disorders, violence and injuries and disabilities.			
TOTAL			
Strategic objective 4: To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, while improving sexual and reproductive health and promoting active and healthy ageing for all individuals, using a life-course approach and addressing equity gaps.			
Organization-wide expected result	**Africa**	**The Americas**	**South-East Asia**
Support to Member States to develop a comprehensive policy, plan and strategy for scaling up towards universal access to effective interventions in collaboration with other programmes, paying attention to gender inequality and gaps in health equity, providing a continuum of care throughout the life course, integrating service delivery across different levels of the health system and strengthening coordination with civil society and the private sector.			
National research capacity strengthened as necessary and new evidence, products, technologies, interventions and delivery approaches of global and/or national relevance available to improve maternal, newborn, child and adolescent health, to promote active and healthy ageing, and to improve sexual and reproductive health.			
Guidelines, approaches and tools for improving maternal care in use at the country level, including technical support provided to Member States for intensified action to ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods, particularly for poor and disadvantaged populations, with progress monitored.			
Guidelines, approaches and tools for improving neonatal survival and health in use at country level, with technical support provided to Member States for intensified action towards the achievement of universal coverage along with effective interventions and progress monitoring.			
Guidelines, approaches and tools for improving child health and development in use at the country level, with technical support provided to Member States for intensified action towards the achievement of universal coverage of the population with effective interventions, along with the monitoring of progress, taking into consideration international and human rights norms and standards, notably those stipulated in the Convention of the Rights of the Child.			

expected result and office, 2008-2009 - continued (in US$ thousands)

Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL

Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL

Annex 2: Allocation by strategic objective, organization-wide

Organization-wide expected result	Africa	The Americas	South-East Asia
Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, along with the scaling up of a package of effective prevention, treatment and care interventions in accordance with established standards.			
Guidelines, approaches and tools available, with technical support provided to Member States for accelerated action towards implementing the Global Reproductive Health Strategy, with particular emphasis on ensuring equitable access to quality sexual and reproductive health services, particularly in areas of unmet need, and with respect for human rights as they relate to sexual and reproductive health.			
Guidelines, approaches, tools, and technical assistance provided to Member States for increased advocacy for ageing and health to be considered as a public health issue, for the development and implementation of policies and programmes aiming at maintaining maximum functional capacity throughout the life course and for the training of health care providers in approaches that ensure healthy ageing.			
TOTAL			
Strategic objective 5: Reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.			
Organization-wide expected result	**Africa**	**The Americas**	**South-East Asia**
Norms and standards developed, capacity built and technical support provided to Member States for the development and strengthening of national emergency preparedness plans and programmes.			
Norms and standards developed, capacity built and technical support provided to Member States for a timely response to disasters associated with natural hazards and to conflict-related crises.			
Norms and standards developed, capacity built and technical support provided to Member States for assessing needs along with planning and implementing transition and recovery actions in post conflict and post disasters situations.			
Coordinated technical support on communicable disease control in natural disaster and conflict situations provided to Member States.			
Support provided to Member States for strengthening national preparedness as well as alert and response mechanisms for food safety and environmental health emergencies.			
Effective communications issued, partnerships formed and coordination developed with other UN agencies, governments, local and international NGOs ,academic institutions and professional associations at the country, regional and global levels.			
TOTAL			

expected result and office, 2008-2009 - continued (in US$ thousands)

Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL

Annex 2: Allocation by strategic objective, organization-wide

Strategic objective 6: Promote health and development, prevent and reduce risk factors for health conditions associated with tobacco, alcohol, drugs and other psychoactive substance use, unhealthy diets, physical inactivity and unsafe sex.			
Organization-wide expected result	**Africa**	**The Americas**	**South-East Asia**
Advice and support provided to countries to strengthen their health promotion capacity across all relevant programmes, and to establish effective multisectoral and multidisciplinary collaborations to promote health and prevent and reduce the occurrence of major risk factors.			
Guidance and support provided to strengthen national systems for major risk factor surveillance by developing, validating and disseminating frameworks, tools and operating procedures to countries with a high or increasing burden of death and disability attributable to the major risk factors.			
Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to countries with a high and increasing burden to strengthen institutions in order to address/prevent public health problems associated with tobacco. Support also provided to the Conference of the Parties to the WHO Framework Convention on Tobacco Control for implementation of the provisions of the Convention and development of protocols and guidelines.			
Evidence-based and ethical policies, strategies, recommendations, standards, guidelines developed, and technical support provided to countries with a high and increasing burden to strengthen institutions in order to address/prevent public health problems associated with alcohol, drugs and other psychoactive substance use.			
Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed and technical support provided to countries with a high and increasing burden to strengthen institutions in order to address/prevent public health problems associated with unhealthy diets and physical inactivity.			
Evidence-based and ethical policies, strategies, interventions, recommendations, standards and guidelines developed, and technical support provided to countries to promote safe sex and strengthen institutions in order to address and manage social and individual consequences of unsafe sex.			
TOTAL			
Strategic objective 7: Address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.			
Organization-wide expected result	**Africa**	**The Americas**	**South-East Asia**
Significance of social and economic determinants of health recognized across the Organization and incorporated into WHO normative work and technical collaboration with Member States and other partners.			
Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels to address social and economic determinants of health and to encourage poverty-reduction and sustainable development.			

expected result and office, 2008-2009 - continued (in US$ thousands)

Europe	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**
Europe	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**

Annex 2: Allocation by strategic objective, organization-wide

Organization-wide expected result	Africa	The Americas	South-East Asia
Social and economic data relevant to health collected, collated and analysed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).			
Ethics- and rights-based approaches to health promoted within WHO and at the national and international levels.			
Gender-analysis and responsive actions incorporated into WHO's normative work and support to countries towards the development of gender-sensitive policies and programmes in Member States.			
TOTAL			
Strategic objective 8: Promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.			
Organization-wide expected result	**Africa**	**The Americas**	**South-East Asia**
Evidence-based assessments, norms and guidance on priority environmental health risks (e.g., air quality, chemical substances, EMF, radon, drinking water, waste water reuse,) developed and updated; technical support to international environmental agreements and for monitoring MDG.			
Technical support and guidance provided to countries for the implementation of primary prevention interventions that reduce environmental health risks; enhance safety; and promote public health, including in specific settings and among vulnerable population groups (e.g. children, elderly).			
Technical assistance and support to countries for strengthening occupational and environmental health policy- making, planning of preventive interventions, service delivery and surveillance.			
Guidance, tools, and initiatives supporting the health sector to influence policies in priority sectors (e.g. energy, transport, agriculture); assessing health impacts; costs and benefits of policy alternatives in those sectors; and harnessing non-health sector investments to improve health, environment and safety.			
Enhance Health Sector leadership to support a healthier environment and influence public policies in all sectors so as to address the root causes of environmental threats to health. Including by responding to emerging and re-emerging environmental health concerns from development, evolving technologies, global environmental change as well as consumption and production patterns.			
TOTAL			

expected result and office, 2008-2009 - continued (in US$ thousands)

Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL

Annex 2: Allocation by strategic objective, organization-wide

Strategic objective 9: To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development.			
Organization-wide expected result	**Africa**	**The Americas**	**South-East Asia**
Partnerships and alliances formed, leadership built and coordination and networking developed with all stakeholders at country, regional and global levels, to promote advocacy and communication, stimulate intersectoral actions, increase investment in nutrition, food safety and food security interventions, and develop and support a research agenda.			
Norms - including references, requirements, research priorities, guidelines, training manuals and standards produced and disseminated to Member States to increase their capacity to assess and respond to all forms of malnutrition, zoonotic and non-zoonotic food-borne diseases, and to promote healthy dietary practices.			
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 increased, in stable as well as humanitarian crisis situations.			
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 as well as humanitarian crisis situations.			
Zoonotic and non-zoonotic foodborne diseases surveillance, prevention and control systems strengthened and food hazard monitoring and evaluation programmes established and integrated into existing national surveillance systems with results being disseminated to all key players.			
Capacity built and support provided to countries, including their participation in international standard-setting 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.			
TOTAL			
Strategic objective 10: To improve the organization, management and delivery of health services.			
Organization-wide expected result	**Africa**	**The Americas**	**South-East Asia**
Service delivery policies and their implementation in Member States increasingly reflect standards, best practices and equity principles endorsed by or developed with support from WHO.			
Organizational and managerial capacities of service delivery institutions and networks in Member States are strengthened with a view of improving service delivery performance.			

expected result and office, 2008-2009 - continued (in US$ thousands)

Europe	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**
Europe	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**

Annex 2: Allocation by strategic objective, organization-wide

Organization-wide expected result	Africa	The Americas	South-East Asia
Mechanisms and regulatory systems are in place in Member States to ensure collaboration and synergies between public and non-public service delivery systems that lead to better overall performance in service delivery.			
Policy, structural and managerial changes in the health services architecture of Member States are implemented to ensure that disease-specific programmes are adequately embedded in general health services so as to enhance overall performance of health service delivery.			
TOTAL			
Strategic objective 11: To strengthen leadership, governance and the evidence base of health systems.			
Organization-wide expected result	**Africa**	**The Americas**	**South-East Asia**
Improved country capacity and practices in national and local health sector policy making, regulation, strategic planning, implementation of reforms, intersectoral and inter-institutional coordination.			
Improved coordination of donor assistance at the global and country level to achieve national health system development targets and global health goals.			
Contribute to strengthened country health-information systems that provide and use quality and timely information for local health problems and programmes and for monitoring of major international goals.			
Contribute to better knowledge and evidence for health decision-making, by consolidation and publication of existing evidence, facilitation of knowledge generation in priority areas and global leadership in research for health, including ensuring ethical conduct.			
Strengthened national health research for health-systems development, within the context of regional and international research and engagement of civil society.			
Knowledge management and e-health evidence, policies and strategies developed to strengthen health systems.			
TOTAL			
Strategic objective 12: Ensure improved access, quality and use of medical products and technologies.			
Organization-wide expected result	**Africa**	**The Americas**	**South-East Asia**
Development and monitoring of comprehensive national policies on access, quality and use of essential medical products and technologies advocated and supported.			
International norms, standards and guidelines for the quality, safety, efficacy and cost-effectiveness of medical products and technologies developed and their national/regional implementation advocated and supported.			
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 WHO, regional and national programmes.			
TOTAL			

expected result and office, 2008-2009 - continued (in US$ thousands)

Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL
Europe	Eastern Mediterranean	Western Pacific	Headquarters	TOTAL

Annex 2: Allocation by strategic objective, organization-wide

Strategic objective 13: To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes.			
Organization-wide expected result	**Africa**	**The Americas**	**South-East Asia**
Strengthened country capacity to lead the process of health workforce development.			
Strengthened information and knowledge base on health workforce development at national, regional and global levels.			
Technical support provided to countries in crisis to reduce their shortages by addressing the production, distribution and skill mix of their health workforce.			
Strengthened networking and partnerships at global, regional, and country level, to strengthen the institutional infrastructure in countries with HRH crisis.			
TOTAL			
Strategic objective 14: To extend social protection through fair, adequate and sustainable financing.			
Organization-wide expected result	**Africa**	**The Americas**	**South-East Asia**
Ethical and evidence-based policy and technical support provided to Member States to improve the performance of health system financing systems in terms of financial protection, equity in finance and use of services as well as efficiency of resource use.			
International, regional and national advocacy, information and technical support designed to mobilize additional and predictable funding for health.			
Measurement tools developed to analyse transparency and accountability in health financing systems, and technical support provided to support their use where needed.			
Norms and standards developed for resource tracking, estimating the economic consequences of illness, costs and effects of interventions, financial catastrophe and impoverishment, and their implementation promoted, supported and monitored.			
Steps taken to build capacity in health financial policy development, production, interpretation and the use of information.			
Steps taken to stimulate the generation, translation and dissemination of valuable knowledge and to shape the research agenda.			
TOTAL			

expected result and office, 2008-2009 - continued (in US$ thousands)

Europe	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**
Europe	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**

Annex 2: Allocation by strategic objective, organization-wide

Strategic objective 15: Provide leadership, strengthen governance and foster partnership and collaboration in engagement with countries, to fulfil the mandate of WHO in advancing the global health agenda as articulated in the 11th General Programme of Work.			
Organization-wide expected result	**Africa**	**The Americas**	**South-East Asia**
Effective leadership and direction of the Organization through the enhancement of governance, coherence, accountability and synergy of the work of WHO.			
Effective WHO country presence to implement WHO Country Cooperation Strategies that are aligned with, Member States' national health and development agenda, and harmonized with the UN country team and other development partners.			
A convening framework maintained for the ethical development and implementation of the normative aspects of health through agreements, treaties, laws, and policies			
Global health and development architecture effectively providing more sustained and predictable technical and financial resources for health, based on a common health agenda which responds to the health needs and priorities of Member States.			
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.			
TOTAL			
Strategic objective 16: Develop and sustain WHO as a flexible, learning Organization, enabling it to carry out its mandate more efficiently and effectively.			
Organization-wide expected result	**Africa**	**The Americas**	**South-East Asia**
The work of the Organization is guided by strategic and operational plans that build on lessons learnt; reflect country needs; are developed jointly across the Organization; and are effectively used to monitor performance and evaluate results.			
Sound financial practices and efficient management of financial resources through continuous monitoring and mobilization of resources to ensure the alignment of resources with the Programme Budgets (as may be revised by the Director-General within his delegated authority).			
Human resource policies and practices in place to attract and retain top talent, promote learning and professional development, manage performance and foster ethical behaviour.			
Information systems management strategies, policies and practices that ensure reliable, secure and cost-effective solutions while meeting the changing needs of the organization.			
Managerial and administrative support services necessary to the efficient functioning of the Organization provided in accordance with Service Level Agreements that emphasize quality and responsiveness.			
A physical working environment that is conducive to the well-being and safety of staff in all locations.			
TOTAL			

expected result and office, 2008-2009 - continued (in US$ thousands)

Europe	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**
Europe	**Eastern Mediterranean**	**Western Pacific**	**Headquarters**	**TOTAL**

Annex 3: Allocation by strategic objective and office (assessed contribution and

Strategic objective	GRAND TOTAL			Regions		
				Country		
	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing
1. To reduce the health, social and economic burden of communicable diseases.						
2. To combat HIV/AIDS, malaria and tuberculosis.						
3. Prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries.						
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, while improving sexual and reproductive health and promoting active and healthy ageing for all individuals, using a life-course approach and addressing equity gaps.						
5. Reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.						
6. Promote health and development, prevent and reduce risk factors for health conditions associated with tobacco, alcohol, drugs and other psychoactive substance use, unhealthy diets, physical inactivity and unsafe sex.						
7. Address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.						
8. Promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.						
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development.						
10. To improve the organization, management and delivery of health services.						
11. To strengthen leadership, governance and the evidence base of health systems.						
12. Ensure improved access, quality and use of medical products and technologies.						
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes.						
14. To extend social protection through fair, adequate and sustainable financing.						
15. Provide leadership, strengthen governance and foster partnership and collaboration in engagement with countries, to fulfil the mandate of WHO in advancing the global health agenda as articulated in the 11th General Programme of Work.						
16. Develop and sustain WHO as a flexible, learning Organization, enabling it to carry out its mandate more efficiently and effectively.						
TOTAL						

estimate for total voluntary contribution), all levels, 2008-2009 (in US$ thousands)

Regions						Headquarters		
Regional			Total					
Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing

Annex 4: Detailed allocation by strategic objective and office (assessed contribution and

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

estimate for total voluntary contribution), by region, 2008-2009 (in US$ thousands)

Africa					
Regional			Total		
Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing

Annex 4: Detailed allocation by strategic objective and office (assessed contribution and

Strategic objective	The Americas		
	Country		
	Assessed contribution	Voluntary contribution	All financing
1. To reduce the health, social and economic burden of communicable diseases.			
2. To combat HIV/AIDS, malaria and tuberculosis.			
3. Prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries.			
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, while improving sexual and reproductive health and promoting active and healthy ageing for all individuals, using a life-course approach and addressing equity gaps.			
5. Reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.			
6. Promote health and development, prevent and reduce risk factors for health conditions associated with tobacco, alcohol, drugs and other psychoactive substance use, unhealthy diets, physical inactivity and unsafe sex.			
7. Address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.			
8. Promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.			
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development.			
10. To improve the organization, management and delivery of health services.			
11. To strengthen leadership, governance and the evidence base of health systems.			
12. Ensure improved access, quality and use of medical products and technologies.			
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes.			
14. To extend social protection through fair, adequate and sustainable financing.			
15. Provide leadership, strengthen governance and foster partnership and collaboration in engagement with countries, to fulfil the mandate of WHO in advancing the global health agenda as articulated in the 11th General Programme of Work.			
16. Develop and sustain WHO as a flexible, learning Organization, enabling it to carry out its mandate more efficiently and effectively.			
TOTAL			

estimate for total voluntary contribution), by region, 2008-2009 (in US$ thousands)

The Americas					
Regional			Total		
Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing

Annex 4: Detailed allocation by strategic objective and office (assessed contribution and

Strategic objective	South-East Asia		
	Country		
	Assessed contribution	Voluntary contribution	All financing
1. To reduce the health, social and economic burden of communicable diseases.			
2. To combat HIV/AIDS, malaria and tuberculosis.			
3. Prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries.			
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, while improving sexual and reproductive health and promoting active and healthy ageing for all individuals, using a life-course approach and addressing equity gaps.			
5. Reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.			
6. Promote health and development, prevent and reduce risk factors for health conditions associated with tobacco, alcohol, drugs and other psychoactive substance use, unhealthy diets, physical inactivity and unsafe sex.			
7. Address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.			
8. Promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.			
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development.			
10. To improve the organization, management and delivery of health services.			
11. To strengthen leadership, governance and the evidence base of health systems.			
12. Ensure improved access, quality and use of medical products and technologies.			
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes.			
14. To extend social protection through fair, adequate and sustainable financing.			
15. Provide leadership, strengthen governance and foster partnership and collaboration in engagement with countries, to fulfil the mandate of WHO in advancing the global health agenda as articulated in the 11th General Programme of Work.			
16. Develop and sustain WHO as a flexible, learning Organization, enabling it to carry out its mandate more efficiently and effectively.			
TOTAL			

estimate for total voluntary contribution), by region, 2008-2009 (in US$ thousands)

South-East Asia					
Regional			Total		
Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing

Annex 4: Detailed allocation by strategic objective and office (assessed contribution and

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

estimate for total voluntary contribution), by region, 2008-2009 (in US$ thousands)

Europe					
Regional			Total		
Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing

Annex 4: Detailed allocation by strategic objective and office (assessed contribution and

Strategic objective	Eastern Mediterranean		
	Country		
	Assessed contribution	Voluntary contribution	All financing
1. To reduce the health, social and economic burden of communicable diseases.			
2. To combat HIV/AIDS, malaria and tuberculosis.			
3. Prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries.			
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, while improving sexual and reproductive health and promoting active and healthy ageing for all individuals, using a life-course approach and addressing equity gaps.			
5. Reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.			
6. Promote health and development, prevent and reduce risk factors for health conditions associated with tobacco, alcohol, drugs and other psychoactive substance use, unhealthy diets, physical inactivity and unsafe sex.			
7. Address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.			
8. Promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.			
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development.			
10. To improve the organization, management and delivery of health services.			
11. To strengthen leadership, governance and the evidence base of health systems.			
12. Ensure improved access, quality and use of medical products and technologies.			
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes.			
14. To extend social protection through fair, adequate and sustainable financing.			
15. Provide leadership, strengthen governance and foster partnership and collaboration in engagement with countries, to fulfil the mandate of WHO in advancing the global health agenda as articulated in the 11th General Programme of Work.			
16. Develop and sustain WHO as a flexible, learning Organization, enabling it to carry out its mandate more efficiently and effectively.			
TOTAL			

estimate for total voluntary contribution), by region, 2008-2009 (in US$ thousands)

Eastern Mediterranean					
Regional			Total		
Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing

Annex 4: Detailed allocation by strategic objective and office (assessed contribution and

Strategic objective	Western Pacific		
	Country		
	Assessed contribution	Voluntary contribution	All financing
1. To reduce the health, social and economic burden of communicable diseases.			
2. To combat HIV/AIDS, malaria and tuberculosis.			
3. Prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries.			
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, while improving sexual and reproductive health and promoting active and healthy ageing for all individuals, using a life-course approach and addressing equity gaps.			
5. Reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.			
6. Promote health and development, prevent and reduce risk factors for health conditions associated with tobacco, alcohol, drugs and other psychoactive substance use, unhealthy diets, physical inactivity and unsafe sex.			
7. Address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.			
8. Promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.			
9. To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development.			
10. To improve the organization, management and delivery of health services.			
11. To strengthen leadership, governance and the evidence base of health systems.			
12. Ensure improved access, quality and use of medical products and technologies.			
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes.			
14. To extend social protection through fair, adequate and sustainable financing.			
15. Provide leadership, strengthen governance and foster partnership and collaboration in engagement with countries, to fulfil the mandate of WHO in advancing the global health agenda as articulated in the 11th General Programme of Work.			
16. Develop and sustain WHO as a flexible, learning Organization, enabling it to carry out its mandate more efficiently and effectively.			
TOTAL			

estimate for total voluntary contribution), by region, 2008-2009 (in US$ thousands)

Western Pacific					
Regional			Total		
Assessed contribution	Voluntary contribution	All financing	Assessed contribution	Voluntary contribution	All financing