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...Health is a state of complete physical, mental and social well-being and **not merely the absence of disease** or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

The health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest cooperation of individuals and States.

The achievement of any State in the promotion and protection of health is of value to all.

Unequal development in different countries in the promotion of health and control of diseases, especially communicable disease, is a common danger.

DRAFT TWELFTH WHO GENERAL PROGRAMME OF WORK
draft for discussion by the regional committees in 2012

Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

Informed opinion and active cooperation on the part of the public are of utmost importance in the improvement of the health of the people.

Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures...

(CONSTITUTION OF THE WORLD HEALTH ORGANIZATION)

DRAFT FOR DISCUSSION BY THE 2012 REGIONAL COMMITTEES

This first draft of the twelfth general programme of work for the period 2014–2019 represents work in progress. It is presented for discussion by the regional committees in 2012 and builds on the outline framework presented in May 2012 to the Sixty-fifth World Health Assembly and the Executive Board at its 131st session. Throughout the document, points where more work is needed or where new text will be added are indicated in *italics*. A final chapter on resources will be added in the version submitted to the Executive Board in January 2013.

In this draft, Chapter 1 provides a short review of the changing global context in which WHO is working. Chapter 2 looks at some of the broad implications of this context, particularly their influence on the direction of reform. Chapter 3 covers the programme and priority-setting aspects of reform. It discusses the scope of each category; describes how cross-cutting issues will be handled; and reviews each of the agreed priorities in turn. Chapter 4 deals with corporate services and enabling functions – the sixth category. Chapter 5 then sets out the logic underpinning the results chain and a first draft of results at impact and outcome level.

As for the World Health Assembly,¹ the draft general programme of work is summarized in the graphic on the following page (Figure 1).

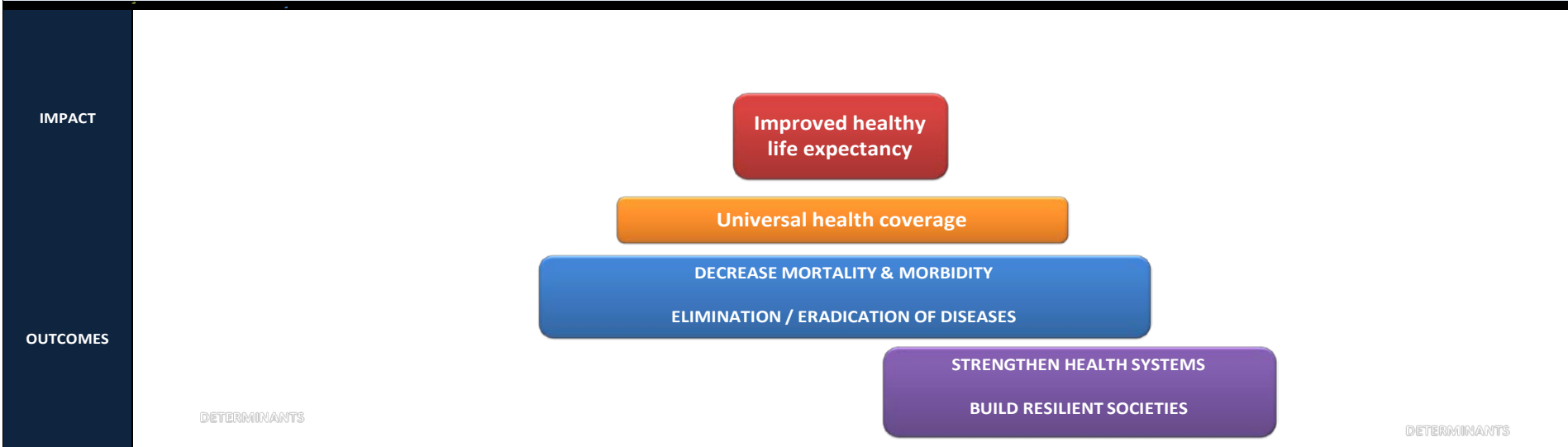
¹ Document A65/5 Add.1.



MISSION

To act as the directing and coordinating authority on international health work, towards the objective of the attainment by all peoples of the highest possible level of health as a fundamental right.

Principles, values and fundamental approaches	WHO's core functions	Criteria for priority-setting
<ul style="list-style-type: none"> Equity and social justice <ul style="list-style-type: none"> Global solidarity Gender equality Emphasis on countries and populations in greatest need <ul style="list-style-type: none"> Multilateralism Due consideration to the economic, social, and environmental determinants of health <ul style="list-style-type: none"> Science and evidence-based Public health approach 	<ul style="list-style-type: none"> Providing leadership Shaping the research agenda Setting norms and standards Articulating policy options Providing technical support and building capacity Monitoring and health trends 	<ul style="list-style-type: none"> Current health situation Existence of evidence-based, cost-effective interventions Needs of countries for WHO support Internationally agreed instruments WHO's comparative advantage



	Communicable diseases	Noncommunicable diseases	Promoting health through the life course	Health systems	Preparedness, surveillance and response
CATEGORIES & PRIORITIES	<ul style="list-style-type: none"> HIV/AIDS; tuberculosis; malaria Neglected tropical diseases (including vector-borne diseases) Vaccine-preventable diseases 	<ul style="list-style-type: none"> Heart disease, cancers, chronic lung diseases, diabetes (and their major risk factors tobacco use, unhealthy diet, physical inactivity, harmful use of alcohol) Mental health Violence and Injuries Disabilities (including blindness and deafness), and rehabilitation Nutrition 	<ul style="list-style-type: none"> Maternal and newborn health Adolescent sexual and reproductive health Child health Women's health Healthy ageing and health of the elderly Gender and human rights mainstreaming Health and the environment Social determinants of health 	<ul style="list-style-type: none"> National health policies, strategies, and plans Integrated people-centred services Regulation and access to medical products 	<ul style="list-style-type: none"> Alert and response capacities Emergency risk and crisis management Epidemic- and pandemic-prone diseases Food safety Polio eradication

CORPORATE SERVICES	Leadership in health	Governance and convening	Strategic communications
	<ul style="list-style-type: none"> Country presence Management and administration 	<ul style="list-style-type: none"> Strategic policy, planning, management and resource coordination 	<ul style="list-style-type: none"> Knowledge management Accountability and risk management

CHAPTER 1

SETTING THE SCENE

New political, economic, social and environmental realities

The Eleventh General Programme of Work, 2006–2015 was prepared in 2005 during a period of sustained global economic growth. Despite a prevailing sense of optimism, the Eleventh General Programme of Work characterized the challenges for global health in terms of gaps in social justice, responsibility, implementation and knowledge.

Subsequent events have shown this analysis to be prescient: as the first decade of the twenty-first century has progressed it has become increasingly apparent that, instead of shared prosperity, globalization has been accompanied by widening social inequalities and rapid depletion of natural resources. This is not to deny the benefits of globalization, which have allowed many countries dramatically to improve their living standards. Rather, it is a function of the fact that globalization has been superimposed upon pre-existing problems and inequities; that current policies and institutions have failed to ensure a balance between economic, social and environmental concerns; and that, as a result, the pursuit of economic growth has been too often seen as an end in itself.

As the decade progressed the world witnessed the most severe financial and economic crisis since the 1930s. The full consequences of this self-inflicted disaster, accompanied by sharp rises in the costs of food, fuel and other assets, have yet to play out. Nevertheless, it is already apparent that it has accelerated the advent of a new order in which sustained growth is now a feature of several emerging and developing economies, and in which many developed countries struggle to maintain fragile recoveries.

At the start of the second decade of this century around three quarters of the world's absolute poor live in middle-income countries. Moreover, many of these countries are becoming less dependent on (and indeed no longer eligible for) concessionary finance. As a result, an approach to poverty reduction based on externally-financed development projects is becoming rapidly outdated. In its place is a need for new ways of working that support the exchange of knowledge and best practice, backed by strong normative instruments, and which facilitate dialogue between states, the private sector and civil society. At the same time, many of the world's poorest people will remain dependent on external financial and technical support. If present trends continue, it is likely that the greatest need – as well as the focus of much traditional development support – will become increasingly concentrated in the world's most unstable and fragile countries.

The new century has also seen a transformation in the relative power of the state on one hand, and markets, civil society and social networks of individuals on the other. The role of the private sector as an engine of growth and innovation is not new. Governments retain the power to steer and regulate, however it is now difficult to imagine significant progress on issues of global importance such as health, food security, sustainable energy and climate change mitigation without the private sector playing an important role. Similarly, in low-income countries, resource flows from foreign direct investment and remittances far outstrip development support and, in the case of remittances, have often proved to be more resilient in the face of economic downturn than aid income.

Perhaps the most dramatic change results from developments in communications technology: empowering individuals and civil society on a scale that was simply not foreseen at the beginning of the decade. Social media have changed the way the world conducts business, personal relationships, and political movements. They have transformed risk communication. Only 10% of the world's poor have bank accounts, however there are already some 5.3 billion mobile phone subscribers, making much wider access to financial services a realistic prospect. At the same time, the rapid increase in connectivity that has fuelled the growth of virtual communications has risks as well as advantages, not least in terms of the potential vulnerability to disruption of the interconnected global control systems on which the world has now come to depend.

This brief sketch suggests several risks, challenges and opportunities, many of which have direct implications for global health:

- A continuing economic downturn with consequent decreases in public spending has implications for all countries. At a macroeconomic level, austerity and low demand in the OECD countries may have an impact on growth worldwide. Reductions in public spending risk creating a vicious cycle with a negative impact on basic services, low health and educational attainment and high youth unemployment. At the opposite end of the age spectrum, those retiring from work face the spectre of impoverishment and ill health in old age.
- By 2050, 70% of the world's population will live in cities. Rapid unplanned urbanization is a reality, particularly in low-income countries and emerging economies. Urbanization brings opportunities for the provision of health services and the promotion of health, but also carries direct threats and significant risks of exclusion and inequity. It also brings into play new institutional actors – most notably powerful city administrations with resources that can be tapped for better health. While migration between countries can offer benefits to both the countries from which migrants leave and to those to which they migrate, this is by no means guaranteed and many migrants are exposed to increased health risks in their search for economic opportunity.
- Falling fertility in many developing countries and the demographic dividend that accrues from a larger working population in proportion to the very young and very old has boosted economic growth in many parts of the world. For many countries this presents a vital opportunity, particularly in relation to adolescent health. Real potential to fuel the engine of growth for the future will be lost in the absence of efforts to increase youth employment. Recent events in different parts of the world have shown how chronic unemployment combined with a lack of economic and political rights and any form of social protection can link to outrage and uprising. More broadly, the long-term impact of the economic downturn in both rich and poor countries puts the social contract between governments and their citizens under ever-increasing pressure.
- The global environment is equally under pressure. Key planetary boundaries (such as loss of biodiversity) have been surpassed; and others soon will be. In many parts of the world, climate change will increasingly jeopardize the fundamental requirements for health, including clean urban air, safe and sufficient drinking-water, a secure and nutritious food supply, and adequate shelter. Competition for scarce natural resources will increase. Most people and governments accept the scientific case for sustainable development. They recognize too that health contributes to its achievement, benefits from robust environmental policies and is one of the most effective ways of measuring progress. Nevertheless, progress at global and national level in creating institutions and policies that are better able to ensure a more coherent approach to social, environmental and economic policy has been disappointingly slow.

- Slow progress on sustainable development is just one of the many challenges for global governance as countries with different national interests seek agreed solutions to shared problems. Global groupings (such as the G20) with more limited or like-minded membership offer a means of making more rapid progress on specific issues but lack the legitimacy conferred by fully multilateral processes. Similarly in health, issue-based alliances, coalitions and partnerships have been influential in making more rapid progress in relation to tackling challenges such as child and maternal mortality and HIV, tuberculosis and malaria. It is equally the case that reasonable solutions to the most complex problems (such as equitable access to medicines) require well-managed intergovernmental negotiations to reach a fair deal for all.

A changing agenda for global health

The last decade has seen greater political attention and funding for health translate into significant progress in terms of health outcomes. Despite the challenges outlined above, public health can remain in the ascendancy, providing that WHO and the governments with which it works adapt to new demands and a changing agenda. *Next draft to have additional points on achievements.*

The changing agenda for global health is in part a consequence of epidemiological and demographic change – particularly the ageing of populations. Increasingly, however, as this section will highlight, the agenda evolves in response to other factors. These include the changing political, social and economic context in which countries and communities address health challenges, and, significantly, a growing understanding of the need for new approaches to promoting and protecting health that address the determinants of ill-health, as well as its immediate biomedical causes.

Noncommunicable diseases

In the context of the epidemiological transition the growing importance of noncommunicable diseases as a cause of mortality is not new. What has changed is the recognition of the enormity of the social and economic consequences of a failure to act on this knowledge. It is evident that sums in the order of US\$ 11 billion spent now on cost-effective interventions can prevent over US\$ 40 trillion-worth of future damage to the world's economies. Nevertheless, there remains a significant gap between rhetoric and reality when it comes to concrete action and the allocation of resources.

Economic, social and environmental determinants

In part, the reason for this gap is that few of the potential solutions lie within the health sector alone. While this is true of many health conditions, an analysis of the causes and determinants of noncommunicable diseases points to a particularly wide and multi-layered range of inter-related determinants. These range from exposure to environmental toxins, through diet, tobacco use, excess salt and/or alcohol consumption and increasingly sedentary lifestyles, which in turn are linked to income, housing, employment, transport, agricultural and education policies, which themselves are influenced by patterns of international commerce, finance advertising, culture and communications. It is possible to identify policy levers in relation to all of these factors individually, however, orchestrating a coherent response across societies that results in better health outcomes at both national and global level remains one of the most prominent challenges in global health.

Epidemiological and demographic transition

For many low- and middle-income countries the continuing **epidemiological and demographic transition** imposes a complex burden: infectious diseases in tandem with chronic noncommunicable disease and mental illness as well as injuries and the consequences of violence. Meanwhile, although

falling rates of fertility and mortality offer potential benefits, as noted above, with population ageing as a universal trend, the demographic window of opportunity will close quickly.

Unfinished business

Noncommunicable diseases occupy a more prominent role in the global health agenda, but they should not replace the world's attention to existing concerns. In terms of health outcomes there is much unfinished business. Monitoring of the Millennium Development Goals highlights a rapid decline in child mortality in some countries, but also reveals much slower progress in reducing maternal and neonatal deaths. Progress on all health-related Millennium Development Goals – between and within countries – is uneven and there is a need to continue to ensure progress against the current set of health goals; to back national efforts with the advocacy work needed to sustain the necessary political commitment and financial support; and to maintain levels of investment in national and international systems for tracking results and resources.

Innovation and technology

Innovation is critical in an era of economic austerity. New technology holds many promises. Astute use of information and communications technology can make health professionals more effective, health care facilities more efficient, and people more aware of the risks and resources that can influence their health. Social media can get messages to places and people beyond the reach of traditional channels of communications. Progress in meeting many of the world's most pressing health needs requires new policy instruments and new medicines, vaccines and diagnostics. At the same time, growing demand for the newest and the best contributes to rocketing costs. For these reasons, the value of health technology cannot be judged in isolation from the health system in which it is used. Electronic medical records can improve quality of care, with adequate safeguards to assure confidentiality. Scientific progress, ethical conduct and effective regulation have to go hand in hand. The fundamental challenge is to harness innovation, in both the public and private sector. Doing so involves using incentives and the stewardship of resources in ways that ensure that technology development is an ethical servant to the health needs of the world's poor. *(Next draft: separate innovation and technology, illustrate relevance of innovation to service delivery)*

Health care systems: financial sustainability

Innovation also needs to influence the delivery of health care. In many developed economies health care costs continue to rise faster than gross domestic product due to a combination of rising public expectations, increasing costs of technology, a growing burden of noncommunicable diseases, and ageing populations. In many countries, the net effect will be to threaten the financial sustainability of health systems. Smart solutions are needed to sustain universal coverage where it has been achieved and to make further progress where it has not. Without such changes, pressures on public funding are likely to result in greater exclusion of those without financial means to access care. *(Next draft: note that solutions need to go beyond financing, link to innovation in health care.)*

Health care systems: ensuring access

In contrast, the future of health systems in many low-income countries will be one in which current challenges continue, with inadequate levels of unpredictable funding; with limited access to life-saving technologies; with the continuing daily toll of unnecessary death and disability from preventable causes; with pressure to deliver quick results taking precedence over the need to build strong institutions; and with conflicting technical advice and increasing demands from a growing diversity of partners. A common factor in all countries is the need for skilled health staff. Access to adequate levels of training, professional development, material reward and a supportive working

environment remain the only sustainable ways of overcoming the pressures within and between countries that fuel shortages and mal-distribution of health staff.

Preparing for the unexpected

Shocks must also be anticipated, including those delivered by new and re-emerging diseases and from conflicts and natural disasters. Such shocks are certain to continue, even though their provenance, location, severity and magnitude cannot be predicted. Conflict and the population displacement that follows especially affect the health of women and children, the elderly and other vulnerable groups. Shocks are also likely in the economic environment. The first decade of the 21st century brought increased attention and resources to health, but this trend is by no means certain to continue, especially as other global challenges, such as food security and climate change, make equally compelling claims. In addition, the impact of the financial crisis will continue to be felt, although the impact will vary from one country to another. Sustaining levels of resources for health in countries will require increased support from national budgets, a broader external funding base, innovative financing mechanisms and continuing commitment from traditional donors.

The institutional landscape for global health

It is traditional to point to the growing complexity of the institutional landscape for global level health, characterized by more partnerships, foundations, financial instruments, bilateral and multilateral agencies and civil society engagement. It is important however to recognize that the foundations of the global system rest at national level.

The changing role of ministries of health

The role of ministries of health in all countries is evolving. If health increasingly requires multisectoral responses, as the agenda for global health suggests, then the role of the ministry of health must expand, from a primary preoccupation with the provision and financing of health services, to becoming a broker and interlocutor with other parts of government. Similarly, ministries need the capacity to steer, regulate and negotiate with a wide range of partners in an increasingly complex environment. Civil society, patient groups, other nongovernmental organizations and the private sector now play a role – in all countries – as both provider of health services and producer of health technologies. In all countries, managing relationships with ministries of finance, planning and the economy is essential if health concerns are to be given due prominence. In countries that receive development support, ministries of health must be able to manage the tensions inherent in an accountability to the people through parliament as opposed to an accountability to external providers of finance.

Health and the global agenda

The World Health Assembly provides a forum for ministers of health to meet with each other, but until recently there have been relatively few opportunities that bring ministers of health together with ministers of finance, foreign affairs, development or other sectoral groups. Similarly, in forums that deal with issues that have a major impact on health, such as trade, agriculture or the environment, health itself is rarely a central concern. Three recent trends suggest ways in which this situation is changing. First, the growing interest in health issues on the part of the United Nations General Assembly, in which ministries of foreign affairs are the main participants. Second, the increasing prominence of regional and subregional organizations that also bring together different sectoral groups. Third, the power of non-state actors in civil society who increasingly insist that human health and well-being be a central concern of global governance.

Global goals post-2015

At present, health in part owes its prominent place in global discussions of development to its position in the Millennium Development Goals. The debate about how the next generation of goals post-2015 should be determined and what their focus should be is already underway. One of the lessons of the Millennium Development Goals is that the way goals and indicators are defined influences how the world understands development. As a result, goals shape political agendas and influence resource transfers. Ensuring that health has a place in the next generation of global goals thus becomes an important priority. *(Next draft: strengthen this section based on UN Task Team, H8 report and thematic health consultations.)*

Engagement with other stakeholders

In contrast to the situation in most countries where multiple interactions between government, civil society and nongovernmental organizations are commonplace, the global health environment is more fragmented. In part to ensure the integrity of the normative role of multilateral organizations such as WHO, and to protect against the risk of vested interests influencing policy, global health governance currently gives pride of place to intergovernmental processes. At the same time, given worldwide changes in society and the potential health benefits of wider engagement and consultation, constructive and principled engagement becomes increasingly important. Such engagement should not undermine the role of governments in having the final say in determining policy, nor compromise the integrity of normative standards and guidelines.

More effective development support

The greatest proliferation of new institutional actors in health has been in the area of providing and financing development support. In a decade of rising donor contributions, a range of new partnerships and alliances, financing channels and sources of technical support have emerged. There is little doubt that the increase in the quantum of funds has made a significant difference to the achievement of the Millennium Development Goals and targets, even if the multiplicity of donors has diminished overall coherence. In the coming decade, there is little doubt that the development architecture will be changed in fundamental ways by the combination of: financial recession in many donor countries, with attendant concerns for fiduciary accountability; sustained growth in many other economies, with decreasing need or eligibility for aid; the growing role of donors from large emerging economies, particularly as financiers of major infrastructure; the shift in development thinking from the Paris Declaration on Aid Effectiveness, through the Acra Agenda for Action to the current Busan Partnership for Effective Development Cooperation, with its focus on South-South and other forms of cooperation. While the precise direction of change is currently unclear, the need will remain for agencies such as WHO to help Member States manage complexity, as will the need to make sure that country experience informs the global debate, and vice versa.¹

Health and security

The world's principal defence against surprises arising from the microbial world (and increasingly the interface between humans and animals – the source of 75% of new diseases) continues to come from the systems and programmes that gather real-time intelligence about emerging and epidemic-prone

¹ The Partnership for Effective Development Cooperation agreed in Busan, Republic of Korea in December 2011 reflects these changes: “We have a more complex architecture for development co-operation, characterized by a greater number of state and non-state actors, as well as cooperation between countries at different stages in their development, many of them middle-income countries. South–South and triangular cooperation, new forms of public-private partnership, and other modalities and vehicles for development have become more prominent, complementing North-South forms of cooperation.”

diseases, that verify rumours, issue early alerts, and mount an immediate international response aimed at containing the threat at its source. The pandemic (H1N1) 2009 confirmed that the International Health Regulations (2005) is the key legal instrument to achieving collective security against microbial and all other threats that can cause public health emergencies of international concern. Nevertheless, the 2011 report of the Review Committee on the functioning of the International Health Regulations (2005) in relation to pandemic (H1N1) 2009 concluded that the world is still ill-prepared to respond to a severe pandemic or to any similarly global, sustained and threatening public health emergency. Ensuring that countries put in place the systems required to conform with the International Health Regulations (2005) is key to ensuring that all links are in place in the chain of surveillance and response to major public health events. Associated with this is the need to reduce the health and economic consequences of foodborne diseases. The International Food Safety Authorities Network, INFOSAN, operates as the investigative arm of efforts to protect the safety of the food supply. This work becomes all the more important given the growing intricacies of the global food trade and the complexity of identifying products that may have entered international trade.

The transformative agenda for major humanitarian action

Decisions made in the immediate aftermath of a large-scale sudden-onset emergency are critical in determining the effectiveness of the humanitarian response. Some of the mega-disasters in recent years have highlighted weaknesses in the multilateral humanitarian response. The “Transformative Agenda” agreed by the principals of the agencies that make up the Inter-Agency Standing Committee (IASC) provides a way of ensuring a collective system-wide response. Principals will meet within 48 hours of a crisis to define the scale of an emergency. If a Level 3 emergency is declared this will trigger a collective response from all IASC agencies, including the deployment of the most senior levels of overall field leadership and the leadership of key clusters such as health. The revision of the 2005 Hyogo Framework for Action in 2015 affords a further opportunity to increase the efficiency of the humanitarian system.

Relief and development

Until recently humanitarian systems have operated separately from those dealing with public health emergencies. Increasingly, it is recognized that a more holistic response to emergency risk management is required that integrates prevention, emergency risk reduction, preparedness, surveillance, response and recovery. This approach is now being reflected in the way that WHO organizes its work. Furthermore, experience demonstrates that the distinction between relief and development is artificial – and that the separation of related programmes can be counterproductive. The increasing frequency of disasters, partially driven by factors such as climate change and rapid urbanization, requires that they be expected and planned for. Moreover, the transition from humanitarian action to development is rarely linear. At least one fifth of humanity lives in countries experiencing ongoing violence and conflict that contributes to insecurity. Countries affected in this way have higher rates of poverty and most have yet to achieve a single Millennium Development Goal. To build greater resilience requires investment in the political institutions that help create stability, a focus on preparedness through emergency risk management, and the recognition that relief and development are deeply interdependent.

CHAPTER 2

THE ROLE OF WHO

WHO has been at the forefront of improving health around the world since its founding in 1948. As Chapter 1 has shown, the challenges confronting public health have changed in profound ways and with exceptional speed. The overall purpose of the WHO programme of reform is to ensure that WHO evolves to keep pace with these changes.

Chapter 2 examines some of the broad implications of the changing context for the work of WHO. Reform, in terms of programmes and priorities, is covered in Chapter 3, and in relation to governance and management reform in Chapter 4.

Enduring principles, values and approaches

WHO remains firmly committed to the principles set out in the preamble to the Constitution (as set out in Box 1). These principles are also reproduced on the cover page of this document.

Box 1. Constitution of the World Health Organization: principles

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

The health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest cooperation of individuals and States.

The achievement of any State in the promotion and protection of health is of value to all.

Unequal development in different countries in the promotion of health and control of diseases, especially communicable disease, is a common danger.

Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

Informed opinion and active cooperation on the part of the public are of utmost importance in the improvement of the health of the people.

Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

In a context of growing inequity within and between countries, competition for scarce natural resources, and a financial crisis that threatens basic entitlements to health care, it would be hard to find

a better expression of health as a fundamental right, as a prerequisite for peace and security, and the key role of equity, social justice, popular participation and global solidarity in the Organization's work.

It is also important in the context of the draft general programme of work to re-state key elements of the approach that WHO adopts to its constitutional role as the independent guardian and monitor of global and regional health status.

- In line with the principle of equity and social justice, WHO will continue to give emphasis where needs are greatest. Whilst WHO's work will continue to be relevant to all Member States, the Organization sees health as being central to poverty reduction. The analysis in Chapter 1 points to the fact that the greatest absolute number of poor people are now citizens of middle-income and emerging economies. The focus is therefore not only on countries, but on poor populations within countries.
- WHO is and will remain a science and evidence-based Organization with a focus on public health. The environment in which WHO operates is becoming ever more complex; however WHO's legitimacy and technical authority lies in its rigorous adherence to the systematic use of evidence as the basis for all policies. This also underpins WHO's core function of monitoring health trends and determinants at global, regional and country level.
- The review of health governance issues points to the need for negotiated solutions to shared international health problems, particularly in instances of interaction between health and other sectoral interests (such as trade, migration, security and intellectual property). In addition, the capacity to convene and facilitate the negotiation of binding international agreements distinguishes WHO from most other health actors. A commitment to multilateralism remains a core element of WHO's work .
- WHO will continue to be both a normative agency that produces a range of guidelines, norms and standards that benefit countries collectively, as well as a provider of technical support to individual Member States.
- As a public health agency, WHO continues to be concerned not with the purely medical aspects of illness, but with the promotion of health as a positive outcome of all policies.

A strategic response to a changing environment

Addressing the social, economic and environmental determinants of health

As the Constitutional principles make clear, WHO is an Organization that is concerned with the promotion of good health, not just the prevention and treatment of disease. The situation analysis and the challenges to global health demonstrate the importance of this role. Moreover, while a concern for health as an outcome of all policies in other sectors and the broader economic, environmental and social determinants are not new in themselves, the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases in September 2011, the Commission on Social Determinants, and the World Conference on Social Determinants of Health in October 2011 gives this area of work renewed emphasis and momentum.¹ The "cross-cutting issues" section of Chapter 3 below

¹ The Political Declaration at the World Conference identified five action areas in which WHO was requested to support Member States:

1. Improved governance for health and development
2. Participation in policy-making and implementation.
3. Reorientation of the health sector towards promoting health and reducing health inequities.
4. Global Governance and collaboration.
5. Monitoring progress and increasing accountability

provides more detail on how work on the social determinants of health will be reflected in all the categories in successive programme budgets.

Adjusting to a new financial reality

Most analysts now suggest that the financial crisis will have long-term consequences, and not only in the OECD countries that provide a large proportion of WHO's voluntary funding. It is therefore evident that WHO needs to respond strategically to a new, constrained financial reality rather than respond managerially to a short-term crisis. The response has a number of elements. At a programmatic level, as this general programme of work highlights, the need is for priorities to be agreed by Member States so that countries define what is important rather than donors alone. Priorities need to be linked to a hierarchy of measurable outcomes and outputs, so that the tangible benefits of an investment in WHO are clear to as wide an audience as possible. Accountability linked to transparent, objective and timely reporting of results is needed not just for WHO as a whole but all its constituent parts. The current financial environment is one of uncertainty; measures to increase predictability of WHO's financing and thereby facilitate realistic planning and budgeting, are therefore essential.

Integrated health services

Paragraph to be added on the shift away from categorical disease-focused programmes towards greater health service integration reflecting concerns for more people-centred services as well as efficiency and value for money. Key points: integration across whole health care continuum from primary prevention through acute management to rehabilitation; links between medical, social and long-term care; key benefits in terms of noncommunicable diseases; links between maternal and child health and associated health impact; ageing populations.

Health governance: the role of WHO

The review of the institutional landscape highlights the need for WHO to broaden its health governance role. Traditionally, this role has been seen primarily in terms of convening countries to negotiate solutions for shared problems at both headquarters and regional level to **produce conventions, regulations, resolutions, and technical strategies**. While this role remains a key part of the Organization's business, there are many new challenges to be addressed, not just at headquarters but at country and regional level.

At country level, WHO's role is in support of national authorities, facilitating the development of national policies and strategies around which other partners align; ensuring that health is well positioned and coordinated in the work of the United Nations country team; and where national governments are disabled by conflict or disaster, WHO fulfills a similar role as coordinator of the health cluster in emergencies. Strengthening country offices to fulfill these roles is discussed in more detail in Chapter 4.

In the changing landscape regional and subregional integration is a growing trend. It is therefore important that health is well-represented. Given the many actors involved, WHO's regional offices have a vital role to play in terms of coordination and direction. A growing network of relationships beyond the regional committees will ensure links between ministries of health and WHO regional committees, regional United Nations bodies, and a range of regional political, economic and development organizations.

At a global level, governance for health is also understood in terms of how other inter-governmental processes (foreign policy, trade negotiations, climate change agreements etc.) that do not have health as their prime concern can impact on health outcomes. WHO's role in

NOT MERELY THE ABSENCE OF DISEASE
GPW12 draft for regional committees

these interactions is seen in terms of how it can use evidence and influence to secure more positive health outcomes from such processes. The priority to be given to governance for health in this sense is central to the Global Health and Foreign Policy Initiative and is a feature of the Political Declaration on Social Determinants. Equally, global governance of health encompasses the work of WHO in promoting health as an issue of importance in the United Nations General Assembly and other bodies such as the G8, G20 and a range of regional and sub-regional forums.

CHAPTER 3

PRIORITIES 2014–2019

Introduction

A meeting of Member States on programmes and priority setting in early 2012 agreed the criteria and categories for priority setting and programmes in WHO for the period 2014–2019 to be covered by the Twelfth General Programme of Work. The five categories (plus an additional category for corporate services) provide the main structure for the programme of work set out in this document and the programme budgets that flow from it.

The agreed categories and criteria are set out in Table 1 and the priorities for the period 2014–2019 in Table 2. The remainder of this section reviews the rationale for their selection and, for each, the focus and direction of WHO’s work in the period covered. The priorities listed in Table 2 are for the whole six-year period covered by the general programme of work, however, the specific focus within selected priorities may change over time. The criteria for selecting priorities make reference to “emerging health issues”, allowing for the possibility that new challenges may attain priority status by virtue of their public health importance.

Table 1. Categories and criteria for priority setting and programmes in WHO

CATEGORIES FOR PRIORITY SETTING AND PROGRAMMES IN WHO
1. Communicable diseases: reducing the burden of communicable diseases, including HIV/AIDS, tuberculosis, malaria, and neglected tropical diseases.
2. Noncommunicable diseases: reducing the burden of noncommunicable diseases, including heart disease, cancer, lung disease, diabetes, and mental disorders as well as disability, and injuries, through health promotion and risk reduction, prevention, treatment and monitoring of noncommunicable diseases and their risk factors.
3. Promoting health through the life-course: reducing morbidity and mortality and improving health during pregnancy, childbirth, the neonatal period, childhood and adolescence; improving sexual and reproductive health; and promoting active and healthy ageing, taking into account the need to address determinants of health and internationally agreed development goals, in particular the health-related Millennium Development Goals.
4. Health systems: support the strengthening, organization with a focus on integrated service delivery and financing, of health systems with a particular focus on achieving universal coverage, strengthening human resources for health, health information systems, facilitating transfer of technologies, promoting access to affordable, quality, safe, and efficacious medical products, and promoting health services research.
5. Preparedness, surveillance and response: surveillance and effective response to disease outbreaks, acute public health emergencies and the effective management of health-related aspects of humanitarian disasters to contribute to health security.
6. Corporate services/Enabling Functions: organizational leaderships and corporate services that are required to maintain the integrity and efficient functioning of WHO.

CRITERIA FOR PRIORITY SETTING AND PROGRAMMES IN WHO

1. The current health situation including: demographic and epidemiological trends and changes, urgent, emerging and neglected health issues; taking into account the burden of disease at the global, regional and/or country levels.
2. Needs of individual countries for WHO support as articulated, where available, through the country cooperation strategy, as well as national health and development plans.
3. Internationally agreed instruments which involve or impact health such as declarations and agreements, as well as resolutions, decisions and other documents adopted by WHO’s governing bodies at the global and regional levels.
4. The existence of evidence-based, cost-effective interventions and the potential for using knowledge, science and technology for improving health.
5. The comparative advantage of WHO, including:
 - (a) capacity to develop evidence in response to current and emerging health issues;
 - (b) ability to contribute to capacity building;
 - (c) capacity to respond to changing needs based on ongoing assessment of performance;
 - (d) potential to work with other sectors, organizations, and stakeholders to have a significant impact on health.

Table 2. Priorities for the period 2014–2019, by category

<ul style="list-style-type: none"> • HIV/AIDS • Tuberculosis • Malaria • Neglected tropical diseases • Vaccine-preventable diseases
<ul style="list-style-type: none"> • Heart disease, cancers, chronic lung diseases, diabetes (and their major risk factors: tobacco use, unhealthy diet, physical inactivity, and harmful use of alcohol) • Mental health • Violence and injuries • Disabilities (including blindness and deafness) and rehabilitation • Nutrition
<ul style="list-style-type: none"> • Maternal and newborn health • Adolescent sexual and reproductive health • Child health • Women’s health • Healthy ageing and health of the elderly • Gender and human rights mainstreaming • Health and the environment • Social determinants of health
<ul style="list-style-type: none"> • National health policies, strategies, and plans • Integrated people-centred services • Regulation and access to medical products
<ul style="list-style-type: none"> • Alert and response capacities • Emergency risk and crisis management • Epidemic- and pandemic-prone diseases • Food safety • Polio eradication

Categories

No single system of categorization can be fully satisfactory. Some degree of overlap is inevitable and the division between categories in some cases is necessarily somewhat arbitrary. The scope of the five

technical categories is summarized below. The scope of category 6, which covers corporate services and enabling functions, is set out in Chapter 4.

- **Category 1: Communicable diseases** includes a *limited* number of communicable diseases, specifically HIV, tuberculosis, malaria and vaccine-preventable diseases. Cancers and other chronic diseases caused by or associated with viruses are included in category 2, sexually transmitted diseases in category 3 as part of sexual and reproductive health, and epidemic-prone communicable diseases in category 5.
- **Category 2: Noncommunicable diseases** and conditions covers *all* noncommunicable diseases and their associated risk factors and includes work on mental health, disabilities (including blindness and deafness from all causes), prevention of violence and injuries, and nutrition.
- **Category 3: Promoting health through the life-course** brings together strategies for promoting health and well-being throughout critical periods from conception to old age. It is concerned with health as an outcome of all policies and with health and the environment, and includes leadership, and mainstreaming and capacity building on the social determinants of health, gender and human rights.
- **Category 4** covers all the main building blocks of health systems: service delivery, human resources, financing, information systems, medical products, vaccines and technologies, and leadership and governance as well as health systems research.
- **Category 5: Preparedness, alert and response** covers the health response to acute and chronic events with public health significance caused by disease outbreaks, antimicrobial resistance, environmental threats, natural disasters and conflict. It includes all elements of emergency risk management: prevention, preparedness, surveillance, response and early recovery. In terms of specific diseases, the category includes polio; a range of diseases with the potential to cause outbreaks, epidemics or pandemics (such as influenza, several zoonoses, viral encephalitis and hepatitis) and food-borne diseases.

Cross-cutting priorities

There are a number of interlinkages between the five technical categories. Among them, three cross-cutting priorities are of particular concern: **social determinants, nutrition and environmental health**.

Social determinants of health

Work on the social, economic and environmental determinants of health affects all categories of work and will be reflected in successive programme budgets as follows:

Ongoing work to address health determinants and promote equity: Several concrete outputs – in each of the five categories – address specific determinants of health. These range from work on social health protection, disaster preparedness, setting standards in relation to environmental hazards, energy and transportation policy, food safety and security, access to clean water and sanitation and many others. In addition, much of the work in category 2 on noncommunicable diseases is based on the idea that health, and the reduction in exposure to key risk factors and determinants, is an outcome of policies in a range of sectors – a concrete expression of health in all policies. Equally, there are outputs that seek to increase equity in access and outcome, particularly in the organization of health care services and the collection and dissemination of health data. Outputs in the draft proposed programme budget that

address specific determinants of health will be highlighted in order to demonstrate the range that they cover.¹

Capacity building to mainstream the social determinants of health approach in the Secretariat and in Member States: There is already a body of work ongoing in WHO on the determinants of health, however there is also a need to build the capacity to give it greater prominence. A set of activities is needed to develop tools, to provide training, and to build greater awareness of the value-added of the social determinants approach. The related outputs will have the common purpose of mainstreaming the social determinants approach in the Secretariat and in Member States. This aspect of work on social determinants is located in category 3 where it is listed as a specific priority.

Governance and health: Implicit in the concept of the social determinants approach to health, as articulated in the Rio Political Declaration on Social Determinants of Health, is the need for better governance of the growing number of actors active in the health sector, generally referred to as “health governance”. Equally, the social determinants approach to health promotes governance in other sectors in ways that positively impact on human health. Global governance for health has become increasingly prominent through the efforts of the Foreign Policy and Global Health Initiative.² A statement made in 2010 by the foreign ministers of seven participating countries noted that “*Foreign policy areas such as security and peace building, humanitarian response, social and economic development, human rights and trade have a strong bearing on health outcomes*”. The statement goes on to identify a number of issues, including universal health coverage, in which interventions from a foreign policy perspective in multilateral processes can have a high impact on health. WHO’s leadership role in health governance at country, region and global levels is addressed in category 6.

Health and the environment

Some work on health and the environment is located in category 5 reflecting the need to protect human health in the face of a range of environmental risks. These range from acute risks attributable to radiation, chemicals and other environmental pollutants through the longer-term threats posed by climate change, loss of biodiversity, scarcity of water and other natural resources. However, work under health and the environment is also central to health promotion and health as an outcome of policies in sectors such as transport, energy, urban planning and employment (through occupational health). The leadership role for health and the environment is located as a priority in category 3.

Nutrition

Nutrition has a role in all five categories. It is an important determinant of health outcomes in relation to communicable and noncommunicable diseases; preventing under- and over-nutrition is central to the promotion of health through the life-course; integrating nutrition into health service delivery remains a challenge; and while food can be a cause of outbreaks and emergencies, undernutrition is a common consequence of humanitarian disasters. Given the close relationship between dietary factors and the prevention of noncommunicable diseases, the leadership and capacity building function is located in category 2.

¹ The present draft of the proposed programme budget does not include the highlighting of social determinants of health outputs; this will be done in subsequent versions.

² The Oslo Ministerial Declaration (2007).

Priorities

Three major **communicable diseases** – **HIV, tuberculosis and malaria** – stand out clearly on the basis of their contribution to the burden of death and disability in most regions of the world. The demand for WHO support is consistent in more than 80% of country coordination strategies, and for each of the three diseases there is a range of multilaterally agreed goals and targets.

HIV

As work in the field of HIV/AIDS moves from an emergency response to a long-term, sustainable model of delivering services, the need is for simplified treatment regimens and technologies (such as diagnostics) to expand antiretroviral access (for treatment and, increasingly, for prevention), and to facilitate service integration (with interventions on tuberculosis, malaria, maternal, newborn and child health, and drug dependence). Ensuring affordable access to antiretroviral medicines, and their strategic use, will remain a key issue as drug resistance increases and profit margins fall on first-line drugs, with the attendant risk of large scale generic manufacturers exiting the market. The countries of Eastern Europe and Central Asia remain of particular concern as this the only region in which the number of people acquiring infection and dying of HIV-related causes continues to increase. Equally, more attention will be needed to reach groups in the population such as prisoners and drug users that are poorly served by routine services. A particular focus of WHO's work will be to accelerate progress toward the goal of zero mother-to-child transmission, simplifying protocols on preventing mother-to-child transmission (PMTCT) of HIV, promoting the development of cheaper diagnostics, and helping countries put new guidelines into practice.

Tuberculosis

Trends that will influence future work include the emergence of tuberculosis in elderly and migrant populations, and the growing problem of drug-resistant tuberculosis. While specific responses are also required to these problems, the fundamental issue of ensuring adequate access to first-line treatment remains key to future progress. In a constrained economic environment it is increasingly evident that sustained domestic financing for tuberculosis services will be critical. At present there is a marked divide between the group of BRICS countries (Brazil, Russian Federation, India, China and South Africa), which are making rapid progress in relation to tuberculosis control and where 95% of funds come from national sources, compared with other high-burden countries, where only 51% of funding is domestic. New diagnostics for tuberculosis have been developed and others are in the pipeline. Challenges for WHO and partner countries are: to ensure sustained technical and financial support for first-line treatment in low-income countries; to link efforts to increase the affordability and access to diagnostics with the provision of treatment in order to fully realize their transformative effect; to promote competition between producers as the most effective means of reducing prices; and to provide the normative guidance needed to translate new technological developments into everyday practice.

Malaria

Several trends are evident in relation to malaria. The scope of malaria-affected areas is shrinking. In the areas that remain, people will be harder to reach and the services they need will be more difficult and expensive to deliver. A sustained response requires a massive scale-up in treatment based on accurate diagnosis. This in turn requires increases in the availability combined with decreases in the cost of rapid diagnostic tests. The potential availability of a

vaccine will bring with it demand for normative advice on how, where and in what circumstances it should be used. These examples point to WHO's comparative advantage in terms of identifying needs, specifying clearly the characteristics of desirable solutions, carrying out normative work when new products become available, monitoring resistance and changing epidemiological patterns, and stimulating innovation both in terms of products and in approaches to their delivery.

Neglected tropical diseases

Neglected tropical diseases, although making a lesser contribution to overall mortality rates, are a major cause of disability and loss of productivity amongst some of the world's most disadvantaged people. Reducing the health and economic impact of neglected tropical diseases is a global priority, their impact is felt more strongly in some regions than others. In the regions and countries affected, neglected tropical diseases are identified as a priority precisely because they have been relatively neglected; because new and more effective interventions are available; because their reduction can help accelerate economic development; and because WHO is particularly well-placed to convene and nurture partnerships between governments, health service providers and pharmaceutical manufacturers.

The road map for accelerating work to overcome the impact of neglected tropical diseases¹ sets out a detailed timetable for the control and, where appropriate, elimination and eradication of the 17 specific diseases in this group. Over the next six years, partnerships with manufacturers will be important in maintaining drug supplies, although in the longer-term there will need to be a shift from donation to generic manufacture. Sustaining the current momentum for addressing these diseases requires not only commodities and financing but also political support. In this regard, neglected tropical diseases cannot be seen as a health issue alone. They are inextricably linked with health as a human right, with poverty reduction and with effective governance.

Vaccine-preventable diseases

Immunization is one of the most cost-effective public health interventions. The protection afforded by vaccines prevents more than 2 million deaths in a context in which, each year, some 2.5 million children under the age of five die from **vaccine-preventable diseases**. The priority given to vaccine-preventable diseases is reflected in the international attention to this subject as part of the Decade of Vaccines and the associated Global vaccine action plan endorsed by the Sixty-fifth World Health Assembly. In addition, the immunization landscape is beginning to change with several new vaccines becoming available and routine immunization being extended from infants and pregnant women as the sole target groups to adolescents and adults. At the same time, up to one fifth of children born each year are classified as hard-to-reach and are thus at risk of being excluded from immunization programmes.

Of particular concern over the next six years is how vaccines can be more effectively deployed as an entry point for broader public health interventions. In practice this will mean focusing on preventing childhood deaths from pneumonia and diarrhoea, with immunization as one part of the strategy, rather than the focus of the whole programme. Similarly, vaccination against

¹ *Accelerating work to overcome the global impact of neglected tropical diseases – a roadmap for implementation*, Geneva, World Health Organization, 2012.

human papillomavirus (HPV) needs to be seen as an integral part of adolescent health care, rather than as an isolated intervention. The potential for transformative innovation is significant in relation to eliminating needles and syringes; reducing reliance on the cold chain; and introducing a new generation of vaccines (increasingly to prevent chronic disease in adults). In respect of innovation, the role of WHO is not to carry out or fund research, but to identify needs, specify the characteristics of needed technologies and to provide normative guidance as new products become available. Lastly, reaching the cohorts of children that remain unvaccinated, through more effective health systems and better risk communication will remain a central concern.

The growing burden of **noncommunicable diseases** will have devastating health consequences for individuals, families and communities; it threatens to overwhelm health systems; and is inextricably linked to poverty reduction and economic development. WHO will focus primarily over the next six years on combating the four primary noncommunicable diseases¹ and their major risk factors.² Cited as one of the greatest overall global risks by the World Economic Forum, failure to act on noncommunicable diseases in the short-term will lead inexorably to massive cumulative output losses, estimated at about US\$ 47 trillion by 2030, from the four primary noncommunicable diseases and mental health disorders alone.

In low- and middle-income countries prevalence of noncommunicable disease is increasing not just among the growing number of the elderly, but among individuals in their most productive years. This trend is most striking in Africa, where the burden of disease due to noncommunicable diseases is expected to exceed communicable, maternal, perinatal and nutritional diseases as the most common cause of death by 2030. Moreover, as the global population – and concomitantly the world’s population over the age of 60 – continues to increase in size, the absolute numbers of annual deaths from noncommunicable diseases are projected to increase substantially over the coming decades.

Though noncommunicable diseases have long been the leading cause of mortality and morbidity in high-income countries, they have only recently become a prominent part of the global health agenda. In addition, the need to deal with a wide range of risk factors and the many social, economic and environmental determinants of chronic diseases means that a single-sector approach to the prevention and control of noncommunicable disease will be inadequate. Success will require coordinated, multisectoral action at global, regional, national and local levels. These two factors have important implications for WHO’s leadership role.

The most important noncommunicable diseases have a long history of many different institutional actors implementing technically mature strategies. The challenge, as noted in the previous section, is for WHO to focus on areas in which it has a clear comparative advantage. WHO’s role is to guide global and national responses by helping others to understand the dimensions of the bigger picture and their place within it.

This role is well illustrated by the requests made to WHO by Member States at the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases in 2011: to develop a comprehensive global monitoring framework and

¹ Cardiovascular disease, cancers, chronic lung diseases, diabetes.

² Tobacco use, unhealthy diet, physical inactivity, and harmful use of alcohol.

recommendations for a set of voluntary global targets; to articulate policy options for strengthening and facilitating multisectoral action, including through effective partnership; and to exercise leadership and a coordinating role in promoting global action in relation to the work of United Nations funds, programmes and agencies. WHO's future work in this area will draw heavily on its normative and capacity-building competencies, however it is equally a prime example of WHO's growing role in health governance, at all levels of the Organization.

Risk factors

Without effective strategies and integrated approaches to control and prevent noncommunicable diseases, and given the imminent epidemiological and demographic shifts which will catalyse their acceleration, the numbers of people exposed to risk factors will continue to increase. **Tobacco** consumption, which is presently responsible for 30% of all cancers, will continue to remain the world's largest preventable cause of death and account for 10% of all deaths by 2020, if left unchecked. Similarly, each year 2.8 million people die as a result of being **overweight or obese**, 2.5 million individuals succumb to the **harmful use of alcohol**, and 6% of all global deaths are linked to **physical inactivity**.

WHO will support countries where effective public health measures are being attacked through legal actions brought by the tobacco industry, and will promote tobacco taxation as a measure to decrease consumption and as a potential additional revenue for health.

More broadly, WHO will build the capacity of national surveillance systems and standardized data collection tools to monitor exposures to noncommunicable disease risk factors, noncommunicable disease -specific mortality and morbidity, and the health system response to these diseases.

Much of the work in this area focuses on different aspects of prevention, however, there is a growing recognition of the need to ensure access to treatment to prevent later complications. Many of the medicines needed are relatively inexpensive but in too many countries they are simply not available to those most in need.

Work on developing cost-effective noncommunicable disease 'best-buys' – strategies for preventing and treating disease as well as reducing exposure to risk factors – will be backed up by technical support to countries. United Nations country teams will be encouraged to include noncommunicable diseases in the United Nations Development Assistance Framework in order to support this effort.

Future work will also explore the growing potential of vaccines in the prevention of cancers.

Nutrition

Nutrition is a cross-cutting issue relevant to all categories of WHO's work (see above). It is also a priority in its own right in relation to noncommunicable diseases. This status is justified by the strong link between diet and several noncommunicable disease risk factors, as well as the role of nutrition in promoting health in relation to these diseases. The role of nutrition illustrates a more general point in relation to this category: that market forces have a major influence on the ability of people to make healthy choices about what they eat and drink and other aspects of their lifestyle. The corollary is that leadership in this field requires a constructive engagement with industry to counter negative trends and to find ways in which

industry, trade and commerce can contribute to and not undermine the achievement of public health goals. *Next draft needs more substance on future directions in relation to nutrition.*

Mental health

Current evidence indicates that eight priority mental health conditions make the largest contribution to morbidity in the majority of developing countries: depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to use of illicit drugs, and mental disorders in children. Mental health conditions can be addressed through the provision of good-quality treatment and care, however, relatively little attention has been devoted to the provision of care and treatment in low-income settings (including establishing a convincing economic rationale for so doing).

Future work will focus on the major determinants and causes of morbidity, particularly dementia, autism, bi-polar disorders and mental health conditions of children, including strategies for preventing suicide in young people. Work will also continue on the improvement of access to social welfare services and opportunities for education, employment, housing and social services for people with, or at risk of having mental disorders. Protecting and promoting the human rights of people with mental health conditions from human rights violations is equally critical. Technology can change the way that health care is provided for all noncommunicable diseases, but is particularly relevant for people with mental disorders, especially elderly people with dementia (see also healthy ageing).

Violence and injuries

Successful approaches to prevent violence and injuries have been implemented in many countries through efforts that involve the health sector and beyond. For example, efforts to address road traffic fatalities, Member States agreed to declare a Decade of Action on road safety, which was launched in May 2011 with the goal to stabilize and then reduce the forecast level of road traffic fatalities around the world by 2020, saving 5 million lives. Future work will be undertaken on **violence against women** as a hidden problem in public health. The aim will be to work towards the development and adoption of a global charter.

Disabilities and rehabilitation

Paragraph to be added on disabilities as a priority area. This will include blindness, noting that 90% of the world's visually impaired live in developing countries, and the link with neglected tropical diseases in the case of onchocerciasis and trachoma. Numbers of people with hearing impairment. Links with points on needs for technological innovation.

The category **promoting health throughout the life-course** is by its nature cross-cutting. It addresses population health needs with a special focus on key stages in life. This approach enables the development of integrated strategies that are responsive to evolving needs, changing demographics, epidemiology, social, cultural and environmental and behavioural factors, and widening health inequities or equity gaps. The life-course approach considers how multiple determinants interact and affect health throughout life and across generations. Health is considered as an integrated, dynamic continuum rather than a series of isolated health states. The approach highlights the importance of transitions, linking each stage with the next, defining protective risk factors, and prioritizing investment in health care and social determinants. Within this broad approach seven priorities will be

given particular emphasis. Social determinants as a priority is discussed under the section on cross-cutting issues above.

Maternal and newborn health: the first 24 hours¹

Effective interventions exist for improving health and reducing maternal, newborn and child mortality. The challenges are to implement and scale up those interventions making them accessible for all during pregnancy, childbirth and the early years and ensuring the quality of care. WHO's particular priority at this stage in the life-course acknowledges that, for mothers and newborn infants, the first 24 hours are critical because half of maternal deaths, one third of newborn deaths and one third of stillbirths as well as most of the complications that can lead to death of the mother or the newborn infant occur in the 24 hours around delivery. It is also only within this same period that the most effective interventions to save mothers and babies can be delivered: management of labour, oxytocin after delivery, resuscitation of the newborn and early initiation of breastfeeding. *Next draft to include additional points on pre-term births.*

Adolescent sexual and reproductive health

The promotion of healthy behaviours at this stage in the life course is crucial, given that many risk behaviours that start in adolescence affect health in later life. WHO's work will focus particularly on the sexual and reproductive health needs of adolescents. Family planning can prevent up to one third of maternal deaths, but in 2012 more than 200 million women had unmet needs for contraception. Within this number, adolescents' unmet needs are particularly significant. Adolescent sexual and reproductive health will also be a focus for research in this area. A consultative exercise is currently underway to determine priorities in this regard.

Child health: ending preventable child deaths

Next draft to include text on reducing child mortality from preventable causes. Responses to Child Survival Call to Action of June 2012. Focus on pneumonia and diarrhoea treatment. Complements and links with category 1 and vaccine-preventable diseases.

Women's health

Next draft to include text on women's health where the focus will be on issues beyond reproductive health, responding to the agenda in the WHO Women and Health Report. Strong links to noncommunicable diseases, health systems and healthy ageing.

Healthy ageing and health of the elderly

Population ageing is a global phenomenon that will change society in many ways creating both challenges and opportunities. Healthy ageing is integral to the work across this category. WHO will give new emphasis to the health of older people. *Next draft to include new text on the health of older people showing priority to be given to maintaining independence and end of life care. Strong links with noncommunicable diseases, hearing and visual disabilities, mental health as well as health systems (highlighting links between health and social services*

¹ The UN Secretary-General's Global Strategy for Women's and Children's Health and related campaign *Every Woman, Every Child* provides an overarching framework for accelerating progress at country level in maternal, newborn and child health. The strategy defines roles and responsibilities for the H4+ partner agencies (WHO, UNICEF, UNFPA, World Bank, UNAIDS and UN Women) and the report of the associated Commission on Accountability and Information provides a framework for holding all partners accountable for resources and results. The performance indicators recommended by the Commission are included in the outcomes listed in Chapter 5 of the draft general programme of work.

and social protection) and technical innovation to reduce costs, simplify care, maintain independence and assisting disability.

Gender equity and human rights mainstreaming

A synergistic approach has been chosen as the basis for institutional mainstreaming of gender, equity and human rights at all levels of the WHO Secretariat, with the objective of creating structural mechanisms that enable programmatic mainstreaming to succeed, and support countries in their realization of gender equality, health equity and the right to health.

Next draft to include further text.

Health and the environment

WHO will promote a sustainable development approach to its work on the environment and will pay particular attention to prevention, mitigation and management of environmental risks. Environmental determinants of health are responsible for about one quarter of the global burden of disease and an estimated 13 million deaths each year. Those mainly affected are poor women and children who live and work in the world's most polluted and fragile ecosystems and who are at risk from diverse factors such as chemicals, radiation, lack of safe water and sanitation, air pollution and climate change.

Next draft to include further text.

The overarching theme for work in **health system strengthening** is access and affordability of services based on the principles of primary health care. Work in this category is integral to extending and safeguarding universal health coverage, with its dual elements of access to essential services, medical products and technologies, combined with financial protection.

National health policies, strategies and plans

Facilitating a policy dialogue that involves all the main players in health system strengthening at national level exploits WHO's comparative advantage as a convenor and facilitator. It reflects a fundamental shift away from being an agency that implements small-scale projects. It also allows the focus of health system strengthening to be adapted to local needs, focusing on specific building blocks such as human resources and health systems financing as part of an overall strategy that ensures governments are able to better align the specific contributions of different partners. The dialogue increasingly will involve actors from the private sector, civil society and nongovernmental organizations, and must also extend to other sectors to ensure that the most important social determinants are addressed. Given the economic and institutional uncertainty facing many countries' health systems and the need for reform to be based on a better understanding of future circumstances, WHO will convene work on scenario building and foresight while working with countries to ensure that strategies for achieving universal health coverage are based on the principles of primary health care and reduce health inequalities.

Integrated people-centred health services

WHO is not an implementing agency, but has an important normative role in the development of health services linked to technical support at country level. With a view to the overall goal of universal coverage, work is needed in several areas, in each case adapting advice and guidance to the circumstances of different countries and regions.

Strategies are needed for reaching hard-to-reach populations such as unimmunized children and populations at risk of HIV or tuberculosis, or groups whose health care needs have been relatively ignored such as adolescents and the elderly.

The growing prominence of chronic noncommunicable disease creates a demand for affordable long-term care, high-quality palliative treatment, and better links between medical and social services (as well as between health and other forms of social protection).

Better health care data is a prerequisite for making investment decisions and for enhancing efficiency and accountability in all health care systems. In the many countries where they still do not exist, establishing systems for vital registration is fundamental. Advances in informatics and information technology have the potential to transform health care management and promote more people-centred care. Authoritative guidance on the use of electronic medical records and other technologies is needed.

Critical shortages, inadequate skill mix and uneven geographical distribution of the health workforce pose major barriers to achieving better health outcomes. Only 5 of 49 low-income countries meet the minimum threshold of 23 doctors, nurses and midwives per 10 000 population necessary to deliver essential maternal and child health services. A well-trained and motivated health workforce is essential for people-centred services.

Many countries are receiving development support to build new health care infrastructure for both primary care and hospital services. Currently there are few sources of advice on capital planning and service standards for health care facilities, particularly in low-income settings. Improvements in service quality and patient safety (including reducing rates of hospital infection) are as vital as improvements in the quantity of services. New approaches will require norms and standards for the accreditation and regulation of health facilities as well as a rethinking of the role of ministries of health. Regulation is of growing importance in relation to the development of standards for training and licensing health workers, accreditation of health facilities, and the regulation of private providers and insurers.

The next draft may include text on monitoring health trends to cover WHO's work on the collection, analysis and dissemination of health statistics, development of standards in relation to the International Classification of Diseases and national health accounts.

Regulation and access to medical products

Equity in public health depends on access to essential, high-quality and affordable medicines, vaccines, diagnostics and other health technologies. Affordable prices ease health budgets everywhere, but are especially important in developing countries, where too many people still have to meet medical expenses out of pocket. Access to affordable medicines becomes all the more critical in the face of the growing burden of noncommunicable disease. This is so because individuals may require life-long treatment, and also because access to essential medicines early in the course of disease can prevent more serious consequences later. Improving access to medical products is obviously central to the achievement of universal coverage. Improving efficiency and reducing wastage is an important component of health financing policy.

There are several elements to this priority, including rational procurement and prescribing that favours greater use of generic over originator brands; promoting research and development for

the medical products needed by low-income countries; and prequalification that facilitates market entry of manufacturers from the developing world.

Future work will build on all these elements but will increasingly focus on creating the conditions for greater self-reliance, particularly in the countries of the African Region. In circumstances where local production offers real prospects for increasing access and affordability WHO will support technology transfer. Regional networks for research, development and innovation are already in place. The missing link in many countries therefore is adequate national regulatory capacity. Thus development and support for regional or national regulatory authorities will become a major priority for WHO's future work in this area, gradually reducing reliance on global prequalification programmes.

Preparedness, surveillance and response aims to reduce mortality, morbidity and societal disruption resulting from epidemics, natural disasters, conflicts, environmental and food-related emergencies through prevention, preparedness, response and recovery activities that build resilience and utilize a multisectoral approach.

The importance of this category to WHO's work is that those countries and communities that have invested in risk reduction, preparedness and emergency management are more resilient to disasters and tend to respond more effectively, irrespective of the cause of the threat. Secondly, deep disparities remain between Member States in their capacity to prepare for and respond to acute and longer-term threats. Thirdly, emergency risk management in the past has had limited impact due to its fragmented and inefficient nature.

The fundamental change that underpins WHO's work is the need to pursue a more holistic approach to disaster reduction. This will require a response to all serious hazards and risks that integrates enhanced prevention, emergency risk reduction, preparedness, surveillance, response and early recovery. In addition the approach reflects lessons learnt from countries that have recently been exposed to major disasters, particularly the need to work more closely with and use the combined assets of civil defence authorities, the military and police. Such an approach will become the basis for work across WHO, within Member States and will link to similar reforms in the broader international humanitarian system. To optimize impact at country level, this approach will be integrated into comprehensive national disaster risk management plans that contribute to improved health outcomes.

Alert and response capacities

The key priority is to ensure that all countries have the core capacities needed to fulfill their responsibilities under the International Health Regulations (2005) prior to the deadline in 2016. These include: national legislation, policy and financing; coordination and national focal point communications; surveillance; response; preparedness; risk communication; human resources; and laboratories. WHO will support countries in support national efforts and report on progress. In addition, WHO's role will be to continue to further develop and maintain the integrity of the policy guidance, information management and communication systems at global, regional and country level needed to detect, verify, assess and coordinate the response to acute public health events as and when they arise.

Emergency risk and crisis management

Health should be at the heart of the response to natural disasters and other emergencies. The overall purpose of WHO's work is to help create a situation in which countries are better prepared to deal with the health consequences of emergencies, and in which the protection of peoples' health is maximized and disruption to travel and trade reduced to a minimum. It starts from the premise that national authorities, not outside bodies, are responsible for coordination and management, and that it is the role of WHO and other parts of the United Nations to build the required capacity for them to do this successfully. A new Emergency Response Framework will guide work to enhance multi-hazard emergency risk management capacity for health, including national responses to conflict and natural disasters, covering the sequence of preparedness, response and early recovery, with a particular emphasis on preparedness. WHO's strategy in this regard is in line with the Inter-Agency Standing Committee Transformative Agenda and the Global Platform for Disaster Reduction.

Epidemic- and pandemic-prone diseases

The focus will be on supporting the implementation of relevant international frameworks and agreements such as the Pandemic Influenza Preparedness Framework and the Global Action Plan for Influenza Vaccines as well as established mechanisms for other epidemic-prone conditions such as the IHR national focal points, the Internet, critical documents and reports, and the WHO *Bulletin* and WHO *Weekly Epidemiological Record*. Support to countries will focus on preparedness, focused on the highest risk epidemics, including support for critical diagnostic capacities and selected supplies through networks and stockpile mechanisms. This priority will address the major knowledge gaps needed to strengthen the world's response to epidemics, including predictive modeling of disease patterns; a wide range of translational and operational research gaps (including promoting a range of strategies to combat the threat of antimicrobial resistance); and important product availability gaps. Work will include the development and dissemination of international standards and recommendations for influenza vaccine strain selection, and for the use of vaccines in the control of other epidemic-prone diseases (including cholera, hepatitis and meningitis).

Food safety

The principles of detection, assessment, prevention, and management apply equally to food-borne public health risks. Similarly, preparedness is based on evidence-based risk management options to control priority hazards along the entire food chain. Future work will give particular priority to the links between agriculture and public health and the links between food and drug regulation.

Polio eradication

Polio eradication is regarded as a programmatic emergency that extends as a priority through the six-year period of the general programme of work. The immediate objective is the complete eradication of wild poliovirus. Thereafter, internationally agreed surveillance, containment and outbreak response is needed for the polio end-game period; regional consensus for the switch from oral vaccines; and international consensus on the goal and process for securing the public health legacy of polio eradication.

CHAPTER 4

ENABLING FUNCTIONS AND CORPORATE SERVICES

This category includes functions and services that contribute to the achievement of the outcomes of WHO governance and management reform, namely to ensure “greater coherence in global health, with WHO playing a leading role in enabling the many different actors to play an active and effective role in contributing to the health of all peoples” and “an Organization that pursues excellence; one that is effective, efficient, responsive, objective, transparent and accountable”.

Its scope therefore encompasses functions that enable WHO to play a more effective leadership role in health at country, regional and headquarters levels. Equally, it encompasses the leadership required within and across WHO itself to ensure synergy, coherence and transparency, as well as the services required to maintain the integrity and efficient functioning of WHO and its working environment.

The challenges in this category are those that have been identified in the governance and management components of WHO reform: alignment and harmonization of governance processes; more strategic decision-making by WHO’s governing bodies; and effective engagement with other stakeholders. Management challenges include more effective technical and policy support for all Member States, with a particular focus on strengthening country presence and clear delineation of roles and responsibilities between headquarters, regional and country offices; staffing that is matched to needs at all levels of the Organization; more predictable and flexible financing aligned with agreed priorities; ensuring that WHO is accountable and that it effectively manages risk; and that it has the capacity to communicate its role and achievements to different audiences.

Category 6 covers the oversight and implementation of strategic management and government reforms. It also accommodates the ongoing management and administrative functions of the Secretariat. Unlike other categories the results chain is not expressed in terms of contribution to health service coverage or health outcome. Instead specific deliverables are judged in terms of performance indicators, benchmarks agreed and applied by similar organizations or opinion surveys of those that utilize services.

Further work is needed to develop aggregate measures of outcome with a clear relationship shown to the indicators to be used to monitor WHO governance and management reforms. These measures are likely to be of, for example, increased effectiveness in health governance, increased predictability of WHO’s financing, stronger WHO country offices, demonstrable value for money in relation to corporate services, and robust risk management .

Because it covers a very wide range of work – both strategic and routine in nature – the corresponding section of the draft proposed programme budget is structured around several thematic areas and sub-areas as a way of organizing a wide range of outputs. These divisions are not all reflected in the present draft of the general programme of work, which provides only a broad overview of the main components of this category. Closer alignment of the structure of both documents will be necessary in subsequent drafts.

Leadership in health

WHO plays a leadership role in health governance and in influencing governance in other sectors in the interests of health through its interactions with a wide range of stakeholders at global, regional and country levels. These include United Nations funds, programmes and specialized agencies; other

intergovernmental and parliamentary bodies; regional political and economic integration organizations; development banks and other providers of official development assistance; philanthropic foundations; a wide range of partnerships, with interests in global health, including those hosted by WHO; as well as civil society organizations and nongovernmental organizations, and selected private commercial organizations. In addition, work in this area is concerned with internal coordination, across all levels of the Organization, so that WHO can present consistent and cogent positions in support of global health. Finally, it covers the management, oversight and facilitation of partnerships that are hosted by WHO.

Country presence

WHO's leadership at country level is a particularly important element of the reform agenda. This category therefore covers the policy, management, staff development and administrative services that increase the effectiveness of WHO Offices in countries, areas and territories, and, more broadly, that shape WHO's cooperation with countries where the Organization has no physical presence. In practice this means regularly updating the processes and tools needed for developing country cooperation strategies in all countries; ensuring that each strategy, as it is developed, is closely aligned with national health policies, strategies and plans; and, where appropriate, that its key components are reflected in the United Nations Development Assistance Framework. Beyond the country cooperation strategy process, this function facilitates the flow of information to, from and between country offices, providing technical guidance as required and keeping all country offices up to date with Organization-wide developments. Country leadership requires a match between country needs, WHO priorities (as set out in the country cooperation strategy) and the staffing, skill mix and classification of the country office. Lastly, strengthening WHO in-country leadership capacity requires staff development services that are tailored to the needs of WHO Offices in countries, areas and territories (particularly in health diplomacy); strengthened selection processes for the Heads of those Offices; and a roster of eligible candidates for them.

Governance and convening

In support of the Organization's leadership role, WHO acts as a convenor for a wide range of negotiations and discussion between Member States and other stakeholders on public health issues. This convening role operates at country level in relation to coordination of health partners; at regional level in relation to cross-border and other issues relevant to groups of countries or the Region as a whole; and at headquarters in relation to an increasing number of intergovernmental meetings. In addition, Member States meet and act in their role as the governors of WHO itself. This component therefore covers the support provided by the Secretariat, including language services, to all WHO's governance processes: statutory meetings at headquarters (of the World Health Assembly and Executive Board) and of regional committees, as well as of ad-hoc intergovernmental committees and working groups. WHO's legal services protect the Organization's interests in all interactions for which legal advice is required and are included in this component.

Strategic policy, planning, management and resource coordination

This component is about leadership of the Secretariat. It covers the role of the senior managers – through mechanisms such as the global policy group – in ensuring coherence, synergy and alignment between the different parts of the Secretariat, including the oversight and direction of WHO reform. It also encompasses strategic planning, budget management, performance assessment, resource mobilization, and reporting at all three levels. Of particular importance is the development, negotiation and implementation of new approaches to financing designed to increase the predictability, flexibility and sustainability of WHO's financing.

Strategic communications

Health is an issue of public and political concern worldwide. The increasingly complex institutional landscape, the emergence of new players influencing health decision-making, 24-hour media coverage, and a growing demand from donors, politicians and the public to clearly demonstrate the impact of WHO's work, means that rapid, effective and well-coordinated communications are essential. Key elements of the communications strategy are to ensure a service that has the surge capacity needed to handle increased demands in the face of emergencies; a more pro-active approach to working with staff and the media in order to explain WHO's role and its impact; and regularly measuring public and stakeholder perceptions of WHO.

Knowledge management

Access to up-to-date evidence, expert opinion and in-depth country knowledge is essential for building and maintaining the professional competence of WHO staff at all levels of the Organization. The means of ensuring such access and for the dissemination and management of professionally-relevant information are changing rapidly. A modern knowledge management strategy and service – for WHO itself – will focus on the cost-effective use of technology to enable staff to create, capture, store, retrieve, use and share knowledge relevant to their professional roles. There is a strong link between the systems described above in relation to country presence and those required to ensure that knowledge management benefits staff at all levels of WHO. This theme also covers the policies and systems required to coordinate WHO's relationships with collaborating centres, expert advisory panels and committees and to manage all aspects of WHO's published output, including working toward more open access policies through copyright management. Lastly, this theme is concerned with quality control as a specific aspect of risk management. The Guidelines Review Committee ensures strict adherence to best practice in how evidence is used in preparing WHO guidelines and recommendations. The Ethics Review Committee fulfils a similar function in relation to the ethical conduct of WHO-financed research.

Accountability and risk management

More effective and more comprehensive management of risk is at the heart of management reform in WHO. This component therefore encompasses a range of services essential to the achievement of that objective. Underpinning these services is a framework that covers all aspects of risk management in the form of a risk register, with established processes in place for ensuring that it is regularly updated and that reports on compliance and risk mitigation are presented to and considered by WHO senior management. To ensure the effective working of the risk management system, internal audit and oversight services will be strengthened, and a new Ethics Office – focusing on standards of ethical behaviour by staff and ensuring the highest standards of business practice (particularly in relation to conflict of interest and financial disclosure) – will be established. The Ethics Office will also work closely with a strengthened internal justice system and will oversee the implementation of a new information disclosure policy. Risk management in the Secretariat is supported by the Independent Expert Advisory Committee (IEOAC) which, in addition, provides the link between internal oversight services and WHO's governing bodies, through the Executive Board, and its subcommittee, the Programme, Budget and Administration Committee. Lastly, this theme includes an oversight function in relation to evaluation, promoting evaluation as an integral function at all levels of WHO and facilitating independent evaluation studies.

Management and administration

This component covers the core administrative services that underpin the effective and efficient functioning of WHO: finance, human resources, information technology, and operations support. It is

NOT MERELY THE ABSENCE OF DISEASE
GPW12 draft for regional committees

a particular priority to ensure the adequacy of the financial control framework (as a specific aspect of risk management), such that expenditure is properly authorized and recorded, account record keeping is accurate, assets safeguarded and liabilities are correctly quantified, along with accurate and timely financial reporting. In a context of austerity in many donor countries, WHO needs to have systems in place that allow it to state, with confidence and on time, how all monies that have been invested in the Organization have been used and what their use has achieved.

The focus in relation to human resources is also in line with the overall management reform, which seeks to ensure that WHO is able to recruit and deploy the right staff to where they are needed; to manage staff contracts in line with existing rules and in ways that encourage mobility and career development; to use modern workforce planning to promote continuity of essential functions; and to ensure that WHO has human resources policies and systems in place that allow the Organization to respond rapidly to changing circumstances and public health needs.

CHAPTER 5

RESULTS CHAIN

Introduction

This chapter sets out how investment in WHO makes a difference to people's health.

The Medium-term strategic plan, 2008–2013, contained 13 strategic objectives and 85 Organization-wide expected results (OWERS) each with several targets and indicators. This approach provided a structure for allocating resources and assessing performance between and within strategic objectives. However, particularly in terms of performance, it did not provide a way of showing how the work of different parts of the Organization comes together to make an overall difference to health outcomes and health equity. The draft twelfth general programme of work sets out to address that deficiency.

Conceptually, the challenge is to develop a clear chain of results that links inputs, outputs, outcomes and impact. Within each category, it is relatively straightforward to list discrete outputs and show their links to a finite number of outcomes. However, progress along the results chain reveals that higher-level results are linked to several categories. Thus, the achievement of a 25% reduction in mortality from noncommunicable diseases is not a product of work in category 2 alone. It depends equally on work in health systems and health promotion (and in the case of a growing number of cancers, on action against vaccine-preventable diseases).

An additional conceptual issue concerns the relative position of different links in the results chain. From a strictly epidemiological perspective, outcomes in terms of reducing risks and access to services contribute to reducing morbidity and mortality. However, in line with the overall thrust of this draft programme of work, WHO is equally concerned with work on well-being, equity and access to health care both as a right, and as something to be valued for itself. This concern is partly addressed through the identification of “improved healthy life expectancy” as the overall impact of the Organization, and “universal health coverage” (itself encompassing the dual elements of access to care and financial protection), as a central means by which to achieve this.

The second, more technical, challenge in defining high level results, is that they have to be expressed in ways that allow meaningful and reliable measurement. This remains very much “work in progress”. In addition, there is the question of attribution. Outputs describe those elements for which WHO is wholly responsible. The achievement of outcomes and higher-level results by contrast depends on collaboration with countries and other partners. In this regard, the draft general programme of work takes a clear stance. The impacts and outcomes set out in the present document are those with which the work of WHO is closely associated; for which WHO shares responsibility (acknowledging the need for collaboration with others); and by which the performance of the Organization as a whole should be judged.

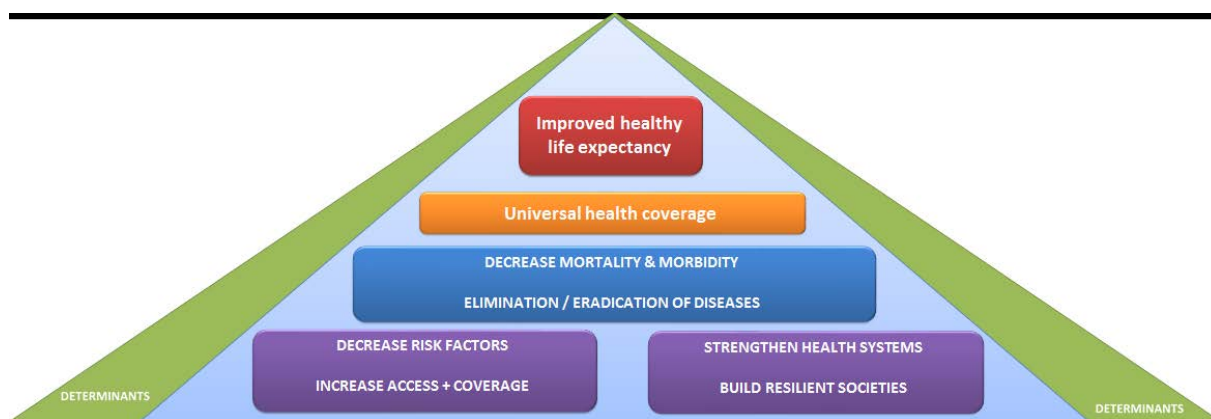
A third challenge is managerial. A budget structure based on mutually exclusive categories with links to organizational structure is required for the costing of outputs and for resource allocation across programmes and levels. At the same time, aggregate measures of performance for the Organization as a whole result from work across categories. To resolve this issue the draft general programme of work

focuses primarily on aggregate measures of performance (at impact and outcome level), while the draft proposed programme budget provides a structure that can be used for costing outputs, for resource allocation and for assessing performance and accountability across the different parts of WHO. Each result at outcome level listed below is also found in one (and only one) of the five categories in the draft proposed programme budget, thereby providing a clear link and ensuring consistency between the two documents.

Making a difference

The impact and outcomes of WHO's work can be conceived of as a pyramid (see Figure 2 below).

Figure 2. Impact and outcomes of WHO's work: a strategic overview



IMPACT

Healthy life expectancy

The overall impact of the work of the Organization is the contribution to increases in healthy life expectancy. Whilst aggregate increases are desirable (and used in some countries and regions as a measure of progress in health), WHO, in line with its core values, is equally concerned with issues of equity. Thus measures are also needed to show progress in reducing the differences in healthy life expectancy within and between countries. Additionally, given the worldwide issue of ageing populations measures may also include a measure of healthy life expectancy at the age of 60 years.

For next draft: measures and targets will draw on existing bodies of work on measuring healthy life expectancy and well-being.

Universal health coverage (UHC)

Universal health coverage is a unifying concept. It requires that all people obtain the health services they need without the risk of severe financial problems linked to paying for them. At the same time, the health services received need to be of good quality. This cannot be achieved overnight, but WHO's work will help countries to take the actions needed to move more rapidly towards it or to maintain the gains they have made. Universal health coverage is conceived not as a minimum set of services but as an active process by which countries gradually increase access to curative and preventive services as well as protecting increasing numbers of people from catastrophic financial consequences when they

fall ill. Universal coverage maintains and improves health, but it also helps people escape from poverty and decreases inequity. It is therefore central to the work and the achievements of WHO.

(For next draft: measures of progress will be developed and will draw on existing bodies of work (such as those in the Millennium Development Goals; measures of access to or coverage of services; and measures of financial protection) for measuring universal health coverage.)

Reducing mortality, morbidity, eradication and elimination of diseases

In addition to healthy life expectancy and universal health coverage, measures are needed to show the combined impact of work on overall rates of mortality and morbidity. In the case of noncommunicable disease an overall goal has been agreed (a 25% reduction in global mortality from noncommunicable between 2010 and 2025). For communicable diseases, reduction in child deaths is a good indicator of work in category 3 as well as of an overall reduction in these diseases. Some cause-specific measures of impact are also needed to measure progress. Finally, at this level some specific diseases are targeted for eradication or elimination within the period 2014–2019.¹

- Reduction in **childhood mortality**... *post-Millennium Development Goal target/rate of reduction to be defined*
- Reduction in **maternal mortality**... *post-Millennium Development Goal target/rate of reduction to be defined*
- Progress toward 2025 global target of reducing **global mortality from noncommunicable diseases** – *rate of decline/target for 2019 to be defined*
- *Aggregate measures needed for **other noncommunicable conditions** such as mental health, disabilities, violence and injuries*
- Reduce overall number of **AIDS** deaths and reduce new pediatric HIV infections
- Reduction of global **tuberculosis** mortality rate in 2015 compared with 1990
- Reduce number of **malaria** deaths – *target to be defined*
- *Aggregate measures needed to track reductions in **neglected tropical diseases***
- Complete the eradicate of poliomyelitis and dracunculiasis
- Elimination by 2015 of rabies in the Region of the Americas and of schistosomiasis in the Eastern Mediterranean Region;
- Elimination of measles, leprosy and neonatal tetanus globally.

¹ More work is needed to standardize the way in which results are presented and to prepare clear outcome statements linked to indicators and targets.

OUTCOMES

Reduction of risk and access to services¹

The next level looks at what needs to happen in order to achieve these impacts. At this level there are outcomes, which are reductions in risk, and increases in access to services and coverage of interventions (some of which are expressed in terms of indicator targets).

- >50% babies exclusively breastfed for six months
- 40% relative reduction in stunting: prevalence of low height for age (< -2 SD) in children under five years of age
- Global average coverage with three doses of DTP vaccines
- >80% children with suspected pneumonia receive antibiotics
- >50% mothers and babies receive postnatal care within two days of childbirth
- >80% of women receive antenatal care at least four times by a skilled provider during pregnancy
- >80% pregnant women receive skilled attendance at birth
- Reduction in adolescent pregnancies ... to be more precisely defined
- Reduction in unmet need for contraception (to be more precisely defined)
- Number of people living with HIV on antiretroviral therapy
- Percentage of notified tuberculosis patients tested for HIV in settings with high HIV prevalence
- Number of tuberculosis patients enrolled on MDR-TB treatment annually
- Percentage of population at malaria risk targeted for vector control using an insecticide-treated bednet or protected by indoor residual spraying
- Sustainable dengue prevention and control interventions established in disease-endemic priority countries
- Coverage of preventive chemotherapy to control lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminthiasis and trachoma.
- Cancer prevention and early detection scaled up to achieve: a) 70% of women between ages 30–49 screened for cervical cancer at least once; b) 25% increase in the proportion of breast cancers diagnosed in early stages; c) <1 % prevalence of HBsAg carrier
- Blood pressure/hypertension (25% relative reduction): age-standardized prevalence of raised blood pressure among persons aged 18+ years
- 10% relative reduction in the harmful use of alcohol: adult per capita consumption in litres of pure alcohol (recorded and unrecorded)
- 30% relative reduction of tobacco smoking: age-standardized prevalence of current tobacco smoking among persons aged 15+ years
- 30% relative reduction in dietary salt intake: age-standardized mean adult (aged 18+) population intake of salt per day
- 10% relative reduction in physical inactivity: age-standardized prevalence of insufficient physical activity in adults aged 18+ years
- No increase in adult obesity: age-standardized prevalence of obesity in adults aged 18+ years
- No increase childhood obesity: age-standardized prevalence of obesity in children aged less than 5 years
- 80% coverage of multidrug therapy for people aged 30+ years with a 10 year risk of heart attack or stroke $\geq 30\%$, or existing cardiovascular disease
- Cataract surgical rate (number of surgeries performed per year per million population)

¹ Work in progress. There are clear links between some outcomes and the impacts listed above, new or better measures of risk reduction and access to services are needed for healthy ageing and the health of the elderly, mental health and disabilities (including deafness and blindness).

Reduction of risk, access to services, strong health systems and resilient societies

Countries need strong health systems as well as access to treatment and decreasing risk if they are to deliver better health. This means taking account of the needs of systems both in a stable situation, and those addressing public health hazards and emergencies. The table below therefore includes outcomes in relation to emergency risk management (some of which are expressed in terms of indicator targets).¹

Health systems

- Number/proportion of Member States in which a **national intervention coverage index of core services** is improving
- Number/proportion of Member States that: (i) have a **national health sector strategy** with goals and targets; (ii) conduct an annual multi-stakeholder review; and (iii) produce a health sector performance assessment report to inform annual reviews
- Number/proportion of Member States in which the percentage of households with **catastrophic out of pocket expenditure**: (i) are below XX%; and (ii) where the percentage in the poorest quintile of households is not greater than in the richest quintile (*to be used in measuring progress on UHC*)
- Number/proportion of Member States in which the percentage **of households impoverished** due to paying out of pocket for health services is below XX%
- Number of Member States where payment of **health care providers is regulated**
- Number of Member States with appropriate **accreditation of service providers**
- Number of Member States implementing appropriate **regulatory oversight of medical products**
- Number of Member States with monitoring systems on **price and availability of medicines** and medical products
- Number of countries using **essential medicines list** updated in the last five years for public procurement and reimbursement
- Number of Member States that are implementing sectoral policies that prevent and/or mitigate **environmental and occupational risks**
- *TBD: indicator for health workforce*
- Number/proportion of Member States in which the coverage **of birth and death registration**, with reliable cause of death, is improving among Member States with coverage less than 90%
- Number of Member States with a **food safety programme** that has a legal framework and enforcement structure
- Number of countries with an increase in **mental health budget** as a proportion of health budget
- Proportion of countries with comprehensive **laws** addressing five key risk factors for **road safety**
- Number of Member States with an active **‘Safe Hospital Programme’**

¹ Most of the health systems indicators are expressed in terms of number of Member States. Where appropriate these will be converted to absolute numbers or proportions of the population. Several additional measures needed including health workforce. Indicators of equity will draw on measures currently tracked in the *World Health Statistics*.

- *TBD - equity tracer indicator across socioeconomic groups?*
- *TBD - equity tracer indicator for women?*

Resilience

- Percentage of Member States with national **emergency risk management plans** that include epidemic and pandemic diseases.
- Number of Member States meeting and sustaining **International Health Regulations (2005) core capacities**.
- Number of Member States conducting or updating a **multi-hazard health emergency risk assessment** at least every two years.
- Percentage of Member States conducting a **national health emergency response exercise** at least every two years.
- Percentage of Member States delivering a basic package of **emergency** health services to affected populations within 10 days of a major emergency

Social, economic and environmental determinants

The determinants of health are linked to the results chain in different ways. As noted in Chapter 3, the draft proposed programme budget includes a wide range of outputs that address health determinants. These include outputs in relation to equitable access to services, standard setting in relation to food safety, drinking-water and sanitation and many others. In each category they contribute to the achievement of specific outcomes.

In this same vein, the cross-cutting character of determinants of health means that they will contribute to higher-level results across categories. The implications of international trade policies, for example, can play a role in reduction of exposure to noncommunicable disease risk factors, while concurrently linking to food security, access to medicines and technology transfer. Ensuring that determinants of health are adequately addressed at this level is as critical to achieving the desired impact as is producing specific health determinant-related outputs.

Determinants of health influence results in a manner that transcends specific outputs, outcomes and impact (as illustrated by the encompassing triangle in Figure 2). The circumstances of people's lives, in terms of the physical environment (safe water, clean air, healthy workplaces, safe communities etc.), income and social status, education, social support networks, and genetics, are as vital to health status as access to health services. Determinants of health in this sense are the structure upon which health results at every level are built.

Further work is required to ensure (a) that outputs related to social determinants are highlighted in the proposed programme budget; (b) that the link between these outputs and outcomes attributable to work in the area of social development are properly represented in the results chain (including in the outcomes of category 6 on WHO's role in health governance); and (c) that the mainstreaming aspect of social determinants (a priority within category 3) is reflected in the outcome tables.

CHAPTER 6

RESOURCES

A chapter on resources will be added in the next draft of the general programme of work.

EM/RC59/12

DRAFT PROPOSED PROGRAMME BUDGET 2014–2015
REGIONAL COMMITTEE VERSION



**World Health
Organization**

The draft proposed programme budget 2014–2015 is presented for regional committee consideration in its early stages of development in order to allow programmatic review and discussion of the priorities and results/deliverables proposed for the work of the Organization in 2014–2015. During recent governing body discussions on the reform agenda, Member States requested a more active engagement in the process. The discussion and elaboration of the draft twelfth general programme of work 2014–2019 is a close parallel process, given the direct links between the two texts. Specific input and guidance from Member States will support the further development of both.

The next version of the draft proposed programme budget 2014–2015 will be presented to the Executive Board in January 2013, through the Board's Programme, Budget and Administration Committee. That draft will be informed by the discussions of the regional committees and will include a realistic budget that is costed on the basis of the agreed results.

INTRODUCTION

1. Overview of the context: WHO reform

The three main areas of the WHO reform process are: (i) programmes and priority setting; (ii) governance; and (iii) managerial reforms. The development and subsequently the execution of the Twelfth General Programme of Work 2014–2019 and its associated programme budgets are an essential means of advancing the WHO reform process. In particular, the aim is to improve results-based management and accountability through a simplified and robust planning framework that serves as an effective tool for accountability and transparency, programming and resource mobilization.

The six-year general programme of work outlines the higher levels of the results chain (impact and outcomes) and the biennial programme budgets state clearly the deliverables of the Secretariat (outputs) that are linked to the impacts and outcomes. The programme budgets are realistically budgeted based on projections of income and expenditure.

The programme budget is a core organizational instrument through which to strengthen financing, resource mobilization and strategic communication. It will be used for corporate resource mobilization and to promote joint proposals that are fully aligned with organizational priorities and responsive to the needs of Member States. The goal is to increase the proportion of flexible and predictable funds so as to achieve a fully financed budget.

The categories and criteria agreed by Member States in February 2012, and the comments and suggestions from Member States at the Sixty-fifth World Health Assembly have been used to elaborate a set of high-level priorities for WHO in the draft general programme of work for 2014–2019. The five categories (plus corporate services) provide the main structure for the programme budget. The agreed criteria, along with the core functions of WHO, have been used to define the more detailed priorities and the organizational deliverables that now appear in the draft proposed programme budget 2014–2015.

Priorities based on the collective and individual needs of Member States will guide resource allocation and provide the basis for systematic and comprehensive monitoring of resources and performance.

2. Global health - challenges and prospects

(Next draft – for EB132: This section will be aligned with the draft twelfth general programme of work and will be added to the next draft of the proposed programme budget 2014–2015. It will contain a review of the context in which WHO would work during the biennium 2014–2015. Highlights (specific to the biennium) from the draft twelfth general programme of work will be provided in relation to: the new political, economic and social context; global health challenges and the institutional landscape of global health.)

3. Priorities for 2014–2019 and emphases for 2014–2015

The agreed categories and proposed priorities for the period 2014–2019 that are set out in Table 1 and the criteria that are shown in Table 2 are reproduced identically from the draft twelfth general programme of work.

Table 1. Categories for priority setting and programmes in WHO

Categories	Priorities*
1. Communicable diseases: reducing the burden of communicable diseases, including HIV/AIDS, tuberculosis, malaria, and neglected tropical diseases.	<ul style="list-style-type: none"> • HIV/AIDS • Tuberculosis • Malaria • Neglected tropical diseases • Vaccine-preventable diseases
2. Noncommunicable diseases: reducing the burden of noncommunicable diseases, including heart disease, cancer, lung disease, diabetes, and mental disorders as well as disability, and injuries, through health promotion and risk reduction, prevention, treatment and monitoring of noncommunicable diseases and their risk factors.	<ul style="list-style-type: none"> • Heart disease, cancers, chronic lung diseases, diabetes (and their major risk factors: tobacco use, unhealthy diet, physical inactivity, and harmful use of alcohol) • Mental health • Violence and injuries • Disabilities (including blindness and deafness) and rehabilitation • Nutrition
3. Promoting health through the life-course: reducing morbidity and mortality and improving health during pregnancy, childbirth, the neonatal period, childhood and adolescence; improving sexual and reproductive health; and promoting active and healthy ageing, taking into account the need to address determinants of health and internationally agreed development goals, in particular the health-related Millennium Development Goals.	<ul style="list-style-type: none"> • Maternal and newborn health • Adolescent sexual and reproductive health • Child health • Women's health • Healthy ageing and health of the elderly • Gender and human rights mainstreaming • Health and the environment • Social determinants of health
4. Health systems: support the strengthening, organization with a focus on integrated service delivery and financing, of health systems with a particular focus on achieving universal coverage, strengthening human resources for health, health information systems, facilitating transfer of technologies, promoting access to affordable, quality, safe, and efficacious medical products, and promoting health services research.	<ul style="list-style-type: none"> • National health policies, strategies and plans • Integrated people-centred services • Regulation and access to medical products
5. Preparedness, surveillance and response: surveillance and effective response to disease outbreaks, acute public health emergencies and the effective management of health-related aspects of humanitarian disasters to contribute to health security.	<ul style="list-style-type: none"> • Epidemic- and pandemic-prone diseases • Alert and response capacities • Emergency risk management and crisis management • Food safety • Polio eradication
6. Corporate services/enabling functions: organizational leadership and corporate services that are required to maintain the integrity and efficient functioning of WHO.	

*Includes additional priorities proposed for consideration by the regional committees

Table 2. Criteria for priority setting and programmes in WHO

Criteria
1. The current health situation including: demographic and epidemiological trends and changes, urgent, emerging and neglected health issues; taking into account the burden of disease at the global, regional and/or country levels.
2. Needs of individual countries for WHO support as articulated, where available, through the country cooperation strategy, as well as national health and development plans.
3. Internationally agreed instruments which involve or impact health, such as declarations and agreements, as well as resolutions, decisions and other documents adopted by WHO's governing bodies at the global and regional levels.
4. The existence of evidence-based, cost-effective interventions and the potential for using knowledge, science and technology for improving health.
5. The comparative advantage of WHO, including: <ul style="list-style-type: none"> (a) capacity to develop evidence in response to current and emerging health issues; (b) ability to contribute to capacity building; (c) capacity to respond to changing needs based on ongoing assessment of performance; (d) potential to work with other sectors, organizations, and stakeholders to have a significant impact on health.

The priorities listed in Table 1 are for the whole six-year period covered by the general programme of work, although the specific focus within the selected priorities may change from one biennium to another.

The Secretariat's work in 2014–2015 under each priority is described as the “outputs” within the chapters on each of the categories.

4. Results-based framework for programming and budgeting

The programme budget for the period 2014–2015 will be the first of three biennial budget cycles under the six-year general programme of work for 2014–2019. The programme of work establishes the vision and mission of the Organization; the criteria for priority setting and priority results; and the high-level section of the results framework, including impact targets and outcomes.

The proposed programme budget for 2014–2015 presents a detailed analysis of what needs to be done to realize the health vision of the draft general programme of work. It will include the contributions of the Secretariat (outputs) and a realistic budget required to deliver them. The programme budget also emphasizes the responsibility of the individual Member States in relation to achieving the outcomes and eventually the desired impacts.

The programme budget is the basis for detailed operational planning. As such, it is the primary instrument to express the full scope of work of the Organization and to identify the roles, responsibilities and budget allocations of the three levels of the Organization (country offices, regional offices and headquarters).

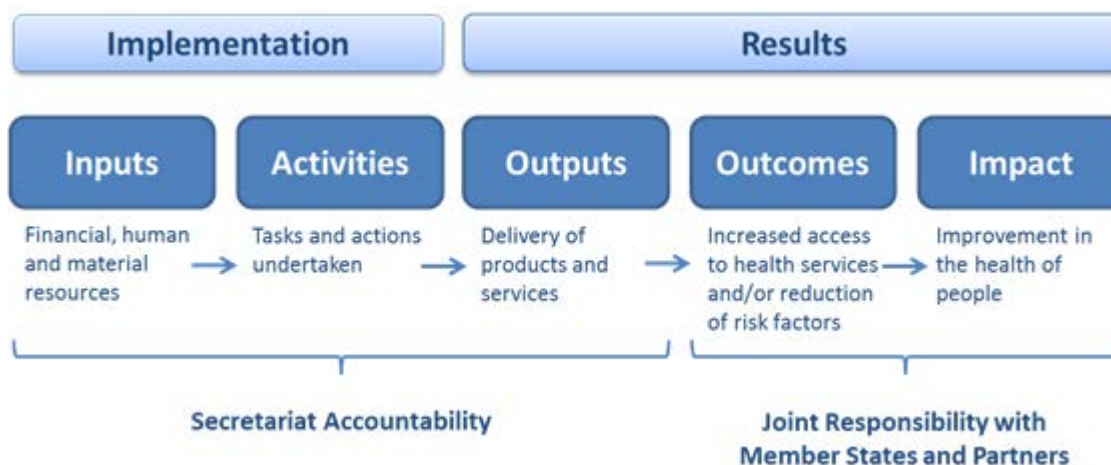
To fulfil these objectives, the programme budget communicates strategically and effectively:

- the priorities of the Organization, based on an objective technical analysis of the collective and individual needs of Member States;
- a clear results chain, linking the work of the Secretariat (outputs) to the health and development changes in countries/globally to which it contributes (outcomes and impacts);
- a realistic and credible budget presenting a sufficient level of detail to allow existing and potential donors to finance directly against it;

- meaningful and measurable performance indicators and targets.

Consistent with these objectives, a revised results chain has been introduced, illustrated in Figure 1 below.

Figure 1. The WHO results chain

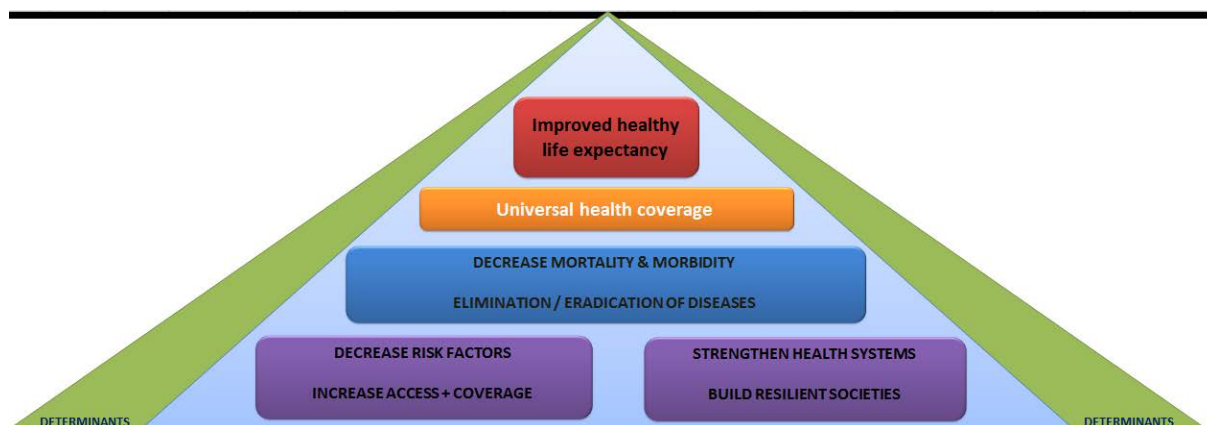


The revised results chain has the following elements:

- **Impacts** – sustainable changes in the health of populations to which the Secretariat and Member States contribute.
- **Outcomes** – the collective or individual changes in Member States to which the work of the Secretariat is expected to contribute.
- **Outputs** – the deliverables of the Secretariat for which it will be held accountable.
- **Activities** – the tasks and actions taken that turn inputs into outputs.
- **Inputs** – the resources (human, financial, material and other) that the Secretariat will allocate to activities and produce the outputs.

The impact and outcomes of WHO’s work can be conceived as a pyramid, as shown in Figure 2 below.

Figure 2. Impact and outcomes of WHO’s work: a strategic overview



IMPACTS

Healthy life expectancy

The overall impact of the work of the Organization is the contribution to increases in healthy life expectancy. Aggregate increases are desirable (and used in some countries and regions as a measure of progress in health), however, WHO, in line with its core values, is equally concerned with issues of equity. Thus measures are also needed to show progress in reducing the differences in healthy life expectancy within and between countries. Additionally, given the worldwide issue of ageing, population measures may also include a measure of healthy life expectancy at the age of 60 years.

(Next draft – for EB132: measures and targets will be developed and will draw on existing bodies of work on measuring healthy life expectancy and well-being.)

Universal health coverage

Universal health coverage is a unifying concept. It requires that all people obtain the health services they need without the risk of severe financial problems linked to paying for them. At the same time, the health services received need to be of good quality. This cannot be achieved overnight, but WHO's work will help countries take the actions needed to move more rapidly towards it or to maintain gains they have made. Universal health coverage is conceived not as a minimum set of services but as an active process by which countries gradually increase access to curative and preventive services as well as protecting increasing numbers of people from catastrophic financial consequences when they fall ill. Universal coverage maintains and improves health, but it also helps people escape from poverty and decreases inequity. It is therefore central to the work and the achievements of WHO.

(Next draft – for EB132: measures of progress will be developed and will draw on existing bodies of work (such as those in the Millennium Development Goals; measures of access to or coverage of services; and measures of financial protection) for measuring universal access to health.)

Reducing mortality and morbidity, and the elimination and eradication of diseases

In addition to healthy life expectancy and universal health coverage, measures are needed to show the combined impact of work on overall rates of mortality and morbidity. In the case of noncommunicable diseases, an overall goal has been agreed (a 25% reduction in global mortality from noncommunicable diseases between 2010 and 2025). For communicable diseases, reduction in child deaths is a good indicator of work in category 3 as well as an overall reduction in communicable diseases. Some cause-specific measures of impact are also needed to measure progress. Finally, at this level some specific diseases are targeted for elimination or eradication within the period 2014–2019.¹

¹ More work is needed to standardize the way in which results are presented and to prepare clear outcome statements linked to indicators and targets.

IMPACT TARGETS

- Reduction in childhood mortality... post-Millennium Development Goal target/rate of reduction to be defined.
- Reduction in maternal mortality... post-Millennium Development Goal target/rate of reduction to be defined.
- Progress toward 2025 global target of reducing global mortality from noncommunicable diseases – rate of decline/target for 2019 to be defined.
- Aggregate measures needed for other noncommunicable conditions such as mental health, disabilities, violence and injuries.
- Reduction of overall number of AIDS deaths and reduction of new pediatric HIV infections.
- Reduction of global tuberculosis mortality rate in 2015 compared with 1990.
- Reduction of number of malaria deaths – target to be defined.
- Aggregate measures needed to track reductions in neglected tropical diseases.
- Eradication of poliomyelitis and dracunculiasis.
- Elimination by 2015 of rabies in the Region of the Americas and of schistosomiasis in the Eastern Mediterranean Region.
- Elimination of measles, leprosy and neonatal tetanus.

OUTCOMES

Reduction of risk, access to services, strong health systems and resilient societies

To achieve the impacts outlined above, outcomes such as reductions in risk, and increases in access to services and coverage of interventions are required. As well as this, countries need to have strong health systems if they are to deliver better health. This means taking account of the needs of systems both in a stable situation, and those addressing public health hazards and emergencies.

The outcomes are further defined in the chapters on each proposed category. At this stage the outcomes are expressed in terms of indicator targets, to which the priorities in a particular category will contribute.

Work is ongoing to standardize the way in which outcomes are presented and to develop a tighter linkage to the priorities – this will be done in future versions of the draft programme budget.

OUTPUTS

The contribution of WHO

The Secretariat's contribution to the outcomes and impact is shown in terms of the outputs for which the Secretariat is funded and for which it is wholly accountable.

The outputs are defined for each priority in the chapters on each proposed category and are based on the core functions of WHO.

Core functions of WHO

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

The activities required to deliver the outputs will be determined during operational planning and implementation.

5. Overview of the proposed budget

The next versions of the draft proposed programme budget for 2014–2015 that will be presented to the Executive Board in January 2013 and to the Health Assembly in May 2013 will have budget figures and more informed and explicit reasons for allocations to categories, priorities, major offices and to the different levels of the Organization. This will have been informed by Member States' review of and guidance on the present version of the draft proposed programme budget 2014–2015, specifically, the review of priorities, approaches and WHO's outputs.

As a starting point for discussion, the figures for the expenditure in 2010–2011 (as presented in the performance assessment) and the approved programme budget for 2012–2013 have been mapped against the six categories and major offices (see Annexes 1 and 2). This is intended to indicate the weighting/budgetary emphases for these categories in the past and present bienniums, as a useful point of comparison. The Programme budget 2014–2015 will not be "business as usual", and will not simply repeat previous allocations.

6. Effective financing

(This section will be added in the next version of the proposed programme budget 2014–2015. It will provide details of the assumptions made regarding the sources of income: assessed and voluntary contributions. It will also provide elements of resource mobilization in the context of WHO reform.)

7. Monitoring and assessing the programme budget

Performance monitoring and assessment are essential for the proper management of the programme budget and to inform the revision of policies and strategies. Monitoring of the implementation of the programme budget will be conducted at the end of the 12-month period (the mid-term review) and an assessment will be made upon completion of the biennium (the programme budget performance assessment).

The mid-term review provides a means to track and appraise progress towards the achievement of the results. It facilitates corrective action, and the reprogramming and reallocation of resources during implementation. It is a process that allows the Secretariat to identify and analyse the impediments and risks encountered, together with the actions required to ensure achievement of the results.

The end-of-biennium programme budget performance assessment is a comprehensive appraisal of the performance of the Organization and will include an assessment of the delivery of the outputs agreed in the programme budget as well as an assessment of the progress towards the achievement of the stated outcomes. The assessment will be based on the measurement of performance indicators and focus on achievements in comparison with planned outputs and outcomes. The assessment will also provide an analysis of lessons learnt in order to inform planning for future programme budgets.

CATEGORY 1: COMMUNICABLE DISEASES

Reducing the burden of communicable diseases, including HIV/AIDS, tuberculosis, malaria, neglected tropical diseases and vaccine-preventable diseases.

Communicable diseases collectively contribute substantially to ill health, poverty and social stigma. They are major impediments to global health and impose great burdens on health systems in developing countries. Without significant reductions in the prevalence of these diseases, the Millennium Development Goals relating to health, education, gender equality, poverty reduction and economic growth will not be met.

PRIORITIES AND RATIONALE

The priorities in this category are HIV/AIDS, tuberculosis, malaria, neglected tropical diseases, and vaccine-preventable diseases. Other important communicable diseases, such as poliomyelitis, yellow fever, sexually transmitted diseases and a range of diseases with the potential to cause outbreaks, epidemics or pandemics (e.g. influenza, several zoonoses, viral encephalitis and hepatitis) are covered in other categories (see Linkages, below).

Three major communicable diseases – **HIV/AIDS, tuberculosis and malaria** – stand out because of their contribution to the burden of death and disability in most regions of the world. The demand for WHO support is consistent in more than 80% of country coordination strategies, and for each of the three diseases there are multilaterally agreed goals and targets.

HIV/AIDS: The African Region continues to have the highest burden of HIV/AIDS; however Eastern Europe and Central Asia are also of particular concern as these are the only regions where there is a continued increase in the number of people acquiring infection and dying of HIV-related causes.

Tuberculosis: Tuberculosis is the second leading cause of death from an infectious disease worldwide after HIV/AIDS. The key disturbing new trends that will influence future work include the growing problem of drug-resistant tuberculosis and the emergence of tuberculosis in elderly and migrant populations.

Malaria: About half of the world's population is at risk of malaria. In 2010 there were an estimated 216 million cases, of which most were in the African Region. The scope of malaria-affected areas is shrinking. In the areas that remain, people will be harder to reach and the services they need will be more difficult and expensive to deliver. The next few years will be critical in the fight against malaria, owing to economic uncertainties, parasite resistance to antimalarial medicines and mosquito resistance to insecticides. Unless properly managed, such resistance threatens progress in malaria control.

Neglected tropical diseases: These diseases, although not the highest contributors to overall mortality rates, are a major cause of disability and loss of productivity amongst some of the world's most disadvantaged people. One billion people are infected with one or more neglected tropical disease, and two billion people are at risk in tropical and subtropical areas. New and more effective interventions are available and disease reduction can help accelerate economic development. WHO is particularly well-placed to convene and nurture partnerships between governments, health-service providers and pharmaceutical manufacturers. These diseases are inextricably linked with health as a human right, with poverty reduction and with effective governance.

Vaccine-preventable diseases: An estimated 2.5 million deaths are prevented each year through immunization. Measles vaccination alone contributed to a 23% decline worldwide between 1990 and 2008 in deaths of children under five years of age. Immunization coverage and equity gaps persist between countries as well as within countries, with coverage rates being lower in rural areas than in urban areas, and the richest fifth of the population being better vaccinated than the poorest fifth.

CHALLENGES

HIV/AIDS: As work moves from an emergency response to a long-term, sustainable model of delivering services, the need is for simplified treatment regimens and technologies to expand antiretroviral access and to facilitate service integration with delivery of interventions including on tuberculosis, malaria, maternal, newborn and child health, viral hepatitis and drug dependence. More than half of those eligible for treatment do not currently have access to antiretroviral therapy. Ensuring affordable access will remain a key issue as drug-resistance increases and profit margins fall on first-line medicines, with the risk that large-scale generic manufacturers will exit the market.

Tuberculosis: Diagnosis and treatment of multidrug-resistant tuberculosis (MDR-TB) remain major challenges as levels of drug resistance continue to increase. Ensuring adequate access to diagnostics and first-line treatment remains key to progress. In a constrained economic environment, sustained domestic financing for tuberculosis services will be critical. At present there is a marked divide between the group of BRICS countries (Brazil, Russian Federation, India, China and South Africa), which are making rapid progress in relation to tuberculosis control and where 95% of funds come from national sources, compared with other high-burden countries, where only 51% of funding is domestic.

Malaria: A massive scale-up of treatment is required, based on accurate diagnosis. This in turn requires increased availability of rapid diagnostic tests and decreased cost. The potential availability of a vaccine will bring with it demand for normative advice on how, where and under what circumstances it should be used.

Neglected tropical diseases: Collaboration with manufacturers will be important in maintaining medicine supplies, although in the longer-term there will need to be a shift from donation to generic manufacture.

Vaccine-preventable diseases: Transformative innovation is needed in order to influence the design of vaccines and vaccine delivery systems; to improve vaccine management and reduce reliance on the cold chain as appropriate; to strengthen pharmacovigilance; and to support assessment of the efficacy and effectiveness of new vaccine products.

In addition to these specific needs, other challenges include lack of quality monitoring and surveillance data. Research, especially on new antimicrobials and insecticides, is constrained by lack of funding and lack of interest in diseases of the poorest. Innovations and technologies move too slowly from development to affordable availability, particularly in low-income countries.

Strong, evidence-based national policies, strategies and guidance are needed to ensure that national disease programmes acknowledge and internalize the social and economic determinants of health approach.

The lack of integrated approaches to communicable diseases and poor alignment with national plans must be overcome through intensive collaboration and coordination. Opportunities exist, for example, to expand support for immunization and related childhood interventions, building on current partnerships and initiatives and aligning with work done by the staff in the Polio Eradication Initiative.

STRATEGIC APPROACHES

There are four main strategic approaches in this category. WHO will continue the development of global norms and standards, simplified treatment guidelines, prevention technologies, diagnostic tests, vaccine delivery platforms and preventive chemotherapy.

WHO will also facilitate formulation and evaluation of policies, strategies and plans by: working with Member States, partners and communities, including civil society, to develop and implement global policies, regional and national strategies, costed plans, and monitoring and evaluation frameworks.

This will be supported by integrating information systems for better evidence-based decision-making and by monitoring the global, regional and country situations by collecting information, analysing it, projecting trajectories of disease burden, reporting, and certification where appropriate.

WHO will work with partners such as UNAIDS, the International Drug Purchase Facility, UNITAID, the Roll Back Malaria Partnership, the Stop TB Partnership, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States President's Emergency Plan for AIDS Relief and the GAVI Alliance, as well as with initiatives such as the Measles & Rubella Initiative, to ensure complementarity. Partners will be supported in the development of new strategic tools, innovations and commodities. WHO will also engage technical partners and communities to strengthen human resource capacities. Work will continue with a range of public and private partners to reach the control and elimination goals for 2020 in the "Roadmap for Implementation" developed to accelerate work to overcome the global impact of neglected tropical diseases.

Finally, WHO will strengthen its support to countries, and emphasize national ownership, sustainability and integration by: strengthening national capacities at all levels for sustainable programme success, disease surveillance, policy development and programme implementation; engaging other sectors and securing high-level political commitments for communicable diseases control/elimination; and ensuring linkages with health systems to tackle health system-related barriers.

LINKAGES

Category 1 contributes to and benefits from category 2 (noncommunicable diseases); category 3 (maternal, newborn, child and adolescent health); category 4 (health systems) and category 5 (surveillance). There is mutual collaboration between category 1 and category 5 on disease-control efforts and health system strengthening. There are linkages with category 5 with respect to International Health Regulations (2005) requirements for strengthening public laboratories; and foodborne diseases.

OUTCOMES

Below are the key outcomes (some of which are expressed in terms of indicator targets) to which the priorities in this category will contribute.

(Work is ongoing to standardize the way in which outcomes are presented and to develop a tighter linkage to the priorities and outputs. This will be done in future versions of the draft proposed programme budget.)

- Number of people living with HIV on antiretroviral therapy (*HIV/AIDS*).
- Percentage of notified tuberculosis patients tested for HIV in settings of high HIV prevalence (*tuberculosis*).
- Percentage of population at malaria risk targeted for vector control using an insecticide-treated bednet or protected by indoor residual spraying (*malaria*).
- Sustainable dengue prevention and control interventions established in disease-endemic priority countries (*neglected tropical diseases*).
- Coverage of preventive chemotherapy to control lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminthiasis and trachoma (*neglected tropical diseases*).
- Number of tuberculosis patients enrolled on MDR-TB treatment annually (*tuberculosis*).
- Global average coverage with three doses of DTP vaccines (*vaccine-preventable diseases*).

OUTPUTS

HIV/AIDS

- Facilitating the implementation of the Global Health Sector Strategy on HIV/AIDS and the achievement of 2015 Universal Access and elimination of mother-to-child targets (eMTCT) targets. Establish the post-2015 global HIV health sector agenda, targets, indicators and plans.
- Technical support to strengthen Member States' policy development updates and implementation and programme governance and implementation, health systems strengthening and resource mobilization, including through protocols and standard operating procedures supported by regional networks (including WHO collaborating centres and knowledge hubs).
- Consolidated simplified guidelines and policy guidance: to prevent and treat paediatric and adult HIV infections (2015 update); on select treatment and prevention technologies, including HIV testing, pre-exposure prophylaxis (PreP), male circumcision, HIV medicines and diagnostics, blood and injection safety; to reach key populations and remove access barriers and gender inequalities; and on integrating HIV and other health programmes, including tuberculosis, maternal, child and neonatal health, sexual and reproductive health, drug dependence and viral hepatitis.
- Facilitate scientific consensus on the research agenda for the development and regulation of priority vaccines and for new diagnostic tools for surveillance.
- Articulation of approaches to strengthening critical health systems components through HIV activities, including strategic information and planning, procurement and supply management, integrated service delivery models, community systems, and the health workforce.
- Global, regional and country progress reports on health sector response to HIV prevention, treatment and care, eMTCT and HIV drug resistance.

TUBERCULOSIS

- Updated and innovative tuberculosis policy guidance, including on HIV-related tuberculosis and multidrug-resistant tuberculosis (MDR-TB) care delivery, tuberculosis diagnostic approaches, tuberculosis screening in risk groups, and integrated community-based tuberculosis prevention and care. Regional adaptation of policy guidance given different regional and country settings including development of service delivery models.
- Updated guidelines, including on the use of new tuberculosis drugs and regimens for drug-sensitive and drug-resistant disease; preventive therapy; tuberculosis laboratory practices (including biosafety, accreditation and introduction of rapid diagnostic methods); and monitoring and evaluation standards. Regional adaptation of guidelines, norms and standards on tuberculosis and MDR-TB treatment, preventive therapy, and laboratory, monitoring and evaluation practices in all Member States.
- Coordinated technical support through the TBTEAM and other regional and country mechanisms to support implementation of the Stop TB strategy. Strengthened surveillance of tuberculosis cases and deaths based on systematic assessment, and national prevalence surveys.
- Post-2015 global tuberculosis strategy and new targets.

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- Promotion of a 2015 “Road map” with global, regional and country priorities in tuberculosis research to improve tuberculosis prevention, care and control, and prevention, and promotion of cross-country operational research collaboration.
- Annual *WHO Global tuberculosis control report* on tuberculosis care, control, and financing based on tuberculosis data collected and analysed at national, regional and global levels.

MALARIA

- Global strategy for malaria control and elimination 2015–2025, including an updated global plan for artemisinin resistance containment.
- Updated guidance on diagnostic testing and treatment, integrated management of febrile illness, vector control, stratification, surveillance, epidemic detection and response, disease elimination, migrant populations and urban malaria control.
- *World malaria report* (global), regional and country reports, based on strengthened in-country surveillance; global reports on drug and insecticide resistance.
- Technical support and capacity building to national health authorities on malaria control and elimination, including development of programmatic and training tools to support implementation of WHO recommended strategies, leveraging the expertise of technical working groups.

NEGLECTED TROPICAL DISEASES

- Facilitating the implementation of the neglected tropical diseases roadmap.
- Technical guidance to ministries of health to adapt WHO’s policies and guidelines, identify needs at country level, sustain neglected tropical diseases coordination mechanisms with a view towards scaling up, and improving prevention, case detection, case management and control of neglected tropical diseases. Technical support to countries to enhance monitoring, evaluation, surveillance, risk assessment and certification/verification of selected neglected tropical diseases elimination.
- Policy and technical guidance to countries to increase and sustain access to essential neglected tropical diseases medicines in countries.
- Coordinate clinical trials for effective and safer treatments and development of rapid and simple diagnostic tests for tool-deficient neglected tropical diseases (Buruli ulcer, human African trypanosomiasis, leishmaniasis, Chagas disease, yaws and dengue).
- Tools and strategies for the treatment and control of infectious diseases of poverty and improved research capacity at individual and institutional levels for countries to respond to their own control needs.
- Guidelines on monitoring and evaluation of neglected tropical diseases intervention and vector control, as well as operational guidelines for capacity building and implementation of preventive chemotherapy.
- Certification of dracunculiasis eradication.
- Monitoring and annual reports on progress and achievements in control, elimination and eradication of neglected tropical diseases, through strengthened monitoring and evaluation of interventions by neglected tropical diseases managers.

VACCINE-PREVENTABLE DISEASES

- Facilitating the implementation and monitoring of the Global vaccine action plan at global, regional and country levels coordinated and progress reported annually.
- Intensify coordination of measles and rubella elimination.
- New and/or updated guidance/tools/regulatory standards for countries: to develop and implement the “Reaching Every Community” strategy for increasing equity in access to immunization; to add vaccines to the national schedule, establish new delivery platforms, and integrate delivery of related interventions; and for immunization programme reviews and vaccine safety surveillance.
- Research priorities to address barriers to immunization, for vaccine-preventable disease control and elimination, and for future immunization system characteristics.
- Technical support for immunization programme management and planning, monitoring and surveillance and for the implementation of coordinated strategies for pneumonia, diarrhoea and cervical cancer control.
- Global annual reports on immunization coverage, disease trends and quality of vaccines used in national immunization programmes.
- Target product profiles for new vaccines and immunization-related equipment.

CATEGORY 2: NONCOMMUNICABLE DISEASES

Reducing the burden of noncommunicable diseases, including cardiovascular diseases, cancers, chronic lung diseases, diabetes, and mental disorders, as well as disability and injuries, through health promotion and risk reduction, prevention, treatment and monitoring of noncommunicable diseases and their risk factors.

Noncommunicable diseases are the leading cause of death worldwide. The growing burden threatens to overwhelm health systems and is inextricably linked to poverty and the stunting of economic development at macroeconomic and household levels that lead to inequalities between countries and populations. Globalization, rapid urbanization and ageing will increase the prevalence of noncommunicable conditions.

A range of other noncommunicable conditions also fall within the scope of this category, including mental disorders, the consequences of violence, road traffic injuries, disabilities, poor nutrition, oral and eye health, and genetic and renal disorders.

PRIORITIES AND RATIONALE

Noncommunicable diseases have recently become a prominent part of the global health agenda. Success will require coordinated, multisectoral action at global, regional, national and local levels. Member States articulated WHO's leadership role in this task in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases in September 2011.

The principal focus will be on the four primary **noncommunicable diseases** (heart disease, cancers, chronic lung disease and diabetes) and their **major risk factors** (tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol). Rapid urbanization, and changes in population behaviour tending towards unhealthy lifestyles, are collectively driving the rise in the incidence of noncommunicable disease risk factors. In low- and middle-income countries the prevalence of noncommunicable disease is increasing not just among the growing number of elderly, but among individuals in their most productive years. This trend is most striking in Africa, where the burden of disease due to noncommunicable disease is expected to exceed communicable, maternal, perinatal and nutritional diseases as the most common cause of death by 2030.

Tobacco use: causes more than 6 million premature deaths in developing countries. It is presently responsible for 30% of all cancers and will continue to remain the world's largest preventable cause of death and account for 10% of all deaths by 2020, if left unchecked. Childhood malnutrition is the cause of death in an estimated 35% of all deaths among children under five years of age. Conversely, each year 2.8 million people die as a result of being overweight or obese. Six per cent of all global deaths are linked to physical inactivity. Some 2.5 million individuals succumb annually to the harmful use of alcohol. Effective and equitable primary health services providing improved disease management can contribute to better health outcomes in all of these areas.

Nutrition: is a cross-cutting, life-course issue, relevant to all categories of WHO's work, but it is a priority in its own right in relation to noncommunicable diseases. Prenatal malnutrition and low birth weight predispose to obesity, high blood pressure, heart disease and diabetes later in life. Maternal and child undernutrition account for 11% of the global burden of disease. Alcohol and illicit drug use during pregnancy, and maternal obesity and gestational diabetes are associated with similar risks in mothers and children.

Mental health: Current evidence indicates that eight priority mental health conditions – depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to use of illicit drugs, and mental disorders in children – make the largest contribution to morbidity in most developing countries. Protecting and promoting the human rights of people with mental health conditions from human rights violations is critical.

Violence and injuries: More than 90% of road fatalities occur in developing countries, despite the presence in those countries of less than half of the world’s vehicles. Children and young people under the age of 25 years account for more than 30% of those killed and injured in road traffic crashes.

Disabilities: About 90% of the world’s visually impaired live in developing countries, with cataracts the leading cause of blindness. More than 220 million people in developing countries have moderate-to-profound hearing impairment.

CHALLENGES

Single-sector approaches to the prevention and control of noncommunicable diseases have not stemmed the epidemic. These diseases are largely preventable by **interventions focused on risk factors**, and in the context of **policies shaped by the determinants of health**. To achieve this requires a **coordinated and robust multisectoral response**, including the private sector, that supports the development and implementation of effective integrated programmes at national level, yet ensures that **vested interests do not negatively influence policy development**. Market forces have a major influence on the ability of people to make healthy choices about what they eat and drink and other aspects of their lifestyle. Leadership in this field requires a **constructive engagement with industry** to counter negative trends and to find ways in which industry, trade and commerce can contribute to and not undermine the achievement of public health goals.

Gaps in the provision of essential services will be a decisive factor in determining the progress of national noncommunicable disease programmes, especially in low- and middle-income countries. For example, mental disorders can be addressed through the provision of good-quality treatment and care, yet the vast majority of people with severe mental disorders receive no treatment. Developing countries, where human resources for mental health are insufficient, account for up to 34% of all years lived with a disability. Effective prevention and control interventions exist, however the **generation of robust evidence and associated implementation models** in low-resource settings will require current research gaps to be filled. Successful approaches to prevent violence and injuries have been implemented in many countries through efforts that involve the health sector and beyond. For example, Member States agreed to declare a Decade of action on road safety, launched in May 2011 with the goal to stabilize and then reduce the forecast level of road traffic fatalities around the world by 2020, saving 5 million lives. Weak **surveillance systems**, disconnected from national health information systems must be addressed as this area of weakness inhibits monitoring and evaluation, and prevents **adaptation of national noncommunicable disease programmes**.

Few governments have increased and prioritized budgetary allocations for addressing noncommunicable diseases; a large number of **national multisectoral plans remain unfinanced** and most are for individual diseases rather than an integrated approach. A high percentage are not operational or are insufficiently funded. Official development assistance to build sustainable institutional capacity remains insignificant despite explicit recognition of the negative impact on socioeconomic development.

STRATEGIC APPROACHES

Work by WHO, the World Bank and other international organizations have identified quick gains that can support Member States. Technical support is needed to promote widespread implementation of evidence-based packages of cost-effective “best buy” policy interventions with the potential to treat people with noncommunicable conditions, protect those at high risk of developing them, and reduce risk across populations. This is aimed at strengthening governments’ capacity to: develop national targets; establish and implement multisectoral national programmes and plans across the health and non-health sectors that involve all government departments and civil society; provide guidelines and norms for the management of noncommunicable diseases; provide services for early detection and treatment in strengthened health systems with renewed efforts to ensure access to the essential medicines required; and measure results, taking into account tools endorsed by the World Health Assembly.

WHO will support national governments in conducting situation analyses, setting targets and indicators, strengthening surveillance and monitoring systems, planning process guidance, developing policies and plans based on whole-of-government approaches, and strengthening capacities to implement a core set of interventions.

WHO will provide support for the greater use of new technologies, including mobile technologies and evolving social media platforms, which have the potential to influence the communication of health messages and to change unhealthy behaviours. Technology has particular relevance for people with mental disorders, especially elderly people with dementia.

At country level, WHO will promote collaborative efforts to ensure that United Nations Country Teams integrate these challenges into the United Nations Development Assistance Framework (UNDAF) design processes and implementation, with initial attention being paid to Member States where UNDAF roll outs are scheduled for 2014–2015.

At regional level, WHO will promote North–South, South–South and triangular cooperation to raise the priority given to noncommunicable conditions on the regional health and development agendas, and exchange best practices in the areas of health promotion, legislation, regulation and health system strengthening, including training of health personnel, development of appropriate health-care infrastructure, and diagnostics.

At global level, WHO will exercise its leadership and coordination role in promoting and monitoring global action against noncommunicable conditions in relation to the work of other United Nations agencies, development banks and other international organizations. In particular, the WHO Secretariat will develop and implement, in full collaboration with United Nations agencies, a global implementation (action) plan for noncommunicable diseases, covering the period 2013–2020, as well as a global action plan for mental health, covering the same period.

WHO will support the implementation of the WHO Framework Convention on Tobacco Control, including supporting countries where effective public health measures are being attacked through legal actions brought by industry, and promoting tobacco taxation.

The WHO Secretariat will support and promote the development of options for innovative financing mechanisms for prevention and control of noncommunicable conditions.

LINKAGES

The focus on these noncommunicable conditions will act as a driver and an integrating force for the work of WHO, addressing them through the work of all parts of the Organization. They will be tackled through communicable diseases, health through the life-course, and health systems, in particular, primary care, similarly to the way in which communicable diseases and maternal and child health have been tackled.

OUTCOMES

Below are the key outcomes (some of which are expressed in terms of indicator targets) to which the priorities in this category will contribute.

(Work is ongoing to standardize the way in which outcomes are presented and to develop a tighter linkage to the priorities and outputs. This will be done in future versions of the draft proposed programme budget.)

- 25% relative reduction of blood pressure/hypertension as measured by age-standardized prevalence of raised blood pressure among persons aged 18+ years (*noncommunicable diseases*).
- 10% relative reduction in the harmful use of alcohol as measured by adult per capita consumption in litres of pure alcohol (*noncommunicable diseases*).
- 30% relative reduction of tobacco smoking as measured by age-standardized prevalence of current tobacco smoking among persons aged 15+ years (*noncommunicable diseases*).
- 30% relative reduction in dietary salt intake as measured by age-standardized mean adult (aged 18+) population intake of salt per day (*noncommunicable diseases*).
- 10% relative reduction in physical inactivity as measured by age-standardized prevalence of insufficient physical activity in adults aged 18+ years (*noncommunicable diseases*).
- No increase in adult obesity as measured by age-standardized prevalence of obesity in adults aged 18+ years (*noncommunicable diseases*).
- No increase in childhood obesity as measured by age-standardized prevalence of obesity in children aged less than five years (*noncommunicable diseases*).
- >80% coverage of multidrug therapy for people aged 30+ years with a 10-year risk of heart attack or stroke \geq 30%, or existing cardiovascular disease (*noncommunicable diseases*).
- 40% relative reduction in stunting as measured by prevalence of low height for age ($<$ -2 SD) in children under 5 (*nutrition*).
- Cataract surgical rate as measured by number of surgeries performed per year per million population (*disabilities*).
- Proportion of countries with comprehensive laws addressing five key risk factors for road safety (*violence and injuries*).
- Number of countries with increase in mental health budget as a proportion of health budget (*mental health*).
- Cancer prevention and early detection scaled up to achieve: a) 70% of women between ages 30-49 screened for cervical cancer at least once; b) 25% increase in the proportion of breast cancers diagnosed in early stages; c) $<$ 1 % prevalence of HBsAg carrier (*noncommunicable diseases*).

OUTPUTS

NONCOMMUNICABLE DISEASES

- Facilitate development of national and regional noncommunicable disease strategies taking into account the 2013–2020 Action plan for the global strategy for the prevention and control of noncommunicable disease and the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases.
- Inclusion of the noncommunicable disease agenda in the development work of other relevant United Nations agencies, development banks and other regional and international organizations, relevant nongovernmental organizations and selected private sector entities.
- Policy and technical guidance to countries on the implementation of the noncommunicable disease ‘best buy’ interventions and in relation to prevention and control of the major noncommunicable disease risk factors with a view to addressing demand and supply of tobacco products as well as other provisions of the WHO Framework Convention on Tobacco Control and its protocol including countering tobacco industry interference; physical inactivity through comprehensive policies and interventions, including creation of enabling environments; the harmful use of alcohol through comprehensive alcohol control policies and interventions; the global burden of diet-related noncommunicable diseases by comprehensive policies and interventions to limit the consumption of salt, free sugars, *trans* fats, and saturated fats and to address the overconsumption of energy.
- Strengthened national capacities to implement a planning process to address noncommunicable diseases including needs assessments, programming multisectoral action, and monitoring and evaluating results, in accordance with the 2013–2020 Action plan for the global strategy for the prevention and control of noncommunicable disease.
- Policy and technical guidance and surveillance for the monitoring of global indicators and targets, and on health systems strengthening, training of health personnel, development of appropriate health-care infrastructure and diagnostics, and access to affordable essential medicines in relation to noncommunicable diseases.
- Progress and monitoring reports: monitor progress in realizing the commitments made in the “Political Declaration”, including the preparation of WHO’s inputs into the United Nations Secretary General’s report on progress achieved in realizing the commitments made in the Political Declaration; the *World health report* on noncommunicable diseases and universal health coverage; the *WHO Report on the global tobacco epidemic*; the *Global status report on alcohol and health*; the *Global status report on noncommunicable diseases*; final evaluation of the implementation of the 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable diseases, and a two year-term assessment of the implementation of the 2013-2020 Action Plan.
- Strengthened capacity to adapt and implement the *Prioritized research agenda for prevention and control of noncommunicable diseases* at regional and national levels. Investments for research on major noncommunicable diseases and their risk factors, with a particular focus on developing countries.

MENTAL HEALTH

- Regional mental health strategies, taking into account the 2013–2020 global mental health action plan, and adoption into national policies and plans in accordance with individual country needs.

- Revised package of expanded guidelines in relation to priority mental health conditions and develop and disseminate the Mental health Gap Action programme (mhGAP) “toolkit” of essential interventions.
- Technical norms and standards on: mental health and substance abuse in emergencies; mental and neurological disorders in *the International Classification of Diseases*, 11th edition (ICD-11); human rights within mental health services; identification and management of substance abuse during pregnancy; supporting effective interventions, including those for stress assessment and management.
- Policy and technical support to countries to strengthen capacity to establish country-level surveillance and monitoring systems, conduct assessments of prevention and treatment systems for mental health (WHO-AIMS – Assessment Instrument for Mental Health Systems) and substance abuse (WHO-SAIMS-Substance Abuse Instrument for Mapping Services), address drug dependence treatment and care, and implement the 2013–2020 global mental health action plan and the global strategy on reducing the harmful use of alcohol.
- Progress reports to monitor and report: collect, aggregate and disseminate information on mental, neurological and substance use disorders and health system responses leading to the following reports which will provide the foundation for further advocacy, policy development and global action: *WHO world suicide report*; *WHO mental health atlas*; *WHO substance abuse atlas*; publish and disseminate global data sets on mental health conditions; monitor inclusion of commitments in the 2013–2020 global mental health action plan, and conduct a two year-term assessment on progress towards implementation.
- *WHO prioritized research agenda for interventions and services for mental, neurological and substance use disorders*. Strengthened capacity, particularly in developing countries, to conduct research included in the prioritized research agenda, and to establish network research funders to promote investments for the prioritized research agenda.

VIOLENCE AND INJURIES

- Global charter on the prevention of violence against women, and services for victims.
- Technical support to: develop regional and national level action plans to reduce violence and injuries; develop and evaluate model prevention, health services, and data collection programmes; increase technical knowledge and competencies in countries and regions through capacity-building workshops; develop regional integrated frameworks for violence and injury prevention with corresponding action plans.
- Guidelines on the prevention of youth violence; the prevention of violence against women and girls, including sexual violence; and trauma system development. Good practice manual on motorcycle safety and drowning prevention in low- and middle-income settings. Data collection tool and methodology for burns and burn risk in low- and middle-income settings.
- *Global status report on violence prevention*. Monitoring of the Decade of action for road safety (2011–2020) through, inter alia, the 3rd *Global status report on road safety*.
- 2nd Ministerial Conference on road safety convened to review progress (mid-term) towards targets for the Decade of action for road safety (2011–2020).
- Coordination of several key global and regional alliances, networks or processes including the United Nations Global Road Safety Collaboration, Violence Prevention Alliance, WHO global alliance for care of the injured, WHO child safety network, and the Decade of action for road safety.

DISABILITY AND REHABILITATION

- Plan of action to implement the recommendations of the High-Level Meeting on Disability.
- Facilitate implementation of the recommendations of the *World report on disability* including through the development of policy and national plans of action and service development. Facilitate implementation of the 2014–2019 action plan on eye health.
- Guidance on disability assessment. Policy and practice related guidance on: health-related rehabilitation; prosthetics and orthotics; management of chronic eye conditions; hearing aid provision; and making health services inclusive for people with disabilities with a focus on primary health care.
- Technical and policy support to countries to build capacity in the areas of: wheelchair service provision; community-based rehabilitation; training for health and rehabilitation personnel on disability; and ear and eye service provision.
- Indicators for monitoring the effectiveness of community-based rehabilitation.
- Report on the economic and social impact of hearing aid provision.
- Secretariat functions and overall coordination of the Community-based Rehabilitation (CBR) Global Network to strengthen regional networks in Africa, the Americas and Asia and the Pacific.
- Disability data in the global health observatory; standardized data collection methods to measure vision and hearing loss.

NUTRITION

- Facilitate implementation of the Comprehensive Implementation Plan on Maternal, Infant and Young Child nutrition and provide technical and policy support to the development of regional nutrition strategies.
- Post-2015 nutrition agenda established through the convening of an International Conference on Nutrition.
- Technical norms and standards on: population dietary goals; nutritional status; effective nutrition actions on stunting, wasting and anemia, breastfeeding code and nutrition contributions to the Codex Alimentarius; case studies illustrating good practice on the implementation of effective nutrition actions.
- Policy and technical support: to address the double burden of malnutrition included in global food and nutrition security initiatives, including improving maternal, infant and young child nutrition and addressing nutrition in emergencies; on improving diet and nutrition through integrated policy implementation tools.
- Reports to monitor the implementation of the global nutrition targets. Data sets for main nutrition indicators. Strengthened national nutritional surveillance and nutrition surveys conducted.

CATEGORY 3: PROMOTING HEALTH THROUGHOUT THE LIFE-COURSE

Promoting good health at key stages of life, taking into account the need to address social determinants of health (the societal conditions in which people are born, grow, live, work and age) and gender, equity and human rights.

This category addresses population health needs throughout the life-course, with a special focus on key stages in life, and the transitions between them, defining protective and risk factors, and prioritizing investment in health care and social determinants. This approach considers health as an integrated, dynamic continuum, not a series of isolated health states, and thus enables the development of responsive, integrated strategies that take into account how multiple determinants interact and affect health throughout life and across generations. Underpinning the work within the category is a focus on social determinants of health, and on gender, equity and human rights.

PRIORITIES AND RATIONALE

Priorities in this category are found at key stages of the life-course, emphasizing ensuring universal access to, and coverage with, effective public health interventions to improve sexual and reproductive health, maternal and newborn health, child and adolescent health, and health in older age, with emphasis on reducing gender inequality and health inequities.

For **mothers and newborn** infants the first 24 hours are a particular priority. Half of maternal deaths, one third of newborn deaths and one third of stillbirths, as well as most of the complications that can lead to the death of the mother or the newborn, occur in that period. The most effective interventions to save mothers and babies can be administered at that point: management of labour, oxytocin after delivery, resuscitation of the newborn, and early initiation of breastfeeding.

Beyond attention to their reproductive health, **women's health care** includes prevention and treatment of later-life conditions, such as cancers. A coherent agenda for action on comprehensive women's health interventions, based on evidence-informed policies, will build government commitment to respond to demographic and epidemiologic transitions.

Access for children in low- and middle-income countries to all the interventions for maternal, child and newborn care that have reduced child mortality in high-income countries, will make **ending preventable child deaths** a reality.

The burden of sexual and reproductive ill-health disproportionately affects women and young people in low- and middle-income countries. Health in adolescence is key to health in adulthood and in older age, thus healthy behaviour in this age group is pivotal in the life-course. In addition, **within the reproductive lifespan there is a focus on adolescents**. Priority topics include enhancing quality of and access to family planning, preventing too-early pregnancies, preventing unsafe abortion, controlling sexually transmitted and reproductive tract infections, improving sexual health care, addressing their mental health and violence and injury prevention, and addressing barriers related to gender inequality, poverty, and adolescents' exposure to risk.

In almost every country, the proportion of **people over 60 years of age** is growing faster than any other age group, as a result of both longer life expectancy and declining fertility rates. Population ageing can be seen as a success story for public health policies and for socioeconomic development, but it also challenges society to adapt, to maximize the health and functional capacity of older people as well as their social participation and security.

The institutional mainstreaming of **gender equality, equity and human rights** will require sustainable, structural changes that enhance efficiency and effectiveness. Examples include incorporating gender, equity and human rights considerations into results-based management planning, monitoring and evaluation; capacity building and continuous learning; advocating for the use of

gender analysis and rights based approach in policy-making; establishing accountability; and promoting the use of data disaggregated by sex, age and other recognized grounds for non-discrimination.

The **social determinants of health** are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities and despite increasing global political attention, health inequities continue to grow within and between countries, aggravated by rapid urbanization, human-made and natural disasters, economic recession, and unemployment.

Environmental determinants of health are responsible for about one quarter of the global burden of disease and an estimated 13 million deaths each year. Those mainly affected are poor women and children who live and work in the world's most polluted and fragile ecosystems and who are at risk from diverse factors such as chemicals, radiation, lack of safe water and sanitation, air pollution and climate change.

CHALLENGES

This area of work is particularly significant in terms of WHO's potential to make progress toward meeting the health-related Millennium Development Goals, given the known efficacy of current interventions. The real challenge is how to scale up those existing effective interventions, making them accessible for all during critical stages of life and ensuring the quality of care.

The lack of universal access to quality, integrated services for reproductive, maternal, newborn, child and adolescent health remains a significant barrier to progress. The use of new or improved communications and technologies will increase intervention coverage and add improved efficiency to delivery approaches. Investments in other sectors such as education, especially girls' education, will add to gains. Efforts will also require new or stronger mechanisms for monitoring and accountability at global and country level.

People's evolving needs in the life-course require innovative approaches and the development of evidence-based interventions to inform policy and programmes. Older people are a significant social and economic resource, particularly if they can age in good health. Population ageing will increase demand for acute and primary health care, particularly in relation to noncommunicable diseases, and particularly in low- and middle-income countries, straining pension and social security systems and increasing the need for long-term and social care. Work is needed on innovations in service provision and targeted technology for ageing populations in both the developed and the developing world.

The key social determinants, including gender, that are likely to influence the priority areas are not always addressed adequately, compounded by weaknesses in health systems. The health workforce (formal and informal/unpaid) is key to meeting the challenge. Decisions and investments in the policy areas of education, housing, urban and rural development, the employment and labour market, environment and agriculture, are decisions about the social determinants of health that shape health opportunities, risks and consequences over the life-course. Health promotion, prevention, improving governance for health in all sectors, and the development of policies that are inclusive and that take account of the needs of the entire population, with specific attention to vulnerable groups, are required in all health and development programmes.

Deficiencies in health-sector leadership for primary prevention of disease through mitigation of environmental determinants of health need to be addressed, so that strategic direction and guidance can be shared with partners in non-health sectors and thus ensure that a range of cross-sectoral policies and investments benefit health. Importantly, that leadership needs to be undertaken in the context of existing and new global and regional multisectoral and multilateral frameworks to assist Member States in the construction and implementation of evidence-based policies, strategies and regulations

for prevention, mitigation and management of environmental risks, in support of sustainable development.

STRATEGIC APPROACHES

The United Nations Secretary-General’s Global Strategy “**Every Woman, Every Child**” provides an overarching framework for accelerating progress at country level in maternal, neonatal and child health. The strategy defines roles and responsibilities for the H4+ partner agencies (WHO, UNICEF, UNFPA, World Bank and UNAIDS), and the report of the associated Commission on Accountability and Information provides a framework for holding all partners accountable for resources and results. “Committing to Child Survival: A Promise Renewed” is a multi-year, global initiative to follow up and implement the Child Survival Call to Action and the Secretary-General’s framework. The Partnership for Maternal, Newborn and Child Health (PMNCH), hosted by WHO, provides a platform for coordinated action and collaboration amongst partners towards the achievement of Millennium Development Goals 4 & 5, and works in close collaboration with the programme areas in this category of work. In addition, WHO’s work in this area is shaped by various other international development goals and targets including those of the Millennium Development Goals and the International Conference on Population and Development (ICPD) Programme of Action, including review of the implementation of ICPD commitments in the context of ICPD+20 and the post-MDG agenda on sustainable development.

The growing body of evidence that shows the links between the health of mothers, newborns, children, and adolescents who then themselves become parents, highlights the key role of applying interventions using the life-course approach. WHO will therefore provide **integrated policies and packages of interventions**, fostering synergies between sexual and reproductive, maternal, newborn, child, and adolescent health, interventions and other public health programmes, including HIV and malaria, supporting implementation of the WHO Global Reproductive Health Strategy and action to strengthen health systems.

WHO will develop evidence-based norms, standards, and tools for **scaling up equitable access** to quality care services within a rights- and gender-based framework.

WHO will support the **generation and synthesis of evidence**, including specific studies on how to deliver interventions to achieve highest population coverage, as well as new technologies to enhance the effectiveness and reach of intervention delivery (such as the Odon device for assisted delivery and the use of interactive mobile telephony); strengthening research capacity in low-income countries; as well as epidemiology, monitoring and accountability, including implementation of the recommendations of the Commission on Information and Accountability, improving maternal death reviews, surveillance and response, and monitoring quality of care.

WHO will promote a more **comprehensive approach towards women’s health**, in order to address needs that go beyond women’s reproductive health such as noncommunicable diseases and treatment of chronic conditions.

WHO will also work with Member States to help them prepare for the **transition to older populations**, promoting a life-course approach that recognizes the different needs of older women and older men, the accumulation of risks and exposures, and that targets critical health events at earlier stages in life and promotes healthy choices across the life-course, strengthening health systems to provide early detection and management of chronic diseases, including rehabilitation, as well as long-term or palliative care for those with advanced disease; creating age-friendly environments and changing the way in which societies think about ageing and fostering empowerment and health literacy of older people.

WHO will also provide leadership on **healthy and active ageing** by increasing awareness of the importance of demographic change, the accumulation of exposures and vulnerabilities across the life-course, and by increasing knowledge of evidence-informed responses. WHO will establish or support

networks and communities of practice that enable the development of innovative intersectoral strategies. Evidence-based policy options will be developed in priority areas, including long-term care and the management of frailty, particularly in low- and middle-income settings.

In its work on **social determinants of health**, WHO will integrate determinants into health sector programmes; it will make it an increasing priority throughout the Secretariat to integrate these issues into all disease-specific programmes, strategies and plans; and it will improve governance for health within the health sector and across other sectors by strengthening the capacity of Member States to develop inclusive policies that take account of the needs of the entire population, with specific attention to vulnerable groups, and monitoring progress to increase accountability.

A synergistic approach has been chosen as the basis for **institutional mainstreaming of gender, equity and human rights** at all levels of the WHO Secretariat, with the objective of creating structural mechanisms that enable programmatic mainstreaming to succeed, and support countries in their realization of gender equality, health equity and the right to health.

WHO will promote a sustainable development approach to its work on the **environment** and will pay particular attention to prevention, mitigation and management of environmental risks.

LINKAGES

The life-course and social determinants approaches have linkages with all other categories and several Millennium Development Goals, especially 3, 4 and 5. There is also a close link to Goals 1, 6 and 7. Some examples of linkages with other categories include: nutrition, which closely links with category 2. Ensuring effective delivery of immunization and other interventions for the control of major infectious diseases, through services for maternal, newborn and child, adolescent, and sexual and reproductive health, links to categories 1 and 4. Monitoring and surveillance of maternal, newborn, and child mortality and other reproductive health trends will be carried out with category 5. Violence against women is closely related to sexual health and rights and will be addressed jointly with category 2. As many of the risk behaviours related to noncommunicable diseases begin in adolescence and some noncommunicable diseases are linked to pregnancy and sexual and reproductive health, joint work will be carried out with category 2. Actions required to strengthen health systems require close collaboration with category 4.

Health promotion, prevention, improving governance for health in all sectors, and developing policies that are inclusive and that take account of the needs of the entire population, with specific attention to vulnerable groups, are required in all health and development programmes. The WHO Global Network of Age-friendly Cities and Communities helps municipalities create environments that foster healthy ageing and the ongoing participation of older people.

OUTCOMES

Below are the key outcomes (some of which are expressed in terms of indicator targets) to which the priorities in this category will contribute.

(Work is ongoing to standardize the way in which outcomes are presented and to develop a tighter linkage to the priorities and outputs. This will be done in future versions of the draft proposed programme budget.)

- Reduction in adolescent pregnancies (*sexual and reproductive health*).
- >80% children with suspected pneumonia receive antibiotics (*child health*).
- >50% babies exclusively breastfed for six months (*maternal and newborn health*).
- >50% mothers and babies receive postnatal care within two days of childbirth (*maternal and newborn health*).
- >80% of women receive antenatal care at least four times by a skilled provider during pregnancy (*maternal and newborn health*).
- >80% pregnant women receive skilled attendance at birth (*maternal and newborn health*).
- Reduction in unmet need for contraception is reported (*sexual and reproductive health*).
- Number of Member States that are implementing sectoral policies that prevent and/or mitigate environmental and occupational risks (*health and the environment*).
- TBD - health service coverage indicator for ageing (*healthy ageing*).
- TBD - equity indicator across socioeconomic groups (*social determinants*).
- TBD – equity indicator for gender (*gender equity*).

OUTPUTS

MATERNAL AND NEWBORN HEALTH

- Technical guidance for the H4+ initiative of the United Nations health-related agencies, the Countdown to 2015 initiative and the setting of targets for the period post-Millennium Development Goals 4 and 5.
- Support Member States to implement key guidelines and tools such as the Integrated Management of Pregnancy and Childbirth (IMPAC) and the Essential Newborn Care Course (ENCC) and strengthen the collection, analysis, monitoring, evaluation and use of data in line with the recommendations of the Commission on Information and Accountability (CoIA) including setting up systems for Maternal and Perinatal Death Surveillance and Response.
- New and updated studies on interventions for care during preconception, pregnancy, delivery, postnatal period and newborn care, including pre-term birth and sepsis, and care and equitable access around delivery and the postnatal period.
- Norms, standards and guidelines for: maternal and newborn health quality of care and clinical management consistent with the life-course approach and universal human rights treaties and standards; and maternal and newborn health interventions at facility and community levels in the 24-hour period around delivery.
- Estimates of morbidity and mortality levels and trends and of causes of death (Child Health Epidemiology Reference Group), maternal and newborn health policy and systems indicators and quality of care.

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

- Coordinate academic and research institutions dealing with sexual and reproductive health, and adolescent health, to identify research priorities and strengthen capacity in low-income countries.
- New or updated norms, standards and guidelines for: family planning; maternal and perinatal health; preventing unsafe abortion; control of sexually transmitted infections and reproductive tract infections; low-cost infertility care; and gynecological cancers.
- New products, interventions and delivery approaches to improve sexual and reproductive health, for example those to improve access to care such as the Odon device as a simple assisted delivery tool or the wheel for rapid assessment of medical eligibility criteria for contraceptive use.

DRAFT PROPOSED PROGRAMME BUDGET 2014–2015

- Global estimates of key sexual and reproductive health-related indicators, e.g. maternal morbidity and mortality and causes of death and violence against women in periodic global reports.
- Support to Member States and capacity built in their conduct of implementation/operations research in sexual and reproductive health, and studies on determinants of adolescent health and interventions and delivery approaches to improve adolescent health, including for prevention of too-early pregnancy.

CHILD HEALTH

- Technical leadership among partners for achieving universal access to integrated child health services, improving child survival and setting targets towards ending child deaths from preventable causes for the post-Millennium Development Goal period and agreed research priorities for improving child health and development interventions for the period up to 2025.
- Studies on: management of fever in the context of integrated child health; determinants of child health and health inequities; interventions and delivery approaches with a focus on pneumonia and diarrhoea; and early childhood development in a manner consistent with the United Nations Convention on the Rights of the Child.
- Norms, standards and guidelines for integrated child health and development with a focus on cross-sector collaboration and delivery of interventions at health facility and community level, e.g. hospital care for children, the Integrated Management of Childhood Illness (IMCI), community packages for case management and child development.
- Support to Member States in the implementation of guidelines and tools aiming at universal coverage with quality child health interventions such as: IMCI, Global Action Plan on Pneumonia and Diarrhoea; Lives Saved (LiST) and ‘OneHealth’.
- Estimates of morbidity and mortality level and trends and of causes of death (Child Health Epidemiology Reference Group), child health policy and systems indicators and quality of care.

WOMEN’S HEALTH

- Awareness interventions to increase commitment at government/political level for the development of a coherent agenda for action on comprehensive women’s health interventions, including beyond the reproductive years.
- Research findings used for the development of an effective and comprehensive approach on women’s health that responds to demographic and epidemiologic transitions.
- Norms, standards and guidelines for women’s health grounded in gender equality and with a focus on interdisciplinary and cross-sector collaboration and policy options to respond to women’s health needs, including issues beyond reproduction such as prevention, treatment and care of women’s cancers.
- Support to Member States in scaling up proven interventions for women’s health, including evidence-informed policies on comprehensive women’s health approaches beyond reproduction and monitoring and evaluation of interventions impacting on women’s health.

HEALTHY AGEING AND HEALTH OF THE ELDERLY

- *World report on ageing and health*, leading to a global strategy on ageing and health and continued development of the WHO Global Network of Age-friendly Cities.
- Studies to better define the health needs of older people and to identify cost-effective models for intervention in different settings, including research through the WHO Study on Global

Ageing and Adult Health (SAGE) multi-country study focusing on low- and middle-income countries.

- Norms, standards and guidelines on: management of frailty; long-term care; chronic and coordinated care; age-friendly environments; and workforce development, with a focus on low- and middle-income countries.
- Improved measures and models of monitoring and surveillance to quantify the health needs of older people and their access to appropriate care.
- Support to Member States in the development of national strategies and plans to address key issues related to ageing and health.

SOCIAL DETERMINANTS OF HEALTH

- Standards on health in all policies and intersectoral action for health as part of the United Nations Platform on Social Determinants of Health.
- Studies on: the economic impact on social determinants of health; the use of health impact assessments; and the impact of intersectoral action for health.
- Policy briefs and guidance to: support disease-specific programmes to better address social determinants of health including good practices for working with other sectors; and improve health equity, including social mobilization and participation.
- Standard sets of indicators to monitor action on the social determinants of health.
- Support to Member States to: adopt better governance for health and development; promote participation in policy-making and implementation; further reorient the health sector towards reducing health inequities; strengthen global governance and collaboration; and monitor progress and increase accountability.

HEALTH AND THE ENVIRONMENT

- Public health promoted in multisectoral and multilateral frameworks such as existing and new Multilateral Environmental Agreements, the United Nations Framework Convention on Climate Change, and the outcome document of the United Nations Rio+20 Conference, “The Future We Want”.
- Studies to better define environmental and occupational health risks and benefits associated with sectoral policies and technologies, including those to promote sustainable development, climate change mitigation and green growth, and examining inter alia the cost-effectiveness of interventions, impacts on specific population groups (e.g. climate-change refugees) and operational research priority needs (e.g. integrated health interventions at household level).
- Norms, standards and guidance on: environmental and occupational determinants of human health and ill-health, including air quality, chemicals, water and sanitation, radiation, and nanotechnologies.
- Reports on: environmental health-related Millennium Development Goals (e.g. for water and sanitation) and sustainable development goals (e.g. for access to clean energy); environmental and occupational health risks and burdens of disease; health and equity impacts of sustainable development policies and investments in key sectors of the economy, including transport, housing, energy, health care and the extractive industry.
- Support to Member States to develop: policies, strategies and regulations for prevention, mitigation and management of environmental and occupational risks, as well as to identify

health gains, in non-emergency and emergency circumstances, including through the use of health impact assessment.

GENDER AND HUMAN RIGHTS MAINSTREAMING

- Implement gender equity and human rights integrated strategy, implementation plan, and monitoring, evaluation and accountability mechanisms to ensure effective mainstreaming in all WHO programmes and offices.
- New evidence on the impact of gender inequalities, health inequities, and human rights violations on health.
- Norms, standards and guidelines on effective mainstreaming of gender equity and human rights in health policies and programmes, including minimum standards, e.g. staff and expert group recruitment, composition and retention, and guidelines and ethics approvals.
- Core health indicators, disaggregated by sex, age, and other relevant grounds, to ensure non-discrimination (e.g. place of residence, education, occupation, income).
- Support Member States for formulation and monitoring of gender equity and human rights policies, legislation, health plans, strategies, programmes and budgets.

CATEGORY 4: HEALTH SYSTEMS

Health systems based on primary health care, supporting universal health coverage

The overarching theme for work in health systems strengthening is access to and affordability of services based on the principles of primary health care. Work in this category is integral to extending and safeguarding universal health coverage.¹ The scope of the work under category 4 includes the development, deployment and organization of the workforce, financial resources, essential medicines, medical products/technologies² and infrastructure together with the elements of health sector governance that steer the system. This work results in policies, plans, regulations and institutions, backed up by health information, research and knowledge management in order to produce safe, effective health services that are financed in a way that allows people to access them.

More than one billion people cannot use the health services they need, when they need them, because those services are either unavailable, unaffordable or of low quality. Every year 100 million people are pushed into poverty because they must use health services and have to pay at the time of treatment. Insufficient and inefficient allocation of public expenditures for health results in inadequate staffing, lack of essential medicines, poorly enforced regulation of providers, and a lack of evidence-based priority setting. Some 30% of the world population lacks regular access to safe and quality medicines and health products. Inadequate capacity of regulatory authorities in many countries is a major impediment towards increased access. At least one in ten hospital patients continues to be harmed as a result of poor quality healthcare. Social determinants of health, such as rapid unplanned urbanization (in cities where soon 70% of the world's population will live) pose challenges for equitable health service access and public health programmes.

As a result, in many parts of the world health inequities are rising. When service delivery does not live up to expectations, this often signals problems in the way health systems are financed, organized and governed. This is particularly true for the coordinated care and integrated approaches needed to prevent, monitor and treat chronic diseases and to care for ageing populations.

In many countries, information systems are weak and fragmented, and civil registration and vital statistics incomplete or missing. Likewise, institutional capacity for health research, knowledge generation, access to knowledge and use of evidence to support universal health coverage is often lacking.

PRIORITIES AND RATIONALE

National health policies, strategies and plans: Facilitating a policy dialogue that involves all the main players in health system strengthening at national level exploits WHO's comparative advantage as a convenor and facilitator. It also allows the focus of health system strengthening to be adapted to local needs. In this way systems can be focused on elements such as human resources and health system financing, as part of an overall strategy in which governments are able to better align the contributions of different partners towards universal health coverage. The dialogue increasingly will involve actors from civil society, nongovernmental organizations and the private sector, and must also extend to other sectors to ensure that important social determinants of health are addressed.

Integrated people-centred health services: Strategies are needed for hard-to-reach populations, such as unimmunized children and populations at risk of HIV or tuberculosis, or groups whose health

¹ Universal health coverage means ensuring access to effective health services (prevention, promotion, treatment and rehabilitation) and essential medicines and medical products and technologies that people need, without risk of their financial ruin in having to pay for these services out of pocket.

² The term "medical products" includes medicines, vaccines, blood and blood products and associated diagnostics.

service needs have been relatively ignored, such as adolescents, especially adolescent girls, and the elderly and other vulnerable groups. In many countries, national and local capacity needs improvement to develop and deploy locally appropriate service delivery models. The growing prominence of chronic noncommunicable disease has led to demand for affordable long-term care, high-quality palliative treatment, and better links between medical and social services (as well as between health and other forms of social protection).

Better data are a prerequisite for enhanced efficiency and accountability in all health systems. This includes transparency in access to information and active participation of patients and the public in decision-making processes, equitable access to health services, protection of privacy, special attention given to the protection of vulnerable groups, prevention of discrimination, and a clear understanding of individual rights and public health goods. Health programmes as well as research activities must be implemented in an ethical way. Advances in informatics and information technology can transform health system management and promote more people-centred care. Authoritative guidance for E-Health aspects such as electronic medical records and other technologies is needed, with a system for vital registration being a fundamental need. In many countries this does not yet exist.

Improvements in service quality and patient safety (including reducing rates of hospital infection) are as vital as improving the quantity of services. New approaches will mean that norms and standards are needed, such as for training and licensing health workers, as well as an expansion in the role of ministries of health in terms of setting the “rules of the game” and ensuring that they are followed. This applies not only to ensuring safe and effective health services, but also to all the components of a health system. The development and implementation of international standards like the International Classification of Diseases (ICD-11) can also contribute to supporting countries to produce and collect information that they can use for decision-making and action.

Regulation and access to medical products: Equity in public health depends on access to high-quality and affordable medicines, vaccines, diagnostics and other health technologies. Affordable prices ease health budgets everywhere, but are especially important in developing countries, where too many people have to meet medical expenses out of pocket. Access to affordable medicines becomes all the more critical in the face of the growing burden of noncommunicable disease. Life-long treatment may be required; access to essential medicines early in the course of disease can prevent more serious consequences later. Improving access to medical products is central to the achievement of universal health coverage, as is the quality of those products, assured through oversight by competent national or supranational regulatory authorities. Related to this is rational procurement and prescribing that favours generic over originator brands; promoting research and development for medical products needed by low- and middle-income countries; and prequalification that facilitates market entry of manufacturers from the developing world. These elements will help to improve efficiency and reduce expenditure, and are important components of health financing policy.

CHALLENGES

Society’s expectations of integrated people-centred health care are not yet matched by health system performance. Challenges include the lack of national and local capacity to develop and deploy locally appropriate service delivery models, and to address obstacles to effective service delivery, with sufficient financial risk protection, in support of universal health coverage. Many countries are still missing adequate national regulatory capacity.

In many countries, policy-makers do not have access to accurate information on the health conditions of their citizens to guide evidence-based decision-making and prioritization of investment in both health services and health research. Challenges to access, delivery and financing of health systems include: migration, and economic and political crises; the disproportionate focus on specialized curative care; and the obstacles to an inclusive governance with the participation of non-health sectors.

The development of new health products and technologies must be driven by public health needs. A further major challenge is to ensure that health programmes as well as research activities are implemented in an ethical way.

STRATEGIC APPROACHES

Equitable progress towards universal health coverage requires that all priority programmatic areas of health systems are addressed and that underlying social determinants of health and ethical practices are explicitly considered. WHO will provide Member States and the global health community with evidence-informed norms, standards and policy options and, where needed, technical and policy support. It will also facilitate the sharing of experiences across countries and the results of research to allow countries to learn from others on the path to universal health coverage. This will be done in ways that buttress: reforms that move towards universal access to people-centred services and equitable financial risk protection; and efforts to improve health systems performance and the capacity to regulate and steer the health sector. The focus on universal health coverage reflects the core value of solidarity and is directly linked to the principle of the right to health for every person. Use of services should be based on need and not factors such as age, sex, income, ethnicity and geographic location.

WHO will work with countries to strengthen their capacity for inclusive and ethical governance and policy dialogue, facilitating analysis, reviews and engagement with key stakeholders (including external partners and civil society in line with the Paris Declaration on Aid Effectiveness). Transparent engagement of the private sector to promote universal health coverage will be sought while minimizing the risk for conflicts of interest. Support and guidance will be provided for building national capacity to develop evidence through research, for information systems and monitoring and evaluation, and then for evidence-based, effective and financially sustainable policies, strategies and plans, including the macroeconomic and fiscal dimensions of financing health systems for achieving universal health coverage, and the transformation and scaling up of education and performance of the health workforce.

Efforts will be intensified to improving access to medicines and medical products and technologies, and will increasingly focus on creating the conditions for greater self-reliance, particularly in the countries of the African Region. The missing link in many countries is adequate national regulatory capacity. Thus development and support for regulatory authorities, including for traditional medicines, is a major priority for WHO's future work in this area, gradually reducing reliance on global prequalification programmes.

A renewed emphasis will be put on inter-sectoral dialogue and engagement to either address or compensate for underlying social factors that contribute to inequitable outcomes. To ensure that these strategic approaches will be evidence- and ethically informed, WHO will engage with country and global partners to develop research and provide opportunities for exchange and dissemination of innovative approaches, through the use of cost-effective information and communication technologies.

LINKAGES

This category contributes to all disease- and population-specific categories by promoting effective health systems and equitable and affordable access to health services, quality medicines, medical products and technologies as a cornerstone of integrated people-centred health services.

This work will develop tools and policies to remove pivotal health system barriers that have hindered universal health coverage, with core services for noncommunicable diseases (category 2) infant, child, adolescent, adult and older people's health (category 3), and AIDS/tuberculosis/malaria/other infectious diseases (category 1). As health systems are essential to preparation for and response to health emergencies of all types, there is an integral link with category 5. This category also has linkages with WHO's cross-cutting work on gender, human rights, equity and the social determinants of health, as it relates both to health in all policies and to ensuring a social determinants of health lens in WHO programmes.

OUTCOMES

Below are the key outcomes (some of which are expressed in terms of indicator targets) to which the priorities in this category will contribute.

(Work is ongoing to standardize the way in which outcomes are presented and to develop a tighter linkage to the priorities and outputs. This will be done in future versions of the draft proposed programme budget.)

- Number/proportion of Member States that: (i) have a national health sector strategy with goals and targets; (ii) conduct an annual multi-stakeholder review; and (iii) produce a health sector performance assessment report to inform annual reviews (*health policies, strategies and plans*).
- Number/proportion of Member States in which the coverage of birth and death registration, with reliable cause of death, is improving among Member States with coverage less than 90% (*health policies, strategies and plans*).
- Number/proportion of Member States in which the percentage of households with catastrophic out of pocket expenditure: (i) is below XX%; and (ii) is not greater in the poorest quintile of households than in the richest quintile (*health policies, strategies and plans*).
- Number/proportion of Member States in which the percentage of households impoverished due to paying out of pocket for health services is below XX% (*health policies, strategies and plans*).
- Number/proportion of Member States in which a national intervention coverage index of core services is improving (*integrated people-centred services*).
- Number of Member States where payment of health care providers is regulated (*integrated people-centred services*).
- Number of Member States with appropriate accreditation of service providers (*integrated people-centred services*).
- TBD: indicator for health workforce (*integrated people-centred services*).
- Number of Member States implementing appropriate regulatory oversight of medical products (*access to medical products*).
- Number of Member States with monitoring systems on price and availability of medicines and medical products (*access to medical products*).
- Number of countries using essential medicines list updated in the last five years for public procurement and reimbursement (*access to medical products*).

OUTPUTS

NATIONAL HEALTH POLICIES, STRATEGIES AND PLANS

- Alignment of partners at country, regional, and global levels for sustainable universal health coverage and building consensus, commitment and policy dialogues on key areas of regulation such as health financing strategies (e.g. insurance), private providers, and quality and safety of health services.
- Facilitation of global consensus on priority ethical issues related to public health and research for health.
- Tools and approaches for prioritization of research and strengthening of ethical conduct of research; facilitation of global, regional, subregional and country research networks through collaborating centres and other mechanisms.
- Frameworks, tools, approaches and guidance for: enhancing country analytical capacity to inform policy dialogue within health and between health and non-health sectors and to ensure

the social determinants of health approach is fully integrated in health programmes; E-Health development; the use of constitutional/legal provisions on the right to health in support of universal health coverage; policy options for how to translate evidence into policy to move closer to universal health coverage.

- Comprehensive monitoring of the global, regional and country health situation and trends (through observatories), and leadership in new data generation and analyses of neglected and emerging health priorities.
- Support to Member States to: generate, access, and use research and evidence; formulate, implement, monitor and evaluate evidence-based policies, strategies and budgeted plans in support of universal health coverage; strengthen national regulatory authorities on health financing and quality of services; generate good quality, timely, and relevant health expenditure data to support decision-making; strengthen health information systems to generate good quality, timely and relevant data and analyses for decision-making; strengthen civil registration and vital statistics systems with focus on causes of death; establish research ethics systems to promote ethical and transparent conduct of research.

INTEGRATED PEOPLE-CENTERED HEALTH SERVICES

- Frameworks, tools, approaches, evidence and information to increase: in-country capacity to prioritize cost-effective interventions; the quality of services and of informal care, patient safety, people-centred and integrated service delivery and referral networks; patient empowerment and health literacy.
- Health systems research to strengthen integrated people-centred health services.
- Guidelines, norms, standards and best practices for: quality and safety of care, particularly for primary level care and hospitals; the education, deployment and retention of human resources for health; regulation of service providers, including complementary medicine and traditional practitioners; regulation of hospital infrastructure and technology.
- ICD-11 and related classifications, and their adaptation for country implementation.
- Monitoring and reporting on: equitable access to comprehensive health services (including chronic care and care at the boundary between health and social services); WHO Global Code of Practice on the International Recruitment of Health Personnel, the health workforce trends and flows, including migration, in particular through the creation and maintenance of HRH observatories.
- Support Member States to: promote integrated people-centred health services, including strategies for appropriate skill mix and distribution of human resources; strengthen national health sector governance and accountability; assess the efficiency and equity of their service delivery strategies, including through the use of cost-effectiveness analysis; assess and increase the readiness of primary and first referral facilities to provide more integrated, safe and quality services (SARA); strengthen capacity to regulate private and commercial health care provision.

REGULATION AND ACCESS TO MEDICAL PRODUCTS

- Facilitation of the implementation of the global strategy and plan of action on public health, innovation and intellectual property.
- Coordination of global and regional strategies that support strengthening and progressive harmonization of regulatory systems practices and facilitate mutual recognition and/or cooperation among national regulatory authorities.

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- Guidance to Member States on priorities in pharmaceutical research and development and institutional strengthening at country level for increased access to essential medical products.
- Norms, standards and guidelines for: quality medical products and technologies, as well as pharmaceutical services; evaluation of substances subject to international controls; the rational use of medicines and technologies; prequalification of quality medicines and medical products; evidence-based selection of essential medicines and medical products (WHO Essential Medicines list), including through the use of Health Technology Assessment (HTA) to inform decision-making.
- Monitoring, evaluation and reporting on: medicines policies and the pharmaceutical sector in Member States and globally using standardized indicators and tools; the functionality of regulatory authorities for oversight of medical products; access to medical products and technologies without financial hardship.
- Support Member States to: strengthen capacities for evidence-based selection, supply (quantification, procurement, reimbursement, and pricing) and appropriate use of medicines and medical products/technologies; strengthen national regulatory authorities to assess the safety and efficacy of medicines (including antimicrobials), medical products and technologies; improve the safety and efficacy of medicines (including antimicrobials), medical products and technologies.

CATEGORY 5: PREPAREDNESS, SURVEILLANCE AND RESPONSE

Reducing mortality, morbidity and societal disruption resulting from epidemics, natural disasters, conflicts and environmental and food-related emergencies, through prevention, preparedness, response and recovery activities that build resilience and utilize a multisectoral approach.

All countries need to be prepared to deal with disasters and emergencies, but there are currently wide disparities between Member States in their preparedness and response capacity. Progress and systems, no matter how well established, can be fragile, and development can be set back many years. Shocks, ranging from the emergence of severe acute respiratory syndrome (SARS) and avian influenza to the devastating effects of tsunamis, earthquakes, severe droughts, human-made disasters, famines and conflicts with their massive public health consequences, have shown that countries and communities that invested in emergency risk management are more resilient to disasters and respond more effectively, irrespective of the cause.

Climate change, globalization and rapid urbanization are likely to expose populations to more frequent and complex disasters; noncommunicable diseases and ageing populations pose new challenges in emergencies.

Included in this category is the programmatic emergency to complete polio eradication, and work on other specific communicable diseases (e.g. hepatitis, yellow fever, zoonoses) and issues (i.e. antimicrobial resistance).

PRIORITIES AND RATIONALE

Priorities in this category fall into three groups.

The first group is concerned with **capacity building** for functions relevant to all types of hazards to human health. It comprises the alert and response capacity needed in all countries and at regional and global levels to fulfil the requirements of the International Health Regulations (2005); and the capacities needed for multihazard emergency risk management for health, with a particular emphasis on preparedness, in order to enhance national and international responses to conflict and natural disasters, as well as epidemics and environmental and food-related emergencies.

The second group of priorities relates to **specific hazards and risks to human health** through the provision of hazard-specific expertise and capacity building in relation to: epidemic and pandemic diseases (including influenza and the capacities to implement the Pandemic Influenza Preparedness Framework, as well as a range of other epidemic-prone communicable diseases); and food safety (with a particular focus on the links between agriculture and public health and the links between food and drug regulation).

The third priority is to complete the **eradication of wild poliovirus**.

These priorities reflect the comparative advantages of WHO in evidence-based emergency risk management and capacity building, development of norms and standards, existing partnerships, and coordinated management of public health emergencies and health in humanitarian crises.

CHALLENGES

Individual countries and the global community must anticipate and prepare for natural and technological disasters, conflicts, new and re-emerging diseases, food crises, and environmental, biological and chemical hazards.

Previous approaches to emergency risk management have generally been fragmented and inefficient, often with limited effectiveness. Enhanced prevention, emergency risk reduction, preparedness, surveillance, response and early recovery, reflecting a more holistic perspective and coordinated multi-hazard approach, within the Secretariat and across Member States and the international health community, are essential to build resilience and better protect populations. For optimal impact this approach must be integrated into comprehensive national emergency risk management plans that involve all sectors and contribute to improved health outcomes. New tools can substantially reduce the impact of many disasters.

STRATEGIC APPROACHES

WHO will take a multi-faceted approach. Activities that are ongoing under existing multilateral, international, and regional frameworks and mechanisms will be fully implemented, particularly those of the International Health Regulations (2005), the Pandemic Influenza Preparedness Framework, the Global action plan for influenza vaccine, the Inter-Agency Standing Committee Transformative Agenda, the Codex Alimentarius, global and regional platforms for disaster reduction, and the International Food Safety Authorities Network (INFOSAN).

Key networks, for example, the Global Outbreak Alert and Response Network (GOARN), the Global Influenza Surveillance and Response System (GISRS), the IASC Global Health Cluster and regional response teams, will be maintained, strengthened and upgraded.

Special attention will be given to supporting Member States in their efforts to meet and sustain capacities in the areas of the International Health Regulations (2005) and intersectoral health coordination. WHO will continue to generate evidence on the dynamics of health risks and the impact of response activities, and to keep abreast of emerging developments that impact health, such as the effect of climate change and new technologies.

WHO will support the improvement of national policies for the identification and reduction of risks to human health, as well as prevention, preparedness, response and early recovery capacities. Activities, such as expanding work on safer health facilities, developing technical guidance on risk assessments and national preparedness policies, augmenting WHO's standby arrangements for emergency response, ensuring WHO's institutional readiness for its Emergency Response Framework, and implementing a WHO Emergency Risk Management Framework, will be scaled up.

WHO will use partnerships to support Member States in enhancing their emergency risk management capacity. WHO will strengthen its interaction with other United Nations, multilateral, bilateral and regional agencies that are active on such issues as hazardous chemicals disposal, ionizing and non-ionizing radiation water and food safety, health rights, trauma care and psychosocial support. WHO will continue to be a spearheading partner in the Global Polio Eradication Initiative to ensure that the objectives of the polio emergency action plan are achieved and that the polio endgame is initiated.

WHO will provide direct support to any country requesting support, giving priority to those most vulnerable to emergencies and that have low or limited capacity to manage the risks and respond. WHO will support Member States through their ministries of health to develop effective and

integrated national health emergency risk management programmes through technical consultations, workshops, expert assessments and guidance. Support will include technical tools and guidelines, norms and standards, model plans and policies, best practices, simulations and table top exercises, information management, and training. Member States will be provided with technical support in capacity building for evidence generation, negotiation and financing, technology transfer, implementation of new measures, and monitoring and evaluation of actions taken.

LINKAGES

Category 5 has strong linkages to all of WHO's other categories of work, as well as its corporate services/enabling functions. The capacities required for risk reduction activities, the International Health Regulations (2005), disaster preparedness, response and recovery are fundamental components of health systems and services. Communicable disease surveillance and control is a major aspect of WHO's responsibilities under the International Health Regulations (2005) and in the context of humanitarian emergencies (including expert guidance on the management of pneumonia, diarrhoeal disease, malaria, tuberculosis and HIV in such settings). The management of noncommunicable diseases, injuries, mental health, environmental health, nutrition, and maternal and reproductive health is central to WHO's policy and incountry work in emergency risk management and in the setting of acute, as well as protracted, crises. The principles of human rights, ethics, equity, gender mainstreaming, sustainable development and accountability inform all of WHO's work in emergencies.

This category has strong links with category 1, on the overall reduction of the burden of communicable diseases.

The priorities in this category are also underpinned by internationally agreed instruments, mechanisms and networks (e.g. the International Health Regulations (2005), Chemical Conventions, the Pandemic Influenza Preparedness Framework, the IASC Transformative Agenda, the Hyogo Framework for Action, Global Health Cluster, the Codex Alimentarius, the International Association for Conflict Management (IACM), INFOSAN, the Global Polio Eradication Initiative and the tripartite One Health initiative). International human rights and humanitarian law guide WHO's work in emergency management.

OUTCOMES

Below are the key outcomes (some of which are expressed in terms of indicator targets) to which the priorities in this category will contribute.

(Work is ongoing to standardize the way in which outcomes are presented and to develop a tighter linkage to the priorities and outputs. This will be done in future versions of the draft proposed programme budget.)

- Number of Member States conducting or updating a multi-hazard health emergency risk assessment at least every two years (*emergency risk and crisis management*).
- Percentage of Member States conducting a national health emergency response exercise at least every two years (*emergency risk and crisis management*).
- Percentage of Member States delivering a basic package of emergency health services to affected populations within 10 days of a major emergency (*emergency risk and crisis management*).
- Number of Member States meeting and sustaining International Health Regulations (2005) core capacities (*alert and response capacities*).
- Percentage of Member States with national emergency risk management plans that include epidemic and pandemic diseases (*epidemic- and pandemic- prone diseases*).
- Number of Member States with an active ‘Safe Hospital Programme’ (*emergency risk and crisis management*).
- Number of Member States with a food safety programme that has a legal framework and enforcement structure (*food safety*).
- All Member States achieve vaccine coverage levels needed to stop poliovirus transmission (*polio eradication*).

OUTPUTS

ALERT AND RESPONSE CAPACITIES

- Implementation of the International Health Regulations (2005), with a focus on strengthening and maintaining core capacities before the 2016 deadline.
- Build Member States’ capacity in order to ensure that they recognize public health events of international concern and apply the International Health Regulations (2005).
- Lead and coordinate policy guidance, information management and communications during acute public health emergencies.
- Timely information available for detection, verification, assessment of and coordinated response to disease outbreaks and acute public health events, including public health emergencies of international concern.
- Training and support for Member States in relation to the detection, notification, risk assessment and response to acute public health events, including potential public health events of international concern (PHEIC) and response mechanisms such as the Global Outbreak Alert and Response Network (GOARN).

EMERGENCY RISK AND CRISIS MANAGEMENT

- Stronger global and regional partnerships for emergency risk and crisis management and health issues fully integrated into the Inter-Agency Standing Committee (IASC) and the United Nations International Strategy for Disaster Reduction (ISDR) decisions and policies.
- WHO Emergency Risk Management Framework implemented with training and support provided to build Member States’ capacity in all-hazard emergency risk and crisis management (prevention, preparedness, response, recovery).
- Enhanced national and international capacity to support Member States effectively during emergencies with public health consequences and, where appropriate, effectively lead and coordinate the response to emergencies as per WHO’s Emergency Response Framework.

- Six-year prioritized research agenda for emergency risk and crisis management; research projects on two priority subjects, e.g. on cost effectiveness of the safe hospitals programme.
- New and updated guidelines including: Health Cluster Guide on Response; Health Cluster Guide on Preparedness and Resilience; standards all-hazard risk assessment. Evidence for Member States on the value of an all-hazard emergency risk management approach for health as well as health-based evidence to influence IASC policy decisions on preparedness and resilience.
- Periodic situation reports and health bulletins in countries impacted by emergencies and global reports on health situation in emergencies; annual report on status of regional Member States emergency risk management; quarterly report on the performance of the global and country health clusters.

EPIDEMIC- AND PANDEMIC-PRONE DISEASES

- Lead and coordinate policy guidance, risk assessment, information management, communications; access to interventions and global and regional actions, when countries face important pandemic or international epidemic diseases/emergencies of known or unknown origin, such as SARS, viral haemorrhagic fevers, and avian and pandemic influenza.
- Support implementation of relevant international frameworks and agreements, such as the Pandemic Influenza Preparedness Framework and the Global Action Plan for Influenza Vaccines and other partner mechanisms and expert groups such as Hepatitis Action Group, Global Task Force for Cholera Control, and medical emergency response and incident teams (MERIT), as required.
- Updated guidance and model templates incorporating a broad approach to national preparedness plans as well as specific guidance on preparedness for selected high priority/risk epidemics such as pandemic influenza.
- Research plan to identify and prioritize critical gaps in knowledge needed to address epidemic and pandemic disease risks/hazards and emergencies, including epidemiological and scientific research gaps (such as burden of disease, predictive modeling of epidemic disease patterns); translational and operational research gaps (such as optimal communications to support vaccination, promoting rational use of medicines to limit antimicrobial drug resistance, and real-time data transmission and analysis); and important product availability gaps (such as affordable, reliable rapid diagnostic tests).
- Critical international standards and recommendations (such as influenza vaccine strain selection recommendations and those by CODEX and the Joint FAO/WHO Expert Committee on Food Additives (JECFA) developed and disseminated and equitable, evidence-based policy options provided for areas important to epidemic and pandemic diseases, such as use of meningitis conjugate vaccines and oral cholera vaccine use, and control of antimicrobial drug resistance and hepatitis.
- Up-to-date epidemiological or laboratory-based surveillance information and risk assessments on epidemic and pandemic disease risks/hazards and emergencies through multiple channels, such as the IHR national focal points, the Internet, critical documents and reports, and the *WHO Bulletin* and *WHO Weekly Epidemiological Record*.
- Technical support to Member States in critical areas to address epidemic and pandemic disease risks/hazards and emergencies including: technical and strategic guidance, expertise and support in areas such as epidemic prevention, control and mitigation, training, field tools, guidelines and standard operating procedures; access to critical diagnostic capacities and selected supplies and treatment through network and stockpile mechanisms.

FOOD SAFETY

- Leadership during international food safety emergencies and cooperation with regions and countries in crises management through mechanisms such as INFOSAN.
- Coordination with international agencies in the food, animal health and agricultural sectors to assess, mitigate, detect and manage of foodborne and zoonotic public health risks.
- International food safety standards and recommendations established and promoted, mainly through the Codex Alimentarius Commission, supporting independent international risk assessments through JECFA, the Joint FAO/WHO Meeting on Pesticide Residues (JMPR), and the Joint FAO/WHO expert meetings on microbial risk assessment (JEMRA) and other ad hoc expert meetings.
- New methods and tools to systematically collect, analyse and interpret data to better guide risk analysis and evidence-based risk management options to control priority hazards along the entire food chain.
- Global estimates on the burden of foodborne and zoonotic diseases for a defined list of causative agents of microbial, parasitic and chemical origin.
- Support to build Member States' capacity to develop risk-based regulatory and institutional cross-sectoral frameworks in order to prevent, monitor, assess and manage foodborne and zoonotic diseases and hazards and support countries during food safety emergencies and crises.

POLIO ERADICATION

- Convene Global Polio Eradication Initiative (GPEI) partners to concur on policy options, strategy, budgets and financing. Internationally agreed mechanism and timeline for managing residual poliovirus risks following eradication and international consensus on the goal and process for securing the public health 'legacy' of polio eradication, building on its systems and infrastructure.
- Convene the Polio Research Committee to prioritize the research for long-term poliovirus risk management; development and licensure of at least one low-cost (<US\$0.50/dose) IPV option to reduce risks associated with the tOPV to bOPV switch; research and development agenda to produce and license a Sabin-IPV and at least one poliovirus antiviral compound.
- Internationally agreed surveillance, containment and outbreak response standards for the polio endgame period; regional consensus and strategy for the use of IPV in the switch from tOPV to bOPV in all immunization programmes.
- Weekly reports of case-based data on acute flaccid paralysis and data on supplementary OPV immunization activities; submission of all necessary information to the Regional Certification Commission to certify eradication in the South-East Asia Region.
- Dissemination and application of all relevant policies and strategies for long-term polio risk management, particularly for the tOPV-bOPV switch and containment; high quality polio surveillance, immunization monitoring and on-going risk analysis to detect and stop outbreaks; provide financial resources for core eradication strategies.

CATEGORY 6: CORPORATE SERVICES/ENABLING FUNCTIONS

SCOPE

This category includes the leadership and corporate services required to maintain the integrity and efficient functioning of WHO. It enables the other five categories to deliver, and addresses challenges identified in the governance and management components of WHO reform. It thereby contributes to the achievement of the third, overarching, stated outcome of WHO reform, namely, to ensure “an Organization that pursues excellence; one that is effective, efficient, responsive, objective, transparent and accountable”.

The category includes the leadership functions that enable WHO to play a more effective role in global health governance, forging partnerships and mobilizing both the scientific and financial resources to improve the health of populations. It includes overseeing the process of reform and ensuring synergy and coherence across the Organization. It encompasses a variety of essential services that contribute to organizational integrity, an enabling work environment, and managing the work at country, regional office and headquarters.

The Organization-wide outputs contribute to the achievement of this outcome across the three levels of the Organization. Unlike other categories, the results chain is not expressed in terms of contribution to health service coverage or health outcomes. Instead, specific deliverables are judged in terms of performance indicators, and benchmarks agreed and applied by similar organizations or opinion surveys of those who use these services.

CONTEXT

WHO continues to play a critical role as the world’s leading technical authority on health, operating within the context of a shifting and complex web of international efforts to improve public health. However, as a results-oriented organization, it needs to adapt its administrative and managerial structure and processes to the changing needs, in order to improve its efficiency and effectiveness.

ISSUES AND CHALLENGES

The reform process has articulated several challenges for this category – including the need to achieve predictable and flexible financing of the Organization; the linkages between the governing bodies and their impact on organizational coherence and strategic focus; the accountability and responsibility structure for the three levels of the Organization; country presence; risk management; change management; and improved workforce planning and management.

The focus of the reform process is adaptation to the changing landscape of public health governance. A sound control environment must be maintained to safeguard WHO’s assets and reputation, and to provide an optimal enabling environment.

WHO needs to become a more integrated, network- and knowledge-based organization. To be able to deliver results, the Secretariat must have skilled and competent staff with rapid and easy access to information, evidence and experts. Considerable investment has been made in improving access to management information through the Global Management System; this should be made full use of. There is a need also to increase the dissemination of country-specific technical knowledge. This shortcoming is a challenge that contributes to the compartmentalization of programme priorities in WHO.

STRATEGIC APPROACHES

This category provides the oversight and enabling environment for the other five categories in achieving targets, safeguarding WHO's constitutional values and principles, including gender equality, equity and social justice, and access to health care as the overarching vision and framework.

The main strategic approaches are to:

- Position WHO to address global, regional and national health challenges and directly contribute to health impact.
- Play the leading role in bringing greater coherence to global health, and in enabling many different actors and stakeholders to effectively contribute to the health of all peoples as stipulated in the Constitution of the Organization.
- Pursue excellence, the highest level of efficiency and effectiveness, responsiveness, transparency and accountability through high-performing staff who are matched to the needs of the three levels of the Organization.
- Drive the process in which WHO's priorities are defined and addressed in a systematic, transparent, and focused manner.
- Build consensus on the design and achievement of predictable and flexible financing and ensure that resources allocated are in alignment with agreed priorities.
- Improve managerial accountability and transparency; strengthen oversight through independent evaluation, efficient provision of corporate services, and rich and timely strategic communications.
- Ensure value for money in enabling administrative services that support the technical work of the Organization, by setting an appropriate risk-management framework and benchmarks for the cost and quality of the technical work delivered.
- Ensure meaningful use of technology to enable staff to create, capture, store, retrieve, use and share knowledge.

PERFORMANCE MEASUREMENT

Work in this category is divided into eight thematic areas. Performance indicators¹ at output level measure contributions made to support achievement of the overarching outcome for this category.

¹ Performance indicators are being developed and will be available for the next version of the proposed programme budget.

OUTPUTS

LEADERSHIP IN HEALTH

- Coherence and synergy in the work of different parts of the Organization in place, including revision and implementation of the roles and responsibilities for the three levels of the Organization.
- Organization-wide “change management” plan for improving management and governance reform.
- Oversight mechanism(s) of mainstreaming issues such as gender, human rights and social determinants in place and functional.
- Coordination mechanisms in place with the United Nations for effective response to humanitarian action, health security, and health and development at country, regional and global levels.
- Alignment across WHO at global, regional and country levels, in preparation for major United Nations events and United Nations reforms initiatives and for collaboration with intergovernmental entities and development banks.
- Frameworks to guide more effective interaction with civil society, the private sector and partnerships that protect WHO’s work from conflict of interest.
- Appraisal of the technical synergy between WHO hosted partnerships and WHO programmes, and ensure that WHO-hosted partnerships comply with WHO’s rules and procedures.

COUNTRY FOCUS

- National health policies, strategies and plans used as a basis for updated country cooperation strategies (CCS) that are available for all countries as a basis for development of biennial technical collaboration. Harmonization with the United Nations Development Assistance Framework and key partners including global initiatives where appropriate. Adjustment of human and financial resources at country level drawing where necessary on headquarters and regional office resources in line with priorities identified in country cooperation strategies.
- Technical guidance and support provided by headquarters and regional offices to country offices on current issues including “South–South and “triangular” collaboration.
- Selection process for heads of WHO Offices in countries, areas and territories further strengthened, and their capacity developed, to improve their leadership competencies, especially in global health diplomacy and successful succession planning.

GOVERNANCE AND CONVENING

- Efficient organization and conduct of statutory and ad hoc governing bodies meetings in all relevant official languages (i.e. the Health Assembly, the Executive Board, the regional committees and intergovernmental committees and working groups established by them).
- Legal status and interests of the Organization protected and promoted through timely and accurate legal advice and services.

- Harmonized practices in place with respect to credentials, observers and the election of the regional directors.

STRATEGIC POLICY, PLANNING, RESOURCE COORDINATION AND REPORTING

- Define and operationalize WHO programmes and priorities in a systematic, transparent and focused manner, and through the coordination of strategic and operational planning, including implementation of a new results chain and strategic cost reduction.
- Strengthened linkages between financing and sustainable staffing through strategic workforce planning that matches the needs of the Organization and the availability of funding that is sustainable, efficient and effective.
- Budget management system in place allowing the programme budget to be strategically managed. Budget allocation and reprogramming determined by results-based principles and emerging issues.
- Alignment of WHO financing with agreed priorities and budget through outreach and resource mobilization, including effective coordination of donor relations (including financing dialogues), strategic resource allocation, donor agreements and reporting.
- Corporate performance assessment management system in place providing relevant stakeholders with timely and regular reports on WHO's performance.

STRATEGIC COMMUNICATIONS

- Effective and cost-efficient communications channels in place that allow WHO to reach stakeholders and other target audiences, including for communications in emergencies.
- Senior leadership and WHO technical experts are able to communicate about WHO's priorities and the Organization's impact on health, and WHO spokespersons have access to up-to-date information on what the Organization is doing on technical issues.
- Global communications strategy and standards in place, including global health campaigns on days mandated by the World Health Assembly.
- Communications surveillance system in place for early warning of reputation and other communications issues.

KNOWLEDGE MANAGEMENT

- Comprehensive management of the publication of WHO information products including copyright management and promotion of multilingualism.
- Evidence-based guidelines provided through the management of the Guidelines Review Committee.
- Global knowledge networks of scientists and scientific institutions through management of WHO collaborating centres and expert advisory panels and committees.

ACCOUNTABILITY AND RISK MANAGEMENT

- Framework for corporate risk management and a risk register developed and implemented.

- Internal audit and oversight services with increased capacity and broader coverage in place.
- Implementation of best ethical practices and principles including establishment of Ethics Office and ensuring that an information disclosure policy is applied and streamlined (including whistle-blower, harassment and investigation policies, financial disclosures, etc.), and research proposals reviewed to ensure they comply with the ethical standards.
- Evaluation policy implemented and evaluation culture promoted as an integral function at all levels of the Organization.
- Internal justice system streamlined (i.e. Board of Appeals, Grievance Panels, Office of the Ombudsman).
- Provision of services by the External Auditor in accordance with Financial Regulation 14, and by the Independent Expert Oversight Advisory Committee and the Joint Inspection Unit to the Programme, Budget and Administration Committee of the Executive Board in accordance with their terms of reference.

MANAGEMENT AND ADMINISTRATION

- Accurate and timely financial reporting provided to donors and Member States through accurate accounting and tracking of expenditure against contributions.
- Safe custody of financial assets ensured, achieving returns on invested funds in accordance with benchmarks, providing banking and cash flow management services and identifying and mitigating foreign exchange risks through treasury.
- Accurate and timely recording of all sources of income, ensuring cash collection, accurate allocation and tracking of specified contributions to donor accounts and that income and expenditure of the Organization match the budget.
- Timely payment of suppliers and staff through the management of suppliers, payment processing of invoices, staff payroll, entitlements, advances, travel requests/claims.
- Adequate financial control framework, such that expenditure is properly authorized and recorded, account record keeping is accurate, assets safeguarded, and liabilities correctly quantified.
- Effective organizational design and efficient recruitment and selection processes in place, implementation of a mobility and rotation framework to ensure highest quality and diversity of staff; contract management and implementation of benefits and entitlements ensured.
- Revised performance management strategy and a model for career development including learning opportunities to ensure skills are maintained and expanded.
- Health and medical services for WHO staff, including oversight of WHO's Occupational Health and Safety policy and management of the medical database.
- Computing infrastructure, network and communications services; corporate and health-related systems and applications (including the Global Management System); and end-user support and training service in place.
- Operational support, procurement of goods and services, infrastructure maintenance and asset management, office support for country offices (including operational support to United Nations organizations), and general administration in the regions and headquarters.

DRAFT PROPOSED PROGRAMME BUDGET 2014–2015

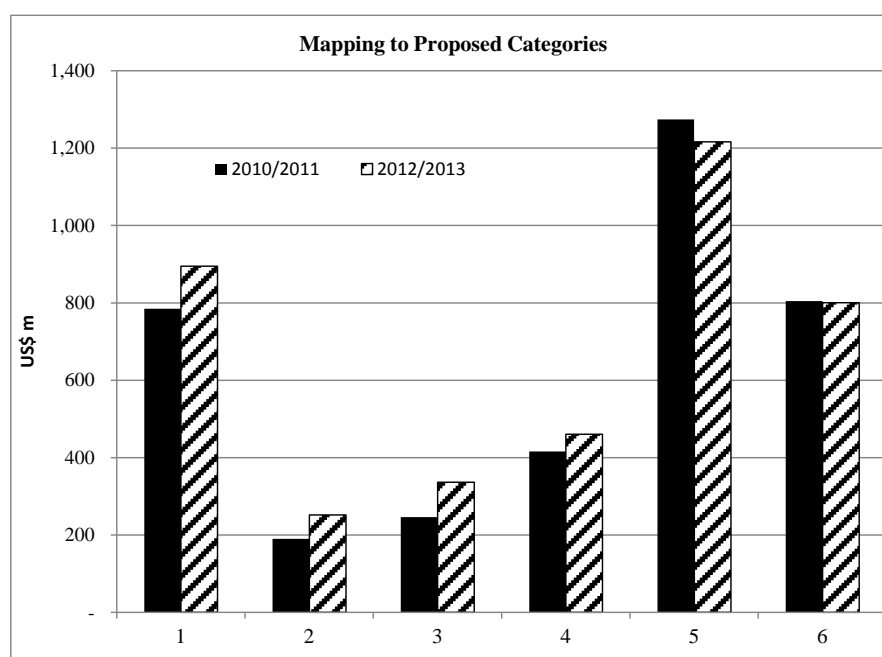
- Secure working environment for staff and WHO's property including Minimum Operational Security Standards (MOSS) and Minimum Operational Residential Security Standards (MORSS), security of premises.

ANNEXES

ANNEX 1

Mapping of previous resource allocation to proposed categories

Categories	2010–2011 ¹		2012–2013 ²	
	US\$ million	%	US\$ million	%
1: Communicable diseases	785	21%	895	23%
2: Noncommunicable diseases	190	5%	252	6%
3: Promoting health through the life-course	246	7%	336	8%
4: Health systems	416	11%	460	12%
5: Preparedness, surveillance and response ³	1 274	34%	1 216	31%
6: Corporate services/ enabling functions ⁴	805	22%	800	20%
Grand total	3 717	100%	3 959	100%



Notes

¹ Expenditure figures rounded to the nearest million as presented in document A65/28 “Programme budget 2010-2011: performance assessment”.

² Approved Programme Budget 2012–2013 figures rounded to the nearest million.

³ Category 5 includes figures for polio and emergency response amounting to US\$ 652 million and US\$ 359 million respectively in 2010–2011, and to US\$ 420 million and US\$ 447 million respectively in 2012–2013.

⁴ Since January 2010, a Post Occupancy Charge (POC) has been introduced to cover costs associated with the level of staffing of programmes and projects (examples of such costs include: staff development and learning, information and communications technology infrastructure, human resources administration, UN common security charges, the Global Service Centre, and office accommodation). In this presentation all such costs have been consolidated under category 6.

ANNEX 2

Mapping of previous resource allocation to proposed categories by major office

2010–2011 expenditure

Categories	AFRO		AMRO		EMRO		EURO		SEARO		WPRO		HQ		TOTAL	
	US\$ m	%	US\$ m	%	US\$ m	%	US\$ m	%	US\$ m	%	US\$ m	%	US\$ m	%	US\$ m	%
1: Communicable diseases	200	20%	23	15%	84	19%	32	16%	83	27%	62	25%	302	22%	785	21%
2: Noncommunicable diseases	26	3%	13	9%	13	3%	17	9%	18	6%	25	10%	78	6%	190	5%
3: Promoting health through the life-course	54	5%	12	8%	14	3%	15	8%	17	5%	17	7%	119	9%	246	7%
4: Health systems	54	5%	21	14%	32	7%	33	16%	31	10%	42	17%	202	15%	416	11%
5: Preparedness, surveillance and response	504	50%	39	26%	236	53%	38	19%	105	34%	52	21%	300	22%	1 274	34%
6: Corporate services/ enabling functions	168	17%	44	29%	65	15%	64	32%	52	17%	51	20%	361	27%	805	22%
Grand total	1 007	100%	152	100%	444	100%	199	100%	307	100%	247	100%	1 360	100%	3 717	100%

2012–2013 Approved Programme Budget

Categories	AFRO		AMRO		EMRO		EURO		SEARO		WPRO		HQ		TOTAL	
	US\$ m	%	US\$ m	%	US\$ m	%	US\$ m	%	US\$ m	%	US\$ m	%	US\$ m	%	US\$ m	%
1: Communicable diseases	229	22%	40	24%	132	25%	35	17%	140	38%	85	35%	233	17%	895	23%
2: Noncommunicable diseases	43	4%	20	12%	20	4%	32	15%	25	7%	28	11%	84	6%	252	6%
3: Promoting health through the life-course	96	9%	24	14%	21	4%	31	15%	24	7%	18	8%	122	9%	336	8%
4: Health systems	93	9%	35	21%	46	9%	32	15%	41	11%	42	17%	172	13%	460	12%
5: Preparedness, surveillance and response	464	44%	18	11%	250	47%	22	10%	94	25%	20	8%	347	25%	1 216	31%
6: Corporate services/ enabling functions	140	13%	30	18%	67	13%	59	28%	48	13%	47	20%	409	30%	800	20%
Grand total	1 065	100%	168	100%	536	100%	211	100%	372	100%	240	100%	1 366	100%	3 959	100%