Weltgesundheitsorganisation
REGIONALBÜRO FÜR Europa

Regionalkomitee für Europa
Zweiundsechzigste Tagung

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Der Programmhaushalt 2014–2015 – Die Perspektive des WHO-Regionalbüros für Europa

In diesem Dokument wird die Perspektive des WHO-Regionalbüros für Europa in Bezug auf den Programmhaushaltsentwurf 2014–2015 (PB2014–2015) erläutert. Es wurde in Verbindung mit dem PB2014–2015 erstellt und sollte auch zusammen mit diesem gelesen werden.

In dem Dokument werden Zusammenhänge und Gründe für die vom Regionalbüro für Europa als Sekretariat geplanten programmbezogenen Entscheidungen im kommenden Zweijahreszeitraum vor dem Hintergrund der gegenwärtigen Reform der WHO erläutert. An dieser Stelle sei darauf hingewiesen, dass im vergangenen Zweijahreszeitraum nach der Amtseinführung der Regionaldirektorin im Februar 2010 eine Reihe von Veränderungen durchgeführt wurden, die in die operative Planung für den Zeitraum 2012–2013 Eingang fanden. Andere Veränderungen wurden dagegen bis zum Vorliegen von Ergebnissen bei den Beratungen über die Reform der WHO auf Eis gelegt. Die Arbeit zur Umsetzung dieser Veränderungen wird nun wieder aufgenommen und ggf. an dem allgemeinen Reformprozess in der WHO ausgerichtet.

Die Prioritätensetzung hat zur Folge, dass einige neue Arbeitsbereiche (Resultate und Produkte) eingeführt werden. Aufgrund des konstanten Haushalts- und Mittelniveaus müssen allerdings zwangsläufig andere Bereiche wegfallen. Das Geschäftsmodell des WHO-Regionalbüros für Europa wird weiter verfeinert, um die umfassende fachliche Hilfe an die Mitgliedstaaten weiter zu optimieren; hierbei soll auf die vorhandene Sachkompetenz in einzelnen Mitgliedstaaten wie auch in europäischen Institutionen zurückgegriffen werden. Im Hinblick auf die Zuteilung von Haushaltsmitteln und die Finanzierungsmodalitäten bietet das vorliegende Dokument einen Ausblick auf die Zeit nach dem PB2014–2015, indem Zahlen genannt werden, die über die Konsequenzen der Priorisierungs- und Finanzierungsentscheidungen Aufschluss geben und so die Debatte im Regionalkomitee beflügeln sollen.

Das Regionalkomitee wird dazu aufgefordert, die in dem Dokument erläuterten Vorschläge im Kontext des Reformprozesses in der WHO, des Zwölften Allgemeinen Arbeitsprogramms und des PB2014–2015 (einschließlich des geplanten konstanten globalen Haushaltsrahmens) zu prüfen, zu erörtern und zu kommentieren.

Inhalt

Seite

1. Einführung

1. Das vorliegende Dokument wurde im Einklang mit den Konzepten „eine WHO“ und „ein Programmhaushalt“ erstellt. Es ist daher in Verbindung mit dem Zwölften Allgemeinen Arbeitsprogramm (GPW12) und dem Programmhaushalt 2014–2015 (PB2014–2015) zu lesen. Konkret ist ein zweistufiger Prozess vorgesehen: als Erstes soll das vorliegende Dokument auf der 62. Tagung des WHO-Regionalkomitees für Europa (RC62) als Grundlage für die Diskussion über den Globalen Programmhaushalt 2014–2015 mit besonderem Augenmerk auf den konkreten Prioritäten und erwarteten Ergebnissen der Arbeit des Regionalbüros für Europa dienen; in einem zweiten Schritt soll auf dem RC63 (nach der Verabschiedung des Globalen Programmhaushalts durch die Weltgesundheitsversammlung) eine Verpflichtung in Bezug auf konkrete Resultate und Produkte für die Europäische Region der WHO eingegangen werden. Diese Verpflichtung bildet dann einen „Vertrag“ zwischen dem Regionalkomitee und dem Sekretariat, über dessen Einhaltung der Ständige Ausschuss des Regionalkomitees (SCRC) wacht. Dieser „Vertrag“ dient der Förderung von Effektivität, Transparenz und Rechenschaftslegung in Bezug auf Ergebnisse und Ressourcen und steht im Einklang mit früheren Ersuchen der leitenden Organe der Europäischen Region (RC und SCRC).

2. Die Arbeit zur Nutzung des Programmhaushalts der WHO als strategisches Instrument für die Rechenschaftslegung (s. EUR/RC61/Inf.Doc./10) begann im vergangenen Zweijahreszeitraum mit einem Plan, der u. a. die Erprobung von Konzepten, Instrumenten und Zuständigkeiten im Zeitraum 2012–2013 vorsah. Allerdings wurden einige der konkreten Aspekte dieses Pilotversuchs vorläufig ausgesetzt, um zuerst einen besseren Überblick über das organisationsweite Meinungsbild in Bezug auf den Reformprozess zu gewinnen. Diese Diskussionen sind inzwischen so weit fortgeschritten, dass der Pilotversuch des Regionalbüros fortgesetzt werden kann. Besonders erwähnenswert ist hierbei, dass der Reformprozess in der WHO sich die in Dokument EUR/RC61/Inf Doc/10 dargestellte Ergebniskette zu eigen gemacht hat, einschließlich der Konzepte der gegenseitigen Rechenschaftslegung in Bezug auf Resultate und der speziell dem Sekretariat obliegenden Rechenschaftspflicht für die Produkte. Der erste Bericht über die erstmalige Erprobung dieses Rechenschaftsrahmens wird dem SCRC auf seiner Tagung im November 2012 vorgelegt. Die Erkenntnisse aus weiteren Pilotversuchen im weiteren Verlauf des Zweijahreszeitraums 2012–2013 sollen ab Anfang 2013 in die operative Planung für den Zeitraum 2014–2015 einfließen.

2. Orientierungsrahmen

3. Das GPW12 und der PB2014–2015 sind entscheidende Instrumente für die Umsetzung der Reform der WHO. In den beiden Dokumenten wird die Vision von einer WHO beschrieben, die nicht alles gleichzeitig erreichen will, sondern sich auf Bereiche konzentriert, in denen der Bedarf am größten ist und die WHO über einen relativen Vorteil verfügt. Diese Neuausrichtung könnte eine Verkleinerung der WHO zur Folge haben, da es mehr zielgerichtete Anstrengungen gäbe, anstatt in allen Themenfeldern weniger in die Tiefe zu gehen. Das WHO-Regionalbüro für Europa und die Regionaldirektorin unterstützen uneingeschränkt die Reformbemühungen, das GPW12 und den PB2014–2015. Das vorliegende Dokument über die Perspektive des Regionalbüros für Europa ist ein erster Schritt, um die Ideen, Konzepte und Pläne in der Europäischen Region in die Tat umzusetzen.

2.1 Werte

4. Das GPW12 nimmt als Ausgangspunkt den einleitenden Satz aus der Präambel der Satzung der Weltgesundheitsorganisation: „Gesundheit ist ein Zustand vollständigen körperlichen, seelischen und sozialen Wohlbefindens und nicht nur das Freisein von Krankheit oder Gebrechen."

5. Die zentralen Werte, die dem neuen Europäischen Rahmenkonzept für Gesundheit und Wohlbefinden, „Gesundheit 2020", sowie der Perspektive des Regionalbüros zum PB2014–2015 zugrunde liegen, sind das in der Satzung verbriefte Recht auf das erreichbare Höchstmaß an körperlicher und geistiger Gesundheit und der Abbau gesundheitlicher Ungleichgewichte. Diese Konzepte bauen auf den Diskussionen der 65. Weltgesundheitsversammlung über die systematische Berücksichtigung der sozialen Determinanten von Gesundheit auf und orientieren sich an der Resolution WHA62.14 der Weltgesundheitsversammlung, in der die WHO ersucht wird, die sozialen Determinanten von Gesundheit zu einem Leitprinzip für die Durchführung von Maßnahmen (einschließlich der Einführung objektiver Indikatoren für die Beobachtung der sozialen Determinanten von Gesundheit) in allen relevanten Arbeitsbereichen zu machen und das Ansetzen an den sozialen Determinanten von Gesundheit zur Verringerung gesundheitlicher Ungleichgewichte in allen Arbeitsbereichen der Organisation, jedoch insbesondere in den vorrangigen Programmen zur Förderung der öffentlichen Gesundheit, als ein maßgebliches Ziel voranzutreiben.

2.2 Prioritätensetzung

6. Im GPW12 werden die WHO-Programme in sechs Kategorien für die Prioritätensetzung angeordnet: 1. Übertragbare Krankheiten; 2. nichtübertragbare Krankheiten; 3. Gesundheitsförderung im gesamten Lebensverlauf; 4. Gesundheitssysteme; 5. Vorsorge, Surveillance und Gegenmaßnahmen; 6. organisatorische und befähigende Funktionen.1 Im GPW12 werden außerdem auf der Grundlage der Konsultationen mit den Mitgliedstaaten im Februar 2012 und der späteren Bestätigung durch die Weltgesundheitsversammlung fünf weltweit gültige Kriterien aufgestellt, die für die Prioritätensetzung innerhalb von Kategorien wie auch über deren Grenzen hinweg angewandt werden sollen. Nachstehend ist kurz zusammengefasst, inwiefern diese für die Europäische Region von Belang sind.

Die aktuelle gesundheitliche Lage

7. Im Europäischen Gesundheitsbericht 2012 werden der Gesundheitszustand der Bevölkerung und die Verteilung von Gesundheit thematisiert. Seine zentralen Aussagen betreffen folgende Bereiche:

- **Demografische Trends:** Aufgrund der sinkenden Geburtenraten in allen Teilen der Europäischen Region wird das Bevölkerungswachstum bald zum Stillstand kommen. Bereits heute ist eine rapide Bevölkerungsalterung festzustellen. Auch die Migration hat Auswirkungen auf die demografischen Übergänge sowie auf das Gesundheitsprofil der einzelnen Länder. Laut Prognosen werden bis zum Jahr 2045 rund 80% der Bevölkerung in städtischen Gebieten leben, im Jahr 2010 waren es noch 70%; ferner wird davon ausgegangen, dass 4% der Bevölkerung in der Region legale und weitere 4% illegale Migranten sein werden.
- **Mortalität:** Die Europäische Region weist weltweit die niedrigsten Indikatoren für Kindersterblichkeit auf. Dabei gibt es jedoch auffallende Unterschiede zwischen den Ländern. Die

[1] Die spezifische Sichtweise des WHO-Regionalbüros für Europa zu jeder dieser sechs Kategorien ist dem Anhang A zu entnehmen.

Müttersterblichkeitsrate ist seit 1990 um rund 50% gesunken, und auch die Sterblichkeit aufgrund aller Ursachen in der Altersgruppe über 65 Jahren ist rückläufig. Doch in beiden Bereichen bestehen beträchtliche Unterschiede sowohl zwischen als auch innerhalb von Ländern.

- **Todesursachen:** Nichtübertragbare Krankheiten waren 2009 für rund 80% aller Todesfälle verantwortlich, wobei knapp 50% auf Herz-Kreislauf-Erkrankungen entfielen, gefolgt von Krebs (20%) und Verletzungen und Vergiftungen (9%). Die Häufigkeit der Fälle von übertragbaren Krankheiten ist im Vergleich zu anderen Teilen der Welt geringer. Allerdings ist seit 1990 eine langsame Zunahme der Infektions- und Parasitenerkrankungen zu verzeichnen. Den größten Grund zur Besorgnis geben die Tuberkulose (insbesondere die multiarzneimittelresistente Tuberkulose MDR-Tb), HIV/Aids (schnellste Ausbreitung der Epidemie in den Ländern Osteuropas und Zentralasiens) und andere sexuell übertragbare Krankheiten sowie die virale Hepatitis.
- **Krankheitslast:** Der vermeidbare Verlust behinderungsbereinigter Lebensjahre (sog. DALY-Verlust) liegt in den Ländern mit niedrigem bis mittlerem Einkommen zwischen 10% und 28% und damit etwa doppelt so hoch wie in den Ländern mit hohem Volkseinkommen. Die für diese Verluste primär verantwortlichen Risikofaktoren sind ungünstige Ernährung, Bewegungsmangel und der Konsum von Suchtmitteln wie Tabak und Alkohol.

8. Die gesundheitlichen Ungleichgewichte breiten sich in der Europäischen Region weiter aus. Um ihre Größenordnung und Hintergründe, aber auch ihre Folgen gründlicher analysieren zu können, hat das Regionalbüro die Untersuchung der sozialen Determinanten von Gesundheit und des Gesundheitsgefälles in der Europäischen Region in Auftrag gegeben.2 Darüber hinaus kommt eine Berichtsreihe der Organisation für wirtschaftliche Zusammenarbeit und Entwicklung (OECD) aus dem Jahr 2011 zu dem Schluss, dass die wichtigste treibende Kraft hinter den zunehmenden Ungleichgewichten die sich in vielen Ländern immer weiter öffnende Einkommensschere ist.3 Die wirtschaftliche Rezession in einer Reihe von Mitgliedstaaten in der Europäischen Region wird aufgrund der durch sie bedingten Sparmaßnahmen eine weitere Verschärfung der Ungleichgewichte zur Folge haben, sofern nicht geeignete Vorsorgemaßnahmen ergriffen werden.

Bedürfnisse der einzelnen Länder

9. Die Bedürfnisse jener Länder, die zweijährige Kooperationsvereinbarungen (BCA) mit der WHO unterzeichnet haben, sind aufgrund entsprechender Bewertungen sowie der dem Abschluss der Vereinbarungen vorausgegangenen Beratungen hinlänglich bekannt. Dagegen wird für Länder, die nicht über eine solche BCA verfügen, in den kommenden Monaten eine erste Bestandsaufnahme erfolgen, die gewährleisten soll, dass ihre Anforderungen und Prioritäten in der Arbeit des Sekretariats gebührend berücksichtigt und anerkannt werden. Damit soll sichergestellt werden, dass die Bedürfnisse aller 53 Mitgliedstaaten in der Europäischen Region berücksichtigt werden und dass der Rahmen für die Zusammenarbeit im Zeitraum 2014–2015 definiert wird, bevor Anfang 2013 die operative Planung für den Zeitraum 2014–2015 beginnt. Zu einem späteren Zeitpunkt sollen alle Mitgliedstaaten Kooperationsstrategien mit der WHO ausarbeiten (s. a. Abschnitt 4.2).

[2] Eine Zusammenfassung der Untersuchung der sozialen Determinanten von Gesundheit und des Gesundheitsgefälles in der Europäischen Region wird dem Regionalkomitee als Hintergrunddokument vorgelegt.

[3] www.oecd.org/els/social/inequality (eingesehen am 21. August 2012)

International vereinbarte Instrumente

10. Eine Durchsicht der Dokumente und Resolutionen der leitenden Organe sowie der Grundsatzerklärungen von Ministerkonferenzen in der Europäischen Region ergab, dass in den 20 Jahren zwischen 1990 und 2010 über 1000 Verpflichtungen eingegangen wurden. Einige dieser Verpflichtungen betrafen jedoch dieselben oder ähnliche Themen. Außerdem wurden auf Ebene der Weltgesundheitsversammlung und anderer Gremien der Vereinten Nationen sowie anderer internationaler Foren, die einen direkten Bezug zur Gesundheit haben, eine Reihe internationaler Vereinbarungen beschlossen. Mit „Gesundheit 2020“ in der dem RC62 vorgelegten Form werden diese konsolidiert und miteinander verknüpft, wobei auf die dringlichsten Prioritäten sowie ggf. das Schließen von Lücken abgezielt wird (s. a. Abschnitt 3).

Evidenzbasierte, kosteneffektive Interventionen und Möglichkeiten zur Nutzung von Wissen, Wissenschaft und Technologie

11. Dies ist die Grundlage für die gesamte in der Region geleistete Arbeit. Für die Entwicklung von „Gesundheit 2020“ wurden in den vergangenen zwei Jahren alle verfügbaren Erkenntnisse systematisch mit dem Ziel geprüft, die kosteneffektivsten Interventionen für die gesundheitlichen Bedürfnisse in der Region zu benennen. Dazu gehörten die Prüfung der sozialen Determinanten von Gesundheit, Führungsfragen und sektorübergreifende Ansätze sowie Aspekte aus anderen Themenbereichen wie Volkswirtschaft, öffentliche Gesundheit, Ökonomie von Prävention/Gesundheitsförderung, Auswirkungen der Finanzkrise und Gesundheitssysteme. Zur Ausweitung und Fortführung dieser Arbeit wurde der Europäische Beratungsausschuss für Gesundheitsforschung (EACHR) wieder ins Leben gerufen.

Der strategische Vorteil des WHO-Regionalbüros für Europa

12. Das Regionalbüro verfügt über eine Vielzahl relativer Vorteile. Die WHO ist eine globale Organisation von Mitgliedstaaten; ihre Mitgliedschaft ist universell, und ihre Entscheidungsprozesse sind demokratisch. Die WHO hat eine starke normative Rolle und besitzt die Fähigkeit, die maßgeblichen Akteure an einen Tisch zu bringen, während sie zugleich gemeinsam mit den Regierungen das in der normativen Arbeit gewonnene Wissen in nationale Konzepte, Programme und Maßnahmen umsetzt. Die WHO ist eine „Wächterin über die öffentliche Gesundheit“, und ihr vorrangiges originäres Interesse ist die Verteidigung der Interessen der Weltbevölkerung in Bezug auf öffentliche Gesundheit auf allen Ebenen der Organisation. In der Europäischen Region – wie in allen anderen Regionen – verfügt die WHO über ein klares Mandat von ihren Mitgliedstaaten: durch das Regionalkomitee, in dem alle Konzepte, Strategien, Aktionspläne und anderen für die Europäische Region wesentlichen strategischen Entwicklungen bestätigt werden. Die WHO ist politisch unparteiisch und soll nur im Interesse der öffentlichen Gesundheit handeln. Das Regionalbüro für Europa kann die Mitgliedstaaten in der Region zu jedem Thema im Bereich der öffentlichen Gesundheit an einen Tisch bringen und dient als Schaltstelle für zahlreiche Netzwerke zur fachlichen Kooperation zwischen Institutionen und einzelnen Experten aus der gesamten Region. Das Regionalbüro verfügt über eine Länderpräsenz, die an die Kapazitäten der Länder angepasst ist und dort am stärksten ist, wo der Bedarf am größten ist. Aufgrund seines dezentralisierten Aufbaus kann das Regionalbüro schneller und bedarfsgerechter auf konkrete Bedürfnisse einzelner Länder reagieren. Das Regionalbüro ist ein ehrlicher Vermittler und Moderator, der langfristig zur Verfügung steht und die kritische Masse an Fachwissen auf einer Reihe von Gebieten besitzt und der auch auf das Fachwissen von Experten aus der gesamten Organisation sowie von anderen Institutionen zugreifen kann.

13. Alle diese Stärken versetzen das Regionalbüro im Verein mit dessen profunden Erfahrungen in die einzigartige Lage, zur Übersetzung von Wissen für Politikgestalter beizutragen, damit diese es leichter einordnen, sortieren und anwenden können, und erleichtern ein bereichsüber-

greifendes und nahtloses Herangehen an Themen, was die Fähigkeiten der meisten anderen Organisationen übersteigt.

14. In den vergangenen zwei Jahren wurde in der Europäischen Region intensiv und systematisch anhand von Priorisierungskriterien gearbeitet, die den von den Mitgliedstaaten auf der globalen Ebene vereinbarten sehr ähneln. Dies gilt sowohl für den Prozess der Gestaltung von „Gesundheit 2020“ als auch für die operative Planung für den Zeitraum 2012–2013. Diese Arbeit orientierte sich an der Zukunftsvision der Regionaldirektorin, die vom RC60 in Moskau unterstützt wurde, in der Absicht, eine umfassendere Rechenschaftslegung gegenüber den leitenden Organen zu gewährleisten. Querverbindungen zwischen dem Programmhaushaltsentwurf 2014–2015 und dem aktuellen Inventar der erwarteten Resultate/Produkte (Outcome/Output Portfolio) des Regionalbüros für 2012–2013 sind den Anhängen B und C zu entnehmen.

3. Wichtigste Prioritäten für die Europäische Region

15. Die Europäische Region hat von jeher ein gesundheitspolitisches Rahmenkonzept verfolgt; deshalb bat das RC60 die Regionaldirektorin darum, das bestehende Konzept zu aktualisieren. Das Ergebnis ist „Gesundheit 2020“4, das übergeordnete integrierte und handlungsorientierte Rahmenkonzept, durch das Gesundheit und Wohlbefinden verbessert und gesundheitliche Ungleichgewichte verringert werden sollen und das dem RC62 nun zur Prüfung vorgelegt wird. Es ist an Gesundheitsminister sowie andere Fachminister und Politikgestalter gerichtet, die mit den sozialen, ökonomischen und ökologischen Determinanten von Gesundheit befasst sind. Künftig werden alle Konzepte, Strategien und Programme in der Europäischen Region unter Verwendung dieses Rahmenkonzeptes entwickelt, und auch die Zusammenarbeit des Regionalbüros mit den Ländern wird sich an ihm orientieren. Die Unterstützung der Länder bei der Weiterentwicklung ihrer Gesundheitspolitik und der Stärkung ihrer Gesundheitssysteme wird das einende Schwerpunktthema sein, und die Determinanten von Gesundheit und Chancengleichheit sollen durch dieses Rahmenkonzept in alle maßgeblichen Fachgebiete und Programme einfließen.

16. „Gesundheit 2020“ verfolgt zwei strategische Ziele: Erstens die Verbesserung der Gesundheit für alle und die Verringerung der gesundheitlichen Kluft und zweitens bessere Führungsarbeit und mehr partizipatorische Politikgestaltung für die Gesundheit. Ferner werden darin vier allgemeine vorrangige Handlungsfelder genannt: Vorrangiges Handlungsfeld 1: „Investitionen in Gesundheit durch einen Lebensverlaufansatz und Stärkung der Handlungsfähigkeit der Menschen“; entspricht Kategorie III aus dem 12. GPW; Vorrangiges Handlungsfeld 2: „Bekämpfung der großen gesundheitlichen Herausforderungen durch nichtübertragbare und übertragbare Krankheiten in der Europäischen Region“; entspricht den Kategorien I, II und V; Vorrangiges Handlungsfeld 3: „Stärkung von bürgernahen Gesundheitssystemen, von Kapazitäten in den öffentlichen Gesundheitsdiensten und von Vorsorge-, Surveillance- und Gegenmaßnahmen für Notlagen“; verteilt sich auf die Kategorien IV und V im GPW; Vorrangiges Handlungsfeld 4: „Schaffung widerstandsfähiger Gemeinschaften und stützender Umfelder“; verteilt sich auf die Kategorien III und V.

17. In „Gesundheit 2020“ werden sechs Dachziele postuliert. Auch wenn die Indikatoren und Ziele kein Selbstzweck sind, so haben sie doch eine fördernde Wirkung in Bezug auf Gesundheit und Wohlbefinden, indem sie als Instrument zur Ausrichtung und Förderung von Leistungsfähigkeit und Rechenschaftslegung dienen. Es handelt sich dabei insofern um Ziele für die Europäische Region, als sie auf dieser Ebene vereinbart und überwacht werden. In Abhängigkeit von ihren jeweiligen Gegebenheiten werden alle Mitgliedstaaten zum Erreichen dieser Ziele

[4] *Europäisches Rahmenkonzept „Gesundheit 2020“ für gesamtstaatliches und gesamtgesellschaftliches Handeln zur Förderung von Gesundheit und Wohlbefinden* (EUR/RC62/9).

beitragen und Fortschritte entsprechend mitverfolgen. Ebenso wird das Sekretariat seine Ressourcen und Anstrengungen konkret darauf ausrichten, die Mitgliedstaaten bei der Erfüllung der Ziele bis zum Jahr 2020 zu unterstützen. Einige der Ziele können konkret mit einer der Kategorien aus dem GPW12 verknüpft werden, während andere nur durch konzertierte Anstrengungen einer Vielzahl von Akteuren und Programmen erreicht werden können (Tabelle 1).

Tabelle 1: Geplante Ziele für die Europäische Region bis zum Jahr 2020 (dürften bis zum Jahr 2013 Veränderungen unterworfen sein)[5]

Hauptbereiche von „Gesundheit 2020“	**Übergeordnete „Dachziele“**	**Wichtigste Zielbereiche** (*Quantifizierung noch mit Mitgliedstaaten zu vereinbaren*)	**Kategorien**				
			I	**II**	**III**	**IV**	**V**
1. Krankheitslast und Risikofaktoren	1. Senkung der vorzeitigen Mortalität in der Europäischen Region bis 2020	1. Relative jährliche Verringerung der Gesamtsterblichkeit aufgrund von Herz-Kreislauf-Erkrankungen, Krebs, Diabetes und chronischen Atemwegserkrankungen bis 2020 [in %]		*			
		2. Erreichung und Aufrechterhaltung der Eliminierung/Eradikation ausgewählter impfpräventabler Krankheiten (Polio, Masern, Röteln, Prävention der Rötelnembryopathie)	*				*
		3. Verringerung der Zahl der Straßenverkehrsunfälle bis 2020 [in %]		*			
2. Gesundheit und Wohlbefinden der Menschen und ihre Determinanten	2. Erhöhung der Lebenserwartung in der Europäischen Region	Weiterer Anstieg der Lebenserwartung unter Fortsetzung der gegenwärtigen Trends			*		*
	3. Abbau gesundheitlicher Ungleichgewichte in der Europäischen Region (Ziel in Bezug auf die sozialen Determinanten)	Verringerung der Kluft beim Gesundheitsstatus zwischen Bevölkerungsgruppen, die von sozialer Ausgrenzung und Armut betroffen sind, und dem Rest der Bevölkerung; und 1- oder 2-prozentige Verringerung der Differenz in der Lebenserwartung zwischen den Bevölkerungen der Länder der Europäischen Region bis 2020	*	*	*	*	*
	4. Förderung des Wohlergehens der Bevölkerung in der Europäischen Region	2012 startete das Regionalbüro für Europa im Rahmen einer internationalen Allianz mit Beteiligung der Europäischen Kommission und der OECD eine Initiative zur Messung und Festlegung von Zielvorgaben in Bezug auf Wohlbefinden. Seitdem hat eine dazu eingesetzte internationale Expertengruppe zweimal getagt und einen Rahmen und eine Definition für Wohlbefinden vorgelegt; Letztere ist in dem Glossar zu „Gesundheit 2020“ enthalten. Zu den nächsten geplanten Schritten im Rahmen der Initiative gehört die Festlegung von Indikatoren und Zielvorgaben.			*		*
3. Prozesse, Führungsfragen und Gesundheitssysteme	5. Flächendeckende Versorgung und das „Recht auf Gesundheit“	Die Finanzierungssysteme für die Gesundheitsversorgung sollten bis 2020 eine allgemeine Versorgung, Solidarität und Tragfähigkeit sicherstellen				*	*
	6. Aufstellung nationaler Ziele und Vorgaben durch die Mitgliedstaaten	Einrichtung und Umsetzung nationaler Prozesse für die Festlegung von Zielen				*	*

[5] Nähere Einzelheiten zu „Gesundheit 2020 – Rahmenkonzept und Strategie“ sind dem Dokument EUR/RC62/8 (Nummern 126–129) sowie dem Kasten 5 zu entnehmen.

4. Was das Sekretariat erreichen will

18. Der Entwurf des GPW12 und der Programmhaushaltsentwurf 2014–2015 bringen eine neue Ergebniskette mit sich, d. h. Aktivitäten/Prozesse, Produkte, Resultate und Wirkung. Die Rechenschaftspflicht für die Produkte liegt ausschließlich beim Sekretariat der WHO, während die Rechenschaftslegung für die Resultate zwischen den einzelnen Mitgliedstaaten und dem Sekretariat verteilt ist. Einer der wichtigsten Grundpfeiler der WHO-Reform, der sowohl dem GPW als auch dem Programmhaushalt zugrunde liegt, ist das Streben nach einer umfassenderen Rechenschaftslegung, einschließlich einer weiter gehenden Konkretisierung der vom Sekretariat erwarteten Ergebnisse.

4.1 Inventar der erwarteten Resultate des Regionalbüros

19. Für die operative Planung im Zeitraum 2012–2013 verwendete das Regionalbüro eine Wertschöpfungskette ähnlich der nun im GPW12 und im PB2014–2015 verwendeten, wenn auch mit mehr Detail und stärkerer Schwerpunktlegung auf den Resultaten auf Ebene der Region, was eine höhere Auflösung und Konkretisierung hinsichtlich der angestrebten Ergebnisse ermöglicht. Darüber hinaus liegt in der Wertschöpfungskette des Regionalbüros der Schwerpunkt nicht ausschließlich auf den Ergebnissen, sondern auch auf den Werten, die im Laufe des Prozesses geschaffen werden, z. B. durch das Sekretariat.

20. Den Ausgangspunkt für die Planung auf Ebene der Region für den Zeitraum 2014–2015 bildet das Inventar der erwarteten Resultate (Outcome Portfolio) des Regionalbüros für den Zeitraum 2012–2013 (s. Anhang C). Die Änderungen an dem gegenwärtigen Inventar dürften 20% nicht überschreiten. Das Inventar für 2012–2013 wurde anhand derselben Ergebnislogik und ähnlicher Priorisierungskriterien wie das GPW und der PB2014–2015 erstellt; dabei wurde berücksichtigt, dass die Erzielung gewünschter Ergebnisse und Wirkungen auf die öffentliche Gesundheit in den meisten Fällen konzertierte und anhaltende Anstrengungen über mehrere Jahre erforderlich macht. Das Inventar für 2014–2015 stellt eher eine Evolution als eine Revolution dar. Das Inventar der erwarteten Resultate für 2012–2013 umfasst 27 zentrale vorrangige Resultate (Key Priority Outcomes – KPO) und 57 sonstige vorrangige Resultate (Other Priority Outcomes – OPO). Derzeit wird eine strikte Priorisierungsprüfung durchgeführt, um zu bestimmen, welche Resultate für die Region aufrechtzuerhalten bzw. aufzugeben sind und welche neuen in das Inventar für 2014–2015 aufgenommen werden sollen.

4.2 Das Geschäftsmodell

21. Der Schwerpunkt der Arbeit der WHO in der Europäischen Region ist beim Regionalbüro für Europa in Kopenhagen angesiedelt. Zusätzlich zu den vier Außenstellen des Regionalbüros (Barcelona, Bonn, Venedig, Athen) und dem Europäischen Observatorium für Gesundheitspolitik gibt es insgesamt 29 Länderbüros, ein WHO-Büro in Brüssel mit Zuständigkeit für die Beziehungen zur Europäischen Union und eine Außenstelle des Länderbüros Serbien in Pristina, deren inhaltlicher Schwerpunkt auf der humanitären Situation im Kosovo liegt.

22. Das Geschäftsmodell des WHO-Regionalbüros für Europa ergibt sich aus seinen relativen Vorteilen (Abschnitt 2.2) und profitiert in erster Linie von dem hohen Maß an Kompetenz und fachlichen Kapazitäten, die innerhalb der Institutionen und der staatlichen Behörden in den Ländern der Region vorhanden sind. Das Geschäftsmodell weist zwei zentrale Merkmale auf.

- Dort, wo dies möglich ist, kommt ein länderübergreifendes Modell zur Anwendung, wenn in den Ländern die fachlichen Kapazitäten vorhanden sind, um ihre gemeinsamen

Bedürfnisse durch regionsweite Konzepte in Angriff zu nehmen. Es wird damit gerechnet, dass in Zukunft ein wachsender Anteil der Arbeit des Regionalbüros auf diese Weise erfolgen wird. Wenn ein Produkt innerhalb eines Resultats nur für eine begrenzte Anzahl von Ländern von Belang ist, kann ein Mehr-Länder-Modell herangezogen werden, bei dem die innerhalb der betroffenen Gruppe von Ländern vorhandenen Ressourcen optimal genutzt werden. Es wird jedoch auch weiterhin Produkte geben, die einen sehr konkreten Bezug zu den Bedürfnissen und Umständen einzelner Länder haben. In diesen Fällen wird auch künftig ein länderspezifischer Modus vorzuziehen sein.

- Aufgrund der systematischen und intensivierten Zusammenarbeit mit den 2846 Kooperationszentren der WHO (WHOCC) in der gesamten Europäischen Region wird in Zukunft ein größerer Anteil der Produkte in Zusammenarbeit mit diesen Zentren erstellt werden. Zu den neu eingeführten Praktiken gehört auch, vor Beschäftigung externer Berater und neuer Mitarbeiter zunächst die Kapazitäten der WHOCC zu prüfen. Die in Zusammenarbeit mit den WHOCC erarbeiteten Produkte werden in den Arbeitsplänen im Global Management System (GSM) aufgeführt.

23. Das vorstehend erläuterte Geschäftsmodell erfordert eine kritische Masse an hochqualifiziertem Sachverstand in den wichtigsten vorrangigen Handlungsfeldern, um die maßgeblichen Akteure zusammenführen, Synergieeffekte erzielen und die notwendigen Koordinationsaufgaben wahrnehmen zu können. Dieser Sachverstand wird überwiegend auf der länderübergreifenden Ebene angesiedelt sein. Eine Einstellung auf der Länderebene kommt für Fachpersonal nur dann in Frage, wenn es die konkreten Umstände verlangen, und auch dann nur für begrenzte Zeiträume. Die Länderarbeit wird mit jedem in Frage kommenden Mitgliedstaat geplant und in einer BCA geregelt, in der jeweils die gewünschte Wirkung, die Resultate und die konkreten Produkte festgelegt werden. Während des Zeitjahreszeitraums 2012–2013 wird die Ausarbeitung von Kooperationsstrategien (CCS) schrittweise auf alle Mitgliedstaaten ausgeweitet, beginnend mit denjenigen, die noch über keine formelle Vereinbarung mit dem Regionalbüro verfügen.7

5. Haushalt

24. Der dem Regionalkomitee zur Beratung und Stellungnahme vorgelegte Programmhaushaltsentwurf enthält keine Haushaltszahlen für 2014–2015, sondern lediglich eine Übertragung der Ist-Ausgaben für den Zeitraum 2010–2011 und des genehmigten Haushalts 2012–2013 vom Mittelfristigen Strategieplan (MTSP) 2008–2013 in die Struktur des GPW12. Dieser Abschnitt in der Perspektive der Europäischen Region enthält eine Reihe erster strategischer Überlegungen über mögliche Haushaltsrahmen und ihre Unterteilung, aber auch eine Analyse des Haushalts 2012–2013. Eine detailliertere Kostenkalkulation wird im Vorfeld der nächsten Tagung des Exekutivrates vorgenommen.

5.1 Zwei Haushaltsszenarien

25. Innerhalb des Konzeptes eines konstanten Gesamthaushalts für die WHO im Rahmen des GPW12 werden zwei Szenarien präsentiert. Bei Szenario 1 wird ein ähnlicher Haushaltsrahmen für die Sektion „Basisprogramme“ zugrunde gelegt wie für den Zeitraum 2012–2013, während die Etats für Sonderprogramme und Kooperationsvereinbarungen (SPA) und Gegenmaßnahmen

[6] Davon werden 111 vom Regionalbüro für Europa initiiert, die übrigen meist vom Hauptbüro.

[7] Siehe auch *Eine Länderstrategie für das WHO-Regionalbüro für Europa* (Dokument EUR/RC61/17).

bei Krankheitsausbrüchen und Krisen (OCR) an gerundete Ausgaben für 2010–2011 angepasst wurden, um das tatsächliche Ausmaß der Aktivitäten genauer wiedergeben zu können. Der Gesamthaushalt nach diesem Szenario beläuft sich auf 221 Mio. US-$ (Tabelle 2).

26. Bei Szenario 2 bleiben die Etats für SPA und OCR gegenüber dem ersten Szenario unverändert, während der Etat für die Basisprogramme auf 212 Mio. US-$ erhöht wird. Die zugrunde liegende Annahme ist, dass innerhalb des konstanten Gesamthaushalts für die WHO bestimmte Aufgaben im Rahmen der WHO-Reform vom Hauptbüro abgegeben werden, um eine Harmonisierung und Klarstellung der Arbeitsteilung auf den verschiedenen Ebenen der Organisation zu bewirken. Hierbei sei darauf hingewiesen, dass bei diesem Szenario die Gesamthöhe des Haushalts der WHO unverändert bleibt und dass sich lediglich die Verteilung der Mittel auf die verschiedenen Ebenen ändert.

27. In Tabelle 3 wird die Übertragung der Ist-Ausgaben im Zeitraum 2010–2011 und des von der Weltgesundheitsversammlung genehmigten Programmhaushalts 2012–2013 von der Struktur des MTSP 2008–2013 in die neue Struktur des GPW12 für die Sektion „Basisprogramme“ dargestellt. In Bezug auf den Zeitraum 2014–2015 werden die beiden in der vorangegangenen Tabelle dargestellten Szenarien nach Kategorie aufgeschlüsselt.

28. Bei Szenario 1 wurde der Etat für Kategorie VI um 5% erhöht, um erwartete Kostensteigerungen im Vergleich zum Zeitraum 2010–2011 abzufedern. Dabei ist zu beachten, dass die Etats für die SO 12 und 13 (Kategorie VI) im Zeitraum 2012–2013 gegenüber 2010–2011 trotz beträchtlich gestiegener Kosten nicht erhöht wurden, was eine deutliche Verringerung der Zahl der in dieser Kategorie beschäftigten Bediensteten zur Folge hatte.

29. In den fachbezogenen Kategorien lagen die Zuweisungen für die Kategorien II und IV erheblich über den im Zeitraum 2010–2011 getätigten Ausgaben, womit die sich bereits im Zeitraum 2012–2013 abzeichnende Aufwertung des Komplexes der nichtübertragbaren Krankheiten und der Stärkung der Gesundheitssysteme bestätigt wurde und gleichzeitig eine Herausforderung mit Blick auf die Bereitstellung der erforderlichen Ressourcen entstand. Die Kategorie III erhielt einen Etat in derselben Höhe wie im Zeitraum 2012–2013, was ca. 15% oberhalb des Ausgabenniveaus von 2010–2011 lag. Doch hier sollte darauf hingewiesen werden, dass ein Großteil der Arbeit im Rahmen von „Gesundheit 2020“, einschließlich der damit verbundenen Studien, unter dem Dach des SO7 erfolgte, das in Kategorie III überführt wurde. Die Folgearbeiten zur Unterstützung der Gesundheitspolitik in den Ländern fallen im Wesentlichen unter Kategorie IV (Gesundheitssysteme) und fließen ansonsten in die Arbeit in allen übrigen Kategorien ein. Die Haushaltszuweisung für Kategorie V liegt ca. 1 Mio. US-$ höher als die Zuweisung für den Zeitraum 2012–2013, allerdings niedriger als das Niveau der Ausgaben im Zeitraum 2010–2011. Dies ist das Ergebnis der internen Prioritätensetzung, das im Rahmen eines Szenarios mit konstanten Ressourcen eine kontinuierliche Erhöhung der Mittel in den Kategorien III und IV erlaubt. Es wird ferner darauf hingewiesen, dass alle Produkte unter der Rubrik OCR in diese Kategorie fallen und dass die Etats für OCR je nach Eintreten von Notlagen angepasst werden.

30. Ebenso wurde die Mittelzuweisung für Kategorie I gegenüber dem Zeitraum 2012–2013 wie auch den tatsächlichen Ausgaben im Zeitraum 2010–2011 reduziert. Dies ist das Ergebnis der Prioritätensetzung innerhalb des Etats des Regionalbüros, die in erster Linie anhand der auf die Gesundheitssituation und die Verfügbarkeit bewährter und kosteneffektiver Interventionen bezogenen Kriterien erfolgte.

31. Das Szenario 2 stellt eine Situation dar, in der bestimmte Aufgaben, namentlich die Bereitstellung fachlicher Hilfe für die Länder, vom Hauptbüro abgegeben werden. Das größte Potenzial wird in den Kategorien I, III und V erwartet. Trotzdem weisen auch alle anderen Kategorien Potenzial auf. Da dies im Rahmen eines konstanten Gesamtetats geschehen würde, hätte eine solche Abtretung von Aufgaben zur Folge, dass Etat und Ressourcen vom Hauptbüro in die Regionen verlagert wird.

Tabelle 2: Zwei Szenarien für den Haushalt 2014–2015 nach Haushaltssektion und im Vergleich mit vorangegangenen Zweijahreszeiträumen

2014–2015 Haushaltsvoranschläge – nach Haushaltssektion	2010–2011 (Ist)		2012–2013 (Soll) Von der WHA genehmigt		2014–2015 Szenario 1			2014–2015 Szenario 2		
	[Mio. US-$]	Anteil am Gesamthaushalt [in %]	[Mio. US-$]	Anteil am Gesamthaushalt [in %]	[Mio. US-$]	Anteil am Gesamthaushalt [in %]	Veränderung gegenüber 2010–2011 [in %]	[Mio. US-$]	Anteil am Gesamthaushalt [in %]	Veränderung gegenüber 2010–2011 [in %]
Basisprogramme (BASE)[Hinweis1]	171,8	86%	192,9	90%	193,0	87%	112%	212,0	88%	123%
Sonderprogramme und Kooperationsvereinbarungen (SPA)	23,3	12%	10,1	5%	23,0	10%	99%	23,0	10%	99%
Gegenmaßnahmen bei Krankheitsausbrüchen und Krisen (OCR)	5,4	3%	11,1	5%	5,0	2%	92%	5,0	2%	92%
Insgesamt	200,5	100%	214,1	100%	221,0	100%	110%	240,0	100%	120%

Hinweis 1: Für den Zweijahreszeitraum 2012–2013 beinhaltet dies im Vergleich zu dem von der WHA genehmigten Programmhaushalt eine Verlagerung von Mitteln in Höhe von 1,1 Mio. US-$ vom WHO-Hauptbüro zum Regionalbüro für Europa, die auf die organisatorische Verlagerung des WHO-Büros bei der EU vom WHO-Hauptbüro zum Regionalbüro für Europa bedingt ist.

Tabelle 3: Zwei Haushaltsszenarien für die Sektion „Basisprogramme“ nach Kategorie im Vergleich zu früheren Zweijahreszeiträumen

2014–2015 Haushaltsvoranschläge – Basisprogramme	2010–2011 (Ist)		2012–2013 (Soll) Von der WHA genehmigt		2014–2015 Szenario 1			2014–2015 Szenario 2		
	[Mio. US-$]	Anteil am Gesamthaushalt [in %]	[Mio. US-$]	Anteil am Gesamthaushalt [in %]	[Mio. US-$]	Anteil am Gesamthaushalt [in %]	Veränderung gegenüber 2010–2011 [in %]	[Mio. US-$]	Anteil am Gesamthaushalt [in %]	Veränderung gegenüber 2010–2011 [in %]
Kategorie I: Übertragbare Krankheiten	24,3	16%	26,9	14%	21,1	11%	87%	27,6	13%	113%
Kategorie II: Nichtübertragbare Krankheiten	17,8	9%	29,6	15%	31,0	16%	175%	32,0	15%	180%
Kategorie III: Lebensverlauf	32,7	16%	37,1	19%	37,5	19%	115%	42,5	20%	130%
Kategorie IV: Gesundheitssysteme	24,8	17%	34,6	18%	35,0	18%	141%	37,0	17%	149%
Kategorie V: Vorsorge-, Surveillance- und Gegenmaßnahmen	16,8	14%	9,7	5%	10,5	5%	62%	15,0	7%	89%
Kategorie IV: Organisatorische Funktionen-Hinweis 1	55,3	28%	55,1	29%	57,9	30%	105%	57,9	27%	105%
Insgesamt	**171,8**	**100%**	**192,9**	**100%**	**193,0**	100%	112%	212,0	100%	123%

Hinweis 1: Für den Zweijahreszeitraum 2012–2013 beinhaltet dies im Vergleich zu dem von der WHA genehmigten Programmhaushalt eine Verlagerung von Mitteln in Höhe von 1,1 Mio. US-$ vom WHO-Hauptbüro zum Regionalbüro für Europa, die auf die organisatorische Verlagerung des WHO-Büros bei der EU vom WHO-Hauptbüro zum Regionalbüro für Europa bedingt ist.

5.2 Analyse des Haushalts 2012–2013

32. Tabelle 4 zeigt eine Analyse der für 2012–2013 veranschlagten Kosten in dem Format, in dem der Haushalt für 2014–2015 möglicherweise später präsentiert wird. Aus der Tabelle gehen die vorgesehene Verteilung der Kosten zwischen Aktivitäten und Personalkosten sowie die veranschlagten Kosten für alle fachlichen Produkte (nur Aktivitäten), jeweils zusammengefasst auf der Ebene der zentralen Aufgaben der WHO, hervor. Eine Reihe von Fragen ergeben sich vor allem hinsichtlich der Zuordnung der Kosten zwischen den zentralen Aufgaben, etwa die Frage, ob die jeweilige Schwerpunktlegung sinnvoll ist. Diese Fragen werden Gegenstand der detaillierten Kostenberechnung sein, die in den kommenden Monaten bei der Erstellung der Fassung des Programmhaushalts 2014–2015 durchgeführt wird, die dem Exekutivrat vorgelegt wird.

Genaue Zuordnung der Personalkosten

33. Nach dem Geschäftsmodell des WHO-Regionalbüros für Europa (s. Abschnitt 4.2) wird die fachliche Hilfe an die Länder größtenteils vom Regionalbüro und seinen Außenstellen geleistet. Nach den Finanzvorschriften der WHO werden die damit verbundenen Personalkosten also auf der Ebene der Region verbucht, und nicht auf der Länderebene, wo der Nutzen entsteht. So ergibt sich ein verzerrtes Bild von den Anstrengungen, den Kosten der entstehenden Produkte und den Investitionen in das Länderprogramm des Regionalbüros. Um ein realitätsnäheres Bild zu erhalten, werden die beteiligten Mitarbeiter künftig darüber Rechenschaft ablegen, wo und in welchen Bereichen sie tätig geworden sind. Das Ergebnis der Analyse für die ersten sechs Monate des Jahres 2012 wird dem SCRC mitgeteilt und in die detailliertere Kostenkalkulation für den Zeitraum 2014–2015 einfließen, die nach dem RC62 durchgeführt wird.

5.3 Finanzierung des Haushalts

34. Die für die Finanzierung der Arbeit des Regionalbüros im letzten Zweijahreszeitraum verfügbaren Mittel setzten sich in etwa folgendermaßen zusammen: Ordentliche Beiträge (assessed contributions – AC): 26%; Einnahmen aus Programmunterstützungskosten (AS): 7%; Konto für zentrale freiwillige Beiträge (Core Voluntary Contributions Account – CVCA): 6%; und zweckgebundene freiwillige Beiträge (specified voluntary contributions – VCS): 61%. Von Letzteren wurden rund zwei Drittel vom Regionalbüro mobilisiert, der Rest stammte aus der organisationsweiten Mittelbeschaffung. Der hohe Anteil der VCS erschwert die langfristige Planung und insbesondere die Personalplanung. Außerdem wird durch VCS oft die Prioritätensetzung verzerrt, sodass einige Programme und Aktivitäten über-, andere hingegen unterfinanziert sind. Der im Reformprozess der WHO vorgesehene Finanzierungsdialog könnte zu einer „Vorabfinanzierung“ des Programmhaushalts führen. Dies hätte enorme positive Auswirkungen auf die Verwirklichung von Ergebnissen und würde sich zudem positiv auf Zweckdienlichkeit und Effizienz auswirken. Darüber hinaus würde durch eine Umstellung von dem gegenwärtig praktizierten System der Zuteilung der freiwilligen Beiträge an 13 Bereiche auf eine Zuteilung an künftig nur noch einen oder zwei Bereiche das Regionalbüro in die Lage versetzt, Ressourcen effektiver einzusetzen, sodass kein vorrangiger Bereich aufgrund einer Zweckbindung freiwilliger Beiträge durch den Geber überfinanziert wird, während andere unterfinanziert bleiben.

Tabelle 4: Erste Analyse der für 2012–2013 veranschlagten Kosten (alle Sektionen), aufgeschlüsselt nach Aktivitäten, Bediensteten und zentralen Aufgaben der WHO

Anhand der Analyse der Produkte (Stand: 10. Mai 2012) – Alle Haushaltssektionen	**Kategorien** (*Zahlen übernommen von der Struktur des MTSP*)						
	I: Übertragbare Krankheiten	**II: Nichtübertragbare Krankheiten**	**III: Lebensverlauf**	**IV: Gesundheitssysteme**	**V: Vorsorge-, Surveillance- und Gegenmaßnahmen**	**VI: Organisatorische Funktionen**	**Insgesamt**
Haushaltsmittel [in Mio. US-$]							
Aktivitäten	11,9	16,6	13,5	13,6	8,2	12,6	76,2
Gehälter	20,1	13,1	23,6	26,0	12,6	42,5	137,9
Insgesamt	**32,0**	**29,6**	**37,1**	**39,6**	**20,8**	**55,1**	**214,1**
Produkte (Aktivitäten) mit Bezug zu den zentralen Aufgaben (CF)							
CF1-Führungsrolle und Partnerschaften	3,1%	18,3%	20,0%	11,3%	8,7%	38,8%	18,1 %
CF2-Forschung und Wissen	4,5%	7,5%	11,7%	35,2%	-	-	10,2 %
CF3-Normen und Standards	27,4%	12,2%	6,3%	8,2%	27,1%	-	11,9 %
CF4-Ethische und evidenzbasierte Grundsatzpositionen	0,6%	6,3%	0,7%	9,0%	-	-	3,1%
CF5-Unterstützung/ Kapazitätsaufbau[Hinweis1]	64,2%	44,5%	60,4%	29,8%	62,6%	11,6%	43,4 %
CF6-Beobachtung der Gesundheitssituation	0,2%	11,3%	0,9%	6,5%	1,6%	-	4,0%
Organisatorische Unterstützung	-	-	-	-	-	49,6%	9,3%
Insgesamt [in %]	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**

Hinweis 1: Alle in Kategorie VI veranschlagten Kosten in den Ländern fallen unter CF5.

Annex A. Specific perspectives on the six categories

In this annex, the specific European perspectives for each of the GPW12 categories are briefly presented in a common format starting with the Health 2020 headline targets to which the category contributes, followed by a general description of the category. There is an explanation of how the five priority-setting criteria agreed by the Member States apply to the particular situation in Europe, followed by a summary of changes to the outcome portfolio from the current biennium, and an explanation of how work with countries on each particular category is foreseen. The 2012–2013 Outcome and Output portfolio, and how it links with the categories and outcomes in the draft proposed Programme Budget 2014–2015, is described in Annexes B and C.

Category I – Communicable diseases

Box 1.

Direct contribution to Health 2020 **Priority Area 2**: Tackling Europe's major health challenges in communicable and noncommunicable diseases

1. **Reduce premature mortality in Europe by 2020** – Achieve and sustain elimination of selected vaccine preventable diseases (polio, measles, rubella, prevention of Congenital Rubella Syndrome).
3. **Reduce inequities in health in Europe (social determinants target)** – Reduce the gap in health status between population groups experiencing social exclusion and poverty and the rest of the population and 1) % or 2) %–% reduction in the difference in life expectancy between European populations by 2020.

In Category I, most of the outcomes for the current biennium (See Annex C) are expected to be retained for the 2014–2015 biennium, with a shift in output emphasis from development and assessment to implementation of policies and practices to achieve and verify regional and national objectives. This is particularly the case for outcomes targeting elimination of diseases, as the 2014–2015 biennium includes the target date for the elimination of measles, rubella, and malaria. As the target dates approach and Member States have achieved incidence of measles and rubella at or below the elimination threshold, the resources needed for the final push to elimination may increase: to enhance surveillance and investigation of suspected cases, to increase immunization outreach to pockets of the very hard to reach and cohorts of underimmunized adults, and to run communication and advocacy campaigns to maintain public and political commitment to sustain high immunization coverage in the face of declining disease. While resources needed to support and strengthen routine immunization are expected to remain constant or increase, extraordinary costs, particularly for vaccines and equipment used in supplemental immunization campaigns, which are borne primarily by Member States and partners such as the GAVI Alliance and the United Nations Children's fund (UNICEF), may decrease as these supplemental activities are phased out. The links between Category I and Category IV (tackling health systems strengthening and policy development) will be enhanced to ensure that the technical gains made are sustainable and fully reflected in moves towards universal coverage, especially with regard to vulnerable groups and populations.

For HIV and TB there are no expected changes in outcomes between biennia, and only modest changes in outputs, primarily in the shift from situation assessment and policy development to

implementation of Member States-endorsed action plans. Member States have endorsed a five-year Consolidated Action Plan to prevent and combat multidrug- and extensively drug-resistant tuberculosis (M/XDR-TB). National TB action plans are being developed and will be implemented over the next biennium with the support of the WHO Regional Office. This will require increased resources to strengthen laboratory capacity including diagnostics, expanded surveillance, especially for M/XDR-TB, and universal access to treatment and care. For HIV, the European Action Plan on HIV/AIDS 2012–2015, endorsed by the Member States in 2011, is based on four strategic directions: optimizing HIV prevention, diagnosis, treatment, care and support outcomes; leveraging broader health outcomes through HIV responses; building strong and sustainable systems; and reducing vulnerability and the structural barriers to accessing services. Sustained and, in some areas such as laboratory support and surveillance, increased support will be required as the Action Plan is implemented during the 2014–2015 biennium.

Key priorities and changes to the portfolio

Current health situation

While significant control of communicable diseases has generally been achieved in the European Region, the burden of some communicable diseases, in particular HIV and drug resistant TB, continues to increase and there is a threat of a resurgence of communicable diseases, including vaccine preventable diseases, such as measles and rubella. Continued support is therefore required to achieve and sustain high vaccination rates and maintain strong routine surveillance and response capacity. The magnitude of the problems related to vector-borne diseases is slowly growing in the region.

Individual country needs

Demand for WHO assistance is high with virtually all countries including support for communicable disease control in their work plans. However, in order to use resources efficiently much of this work is delivered in an intercountry context and thus not reflected in country specific Biennial Collaborative Agreement (BCA) work plans. Countries, in particular in the Southern Caucasus and central Asia, lack the resources, dedicated staff and technical expertise to guide national programmes to cope with the growing burden of vector-borne diseases.

Internationally agreed instruments

Communicable disease control has been addressed in several World Health Assembly and Regional Committee resolutions, ministerial meetings and multilateral agreements, such as resolutions calling on Member States to eliminate measles and rubella by 2015, the Dublin and Berlin Declarations on HIV and TB respectively, and the Tashkent Declaration that sets the goal of eliminating malaria in the Region by 2015.

Evidence-based, cost-effective interventions

Immunization is recognized as one of the most cost-effective interventions in the history of public health. Evidence for the cost effectiveness of prevention and early treatment of TB and HIV is likewise strong.

Comparative advantage of WHO

Since it was founded, WHO has provided stewardship in communicable disease prevention, and is the only international partner to establish processes and set strategies to achieve and certify elimination for key communicable diseases, such as measles, rubella, and malaria. WHO plays

an impartial role in supporting Member States in evidence-based decision-making, such as for the introduction of new vaccines, as well as supporting implementation of evidence-based interventions, such as the case of HIV and TB. WHO also maintains regional and global databases (HFA and CISID) and is unique in being able to place communicable disease initiatives in a wider public health and health system framework to reaching out to vulnerable groups and ensuring equity.

In particular hepatitis B and C constitute public health challenges that require coordinated interventions across several programmes, including vaccines and immunization, HIV/AIDS and sexually transmitted infections (STI), patient and blood safety due to shared risk factors and interventions entry-points. Should resources become available to address the burden of hepatitis, which is growing among at-risk populations in the Region, this will constitute a new and important outcome for the European Region.

While some resources are needed to verify elimination of malaria during the 2014–15 biennium, achievement of this goal has been progressing at a rate suggesting that there overall will be fewer required inputs during the 2014–15 biennium, with an eventual sun-setting of outcomes. This would allow limited resources to be shifted to vector-borne, zoonotic diseases and other neglected diseases of poverty.

Country focus

Through its normative work, WHO is supporting Member States in developing policies, national strategies and action plans, as well as the implementation of standardized data collection and evidence-based interventions, which are relevant to all 53 Member States in the WHO European Region. In addition to Region-wide support, the epidemiology of communicable diseases often requires a specific geographic focus on those subregions or Member States where disease burden, risk, or challenges are greatest (high MDR-TB burden, low vaccination coverage, etc.), or for diseases targeted for elimination (e.g. malaria, measles, rubella). Technical support is often in partnership with a number of international agencies, organizations and institutions. Another area of intercountry work that relates directly to country support is advocacy and communication, such as European Immunization Week.

Category II – Noncommunicable diseases (NCDs)

Box 2

Direct contribution to Health 2020 **Priority Area 2**: Tackling Europe's major health challenges in communicable and noncommunicable diseases

1. **Reduce premature mortality in Europe by 2020** – 1. % relative annual reduction in overall mortality from cardiovascular disease, cancer, diabetes, and chronic respiratory disease until 2020; and 3. % reduction in road traffic accidents by 2020
3. **Reduce inequities in health in Europe (social determinants target)** – Reduce the gap in health status between population groups experiencing social exclusion and poverty and the rest of the population and 1) % or 2) %– % reduction in the difference in life expectancy between European populations by 2020.

Some of the highest burden NCDs, which account for the majority of preventable morbidity and death in the WHO European Region, share common risk factors (tobacco use, harmful use of alcohol, physical inactivity and unhealthy diet). They also share social, economic and

environmental determinants, influenced by policies in a range of sectors, from agriculture and the food industry to education, the environment and urban planning. Furthermore, they share common entry points for interventions through public policy. Obesity merits particular attention, as it is not only a result of many of the same basic risk factors and determinants but also a cause of other noncommunicable diseases. The WHO Regional Office for Europe has been central in establishing the case for intersectoral action on these challenges and for supporting work beyond narrowly defined health system boundaries.

At the same time, the high burden of existing disease in European populations raises the priority attention that must be given to the prevention, control, early detection, and clinical management of cardio-metabolic diseases and certain cancers. High-burden countries in the Region, such as the Russian Federation, Kazakhstan and the Republic of Moldova have in the past five to seven years dramatically reduced mortality from cardiovascular diseases, and illustrate the rapid benefits that accrue from improving access to effective health services.

A combination of population-based measures and management was mandated by the United Nations High-level Meeting on the prevention and control of noncommunicable diseases, and the accompanying Political Declaration. WHO's own package of "best buys" (affordable, cost-effective interventions) and the priority actions within the European Action Plan for the Implementation of the Regional Strategy for the Prevention and Control of NCDs provide a template for the shift in emphasis under Category II. Furthermore, the Comprehensive Global Monitoring Framework for the prevention and control of noncommunicable diseases, which is currently being developed, will propose a set of voluntary targets and indicators to further refine the work in the coming biennium.

The emphasis on the four main NCDs and their risk factors must not, however, obscure the important and avoidable burden of death and disability from violence and injury and from mental health disorders. Effective monitoring and intervention in many countries have resulted in marked success in violence and injury prevention (measures include the strengthening legislation on blood alcohol levels, traffic calming, and the use of restraints in vehicles). These efforts must continue in a measure proportional to the burden. In the area of mental health, work has been done to build capacity in community-based mental health services, promote mental health reform, and mobilize the Region to protect people with intellectual disability. A mental health action plan for the Region is under discussion, along with the global plan, scheduled to be presented to the World Health Assembly in 2013.

Key priorities and changes to the portfolio

Current health situation

Globally, the WHO European Region has the highest proportional burden of NCDs, next to the Americas. Europe has the highest prevalence of smoking among adults and youth, and consequently, compared to the rest of the world, the WHO European Region has one of the highest proportions of deaths attributable to tobacco. It also has high levels of childhood obesity, reaching 30–40% in some countries.

The European Action Plan to reduce the harmful use of alcohol 2012–2020 recognizes alcohol as a major problem in many countries of the Region. Major risk factors for NCDs are also linked to poor nutrition and high blood pressure, hyperlipidaemia, diabetes, and overweight and obesity. The burden of mortality from NCDs in the CIS is many times that of the best performers in the Region and this inequity must be addressed with highest priority.

Needs of individual countries

Despite the high burden of disease related to NCDs, which indicates countries' needs, the demand, stated in biennial collaborative agreements (BCAs) ranks third compared to other categories. There could be several explanations for this: it is a new area and the international drive for action has only recently started to gain momentum; resources for NCD prevention remain limited. It is equally important to recognize the relevance of this issue to countries without BCAs, but which have also undertaken actions and entered into commitments in recognition of their needs with respect to NCD prevention.

Internationally agreed instruments

The United Nations Political Declaration on the prevention and control of NCDs, the Global NCD Action Plan, and the Global Monitoring Framework on NCDs, provide a framework for NCD prevention and control, which is supported in the European Region by the European Action Plans (on NCDs, Alcohol, and food and nutrition). With regard to tobacco, 50 out of the 53 Member States in the European Region, and the European Community, are parties to the WHO Framework Convention on Tobacco Control (FTCT) and have agreed to implement demand reduction measures as well as other policies within the treaty. Ratification by the remaining countries and full implementation of the Treaty should continue to drive public health in this area.

Evidence-based and cost-effective interventions

The package of "best buys" in NCDs provides a set of evidence-based, affordable interventions applicable to all countries. These interventions will be the foundation for all action in the coming biennium and Member States and WHO are challenged to provide evidence that they can be implemented effectively and that public health outcomes may be improved even in the short term.

Comparative advantage of WHO

WHO is providing the main source of technical support for the development of evidence based NCD strategies in the BCA countries and for monitoring NCDs in the Region. WHO is the main driver in supporting countries to tackle and address the tobacco epidemic with a whole-of-government approach. WHO has the potential to convene different sectors to discuss nutrition and health and to promote intersectoral dialogue as well as concerted action. Increasingly, WHO is being requested to provide the evidence base to support national legislative processes in non-BCA countries, as well as being requested to provide an independent evaluation of the effectiveness of national programmes.

Country focus

The shift to a country focus has started in the current biennium. Increasingly the work on NCDs is being planned and reported on the basis of specific "best buys" implemented and evaluated in named countries. By the end of 2013 it will be possible to report on a shift from regional action towards specific outcomes, such as the number of countries that have become smoke-free, or implemented fiscal interventions on tobacco, alcohol, or food, or implemented salt reduction in specific food products or other measures at national level. This will represent a shift from a predominant focus on the production of Regional studies and policies, to priority actions logically and causally related to public health outcomes.

Category III – Promoting health throughout the life course

Box 3

Direct contribution to Health 2020 **Priority Area 1**: Investing in health through the life-course approach and empowering people

2. **Increase life expectancy in Europe** – Continued Increase in life expectancy at current rate
3. **Reduce inequities in health in Europe (social determinants target)** – Reduce the gap in health status between population groups experiencing social exclusion and poverty and the rest of the population and 1) % or 2) %–% reduction in the difference in life expectancy between European populations by 2020
4. **Enhance well-being of the European population** – (*to be elaborated further during 2012/2013*)

Category III covers a very large, complex and diverse range of programme areas. Health advantages and disadvantages accumulate over the span of a person's life. As such a life course approach offers the opportunity for proactive policies and interventions across critical stages in life with the benefit of reducing avoidable illness and associated human and financial costs, increasing well-being and acting on the root causes of inequities and their perpetuation within society and across generations. A healthy start in life comes from improved maternal health and sexual and reproductive health. Increasing health enhancing skills and capacities through public policies and strengthening rights and accountabilities for health education, employment and social protection builds human capital for health through adolescence and working ages and is a strong protective factor in times of personal and/or social crisis. The accumulation of health contributes to prolonging the number of years of healthy life, reduces demand on public services and adds value to social and economic capital at the family and local levels. Public policies for health that are cross-sectoral and engage local people in acting on the social and economic determinants of health and which address gender equity and rights contribute directly to accumulation of good health over the life-course and indirectly contribute to building fairer and more sustainable societies.

With the goal of reducing inequities in health and building on the WHO Reform process, WHO Regional Office for Europe will further integrate the social determinants, gender equity and human rights approaches into its work. The vulnerabilities and health inequities experienced by migrants and the Roma[1] are socially determined, being driven by multifaceted processes within the health sector and in other sectors that influence health. Actions in this area will include support to ministries of health in implementing policies and programmes that benefit the health of Roma and coordinated action by United Nations agencies and partners to build the capacities of governments and other stakeholders to monitor and deliver on the health components of these strategies and related action plans, with a focus on the health of Roma women and children.

Capacity of staff on social determinants, gender and rights at the Regional level, in country offices and Member States will be strengthened as part of the mainstreaming strategy. Concrete tools for moving from a value, conceptual and descriptive level to the implementation level will be a critical for meeting equity objectives and targets and implementing social determinants approaches.

[1] For the justification of the focus particularly on the Roma population, please see EUR/RC62/8, paragraphs 228–232.

Although about a quarter of the disease burden in the Region, and a third of that in developing countries, could be reduced using available environmental health interventions and strategies, health systems on the whole identify only a fraction of the environmental determinants of health as part of their direct remit, and very rarely treat them as a priority when devising ways of improving public health. The health sector has a distinctive role in catalysing public health interventions by other sectors, identifying the risks to and determinants of health, monitoring and evaluating the effects of policies and interventions and participating in, or leading the environment and health governance processes on the global and regional levels. The health sector is also one of the most intensive users of energy, a major source of employment and a significant producer of waste, including biological and radioactive waste. Important opportunities to improve the environment are therefore emerging from the greening of health services. This is new area of environmental health.

Key priorities and changes to the portfolio

Current health situation

The European Review of Social Determinants and Health Divide[2] reveals dramatic differences in health and life expectancy across the European Region, both between and within countries, and between women and men. For example, there is a 25-fold difference between the countries with the highest and lowest rates of infant mortality. There is also an estimated difference of between 30- fold and 40-fold in maternal mortality between the countries with the highest and lowest rates. Under-five mortality remains a problem. Although most countries in the region are on track to meet Millennium Development Goal (MDG) 4, there are huge inequities in under-five mortality and child health conditions within all 53 Member States in the Region. Health and health behaviours in adolescence can lead to an increased NCD burden in later life.

Environment-related mortality and morbidity rates remain excessive: exposure to particulate matter decreases the life expectancy of every person in the Region by an average of almost one year; environmental noise causes the loss of between 2 and 3 million DALYs per year; 4 million people in urban areas and 14.8 million in rural areas still use unimproved water sources, and 34.6 million have unimproved sanitation; cases of serious water-borne diseases have tripled between 2000 and 2010; and helminths affect an estimated 1 million preschool children and more than 3 million school-aged children in the European Region.

Life expectancy for Roma populations in eastern Europe is 10–15 years less than that for the overall population. These differences are not the result of genetic or biological conditions but rather relate to social, economic and political conditions and are therefore largely unnecessary and, most importantly, avoidable. Finally, the proportion of the ageing population is increasing, thus creating need for better care, both short and long term.

Needs of individual countries

Almost all countries (with and without BCAs) state equity and action on social determinants, including gender and human rights, as core goals and approaches in their main policies and strategies. Major challenges arise, however, in translating aspirations and values into tangible results. This has led to an increase in requests from Member States for support: to strengthen how social determinants of health and health equity are considered and can be more effectively

[2] Report on social determinants of health and the health divide in the WHO European Region (http://www.euro.who.int/__data/assets/pdf_file/0004/171337/RC62BD05-Executive-summary-Report-on-social-determinants-of-health-and-the-health-divide-in-the-WHO-European-Region.pdf)

addressed; and training, guidance for evidence based policy options and most promising governance practices capable to reduce inequities in health.

Although there are variations across the programmes within the category there is a discrepancy between the number of international commitments (resolutions, declarations, strategies, etc.), the observations of growing inequities in the region, and the demand from countries in the BCAs and the resources that have been available to support Member States. Resources for some programme areas (primarily the current Strategic Objective 4) included in this Category have not matched the declarations and the talks of the international community.

Internationally agreed instruments

The United Nations Millennium Declaration endorsed a framework for development that called for countries and development partners to work together to achieve eight MDGs, of which MDGs 3, 4, 5, and 7 are related to health. The target year for achieving the MDGs is 2015. Globally agreed strategies exist in the areas of sexual and reproductive health, maternal, child and adolescent health and healthy and active ageing. Some of the global strategies have been, or are in the process of being adapted for the European Region. Outcomes related to reducing health inequities are based on international instruments, including resolutions of the World Health Assembly, the Rio Political Declaration on social determinants of health, and the expected endorsement, by the WHO Regional Committee for Europe, at its sixty-second session (RC62) of Health 2020. Other global instruments in this category include global and regional reproductive health strategies, the United Nations Declaration on the Elimination of Violence against Women, the United Nations Convention on the Elimination of All Forms of Discrimination Against Women, The Beijing Declaration and Platform for Action, the programme of Action of the International Conference on Population and Development and the United Nations Convention on the Rights of the Child.

No less than seven environmental conventions and protocols directly addressing health and in which WHO Regional Office for Europe has a formal role of a party to the Agreement or is part of the secretariat, including the United Nations Economic Commission for Europe (UNECE) Protocol on Water and Health, the Pan-European Programme on Transport and Health (THE PEP) and the Convention on Long-range Transboundary Air Pollution (LRTAP). The basic human right to water under Resolution 64/292 of the United Nations general Assembly and the associated resolution A/HRC/15/L.14 of the United Nations Human Rights Council on Human rights and access to safe drinking-water and sanitation. The WHO Regional Office also contributes to global conventions, such as through the analysis of health impacts as well as the promotion of health in the RIO Conventions, in particular on climate change and biodiversity.

Evidence-based, cost-effective interventions

Feasible and cost-effective interventions for action already exist for several strategies within this category. For example, evidence suggests that investment in early child development is the most powerful tool for countries to (a) make a positive contribution to society, socially and economically; and (b) reduce potential costs to health and social systems in the longer term. Conversely, the costs of not acting to reduce inequities in health are already well documented. In all societies irrespective of development conditions, there is clear and increasing evidence which shows how rates of violence, ill health, and injury increase in populations whose access to food, water, housing, work opportunities and a fair justice system is poorer. In times of economic crisis stronger responses are needed to act on social determinants, gender and human rights to improve health and reduce inequities but also to protect against social unrest and minimise losses to human and productive capitals. Working to reduce inequities at the level of determinants therefore provides benefits that accrue to multiple sectors not only to health.

Globally and regionally agreed instruments have been followed up with the development of evidence-based tools such as *Effective Perinatal Care*, and *Beyond the Numbers* for improving maternal and newborn care, *Integrated Management for Childhood Illnesses* for primary care of children under five, assessment tools for both maternal and paediatric hospitals, and a series of tool to support countries to develop and implement effective policies and action for child and adolescent health.

Although environment and health interventions involve a wide range of actors, the various environmental exposures (such as through air, water, soil, food, noise and ionizing and non-ionizing radiations) should be seen as integrated determinant of health and well-being across the life course and settings of living. The health sector has a distinctive role of catalysing public health considerations by other sectors, identifying the risks to and determinants of health and monitoring and evaluating the public health effects of their policies and interventions.

Comparative advantage of WHO

Within the WHO European Region, the Health for All (HfA) initiative, introduced this topic and put it on the agenda which has been key to ensuring health is now considered as a resource through strengthened cross-sectoral approaches. A dedicated GDO with expertise in the area of Social Determinants of health for reducing inequities, has played a key role in building partnerships, synthesising evidence and producing policy reviews and developing tools and instruments to support Member States to strength how they govern for equity in health through action on social determinants.

WHO is the leader in the MDG 4 and 5 related work in close collaboration with relevant partners – also though involvement in international partnerships such as the Commission on Accountability and Information for Women's and Child Health. WHO is the main driver in supporting countries to improve their health systems, which includes also governance and services for maternal, child, and adolescent health, sexual and reproductive health, as well as for healthy ageing.

WHO Regional Office for Europe has key advisory and supportive role to play in cooperation with other agencies of the United Nations System such as for the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation to monitor progress on achieving towards MDG 7. The European Environment and Health Process was launched 23 years ago. It is an example of a unique governance mechanism, operating through a series of Ministerial Conference, which involves ministries responsible for health and environment on equal footing, amplifies the links and synergy with a number of Multilateral Environmental Agreements (MEAs) and enhances the partnership with other intergovernmental bodies, such as the UNECE the United Nations Environmental Programme (UNEP) and the European Commission, as well as with civil society organizations.

Concrete tools for moving from a value, conceptual and descriptive level to the implementation level will be a critical element in the implementation of social determinants approaches. The integration of gender, rights and social determinants that has started at the conceptual level will be translated in concrete mainstreaming tools and capacity building efforts. The rationale behind this integration lies in the synergies among these approaches and their intersectoral nature. Health equity profiles and equity impact assessments will be used to inform health policy.

With the presentation of the Strategy and Action Plan for healthy ageing in Europe (EUR/RC62/10) WHO Regional Office for Europe will be ready to support Member States in their efforts to improve quality of life in the older population. Health in all approaches is part of the Regional strategy for prevention of maltreatment and other adverse experiences in childhood planned for RC63 for implementation in 2014–15.

Country focus

WHO is giving support to Member States for using the developed tools for improving health across the life-course.

Category IV – Health systems

Box 4

Direct contribution to Health 2020 Priority Area 3: Strengthening people-centred health systems, public health capacity and emergency preparedness

3. **Reduce inequities in health in Europe (social determinants target)** – Reduce the gap in health status between population groups experiencing social exclusion and poverty and the rest of the population and 1) % or 2) %–% reduction in the difference in life expectancy between European populations by 2020.
5. **Universal coverage and "right to health"** – Funding systems for health care guarantee universal coverage, solidarity and sustainability by 2020.
6. **Member States set national targets or goals** – National target setting processes established and targets formulated.

Health information is a basic condition that enables countries to report on targets. Health information systems and evidence therefore contribute to meeting all targets.

This Category houses policy, cross-cutting and strategic elements that frame and enable the work on other priorities. Health 2020 provides a vision for improving the performance of health policies and systems through innovative approaches that find people-centred solutions, boost intersectoral action on wider social health determinants and consolidate a continuous flow of research and policy dialogue that inform decision-makers on how to better achieve health gains. Well-designed and well-functioning health policies and systems improve population health and well-being, protect people from financial hardship when ill and respond to legitimate population expectations. Based on sound intersectoral policy linked to evidence, the work in this category seeks to adapt to changing demographic patterns of disease, increasing migration and rapid technological progress to ensure universal public health coverage. People-centred health system response to these challenges are systematically based on evidence and are as resilient to economic cycles as possible factoring focus to reduce health inequities.

The secretariat for Health 2020 has its home here and with Member States shares the responsibility for the strategic outcomes and focuses on specific technical assistance to Member States in developing, implementing and monitoring national and subnational health policies drawing on the contribution of different sectors and a wide range of stakeholders.

Key priorities and changes to the portfolio

Current health situation

The way health policies are formulated and implemented and the way health systems operate and are financed has a major direct impact on the health situation, i.e. the level as well as the distribution of health and well-being in countries and populations. The Regional Office's new operational approach seeks to make tighter the links between the health situation and the Secretariat's contribution to improving health and well-being across the Region. In doing so, an

analysis of the main health outcomes including social determinants in a particular country, as set out in the countries' national health plans and strategies, then looking at the effective coverage of core individual and population services, leading to the identification of bottlenecks that hinder capacity building, for example to effective public health services. Reduction in the burden of disease from communicable and noncommunicable diseases requires sound public policies, vigilant public health services, a responsive and equitable health care system, a life course approach and intersectoral actions to tackle wider social determinants effectively ensuring that evidence is systematically used in decision-making and policy formulation.

Needs of individual countries

There is a very high country demand for support from the Secretariat. In responding to this demand, the Regional Office seeks to reduce divide among the countries of the Region. Country demands are higher in those countries that are more in need, whose health systems are more fragmented and fragile. The Regional Office seeks to respond to demands for evidence and informed-based policies, assessment of health systems performance and financial sustainability in times of austerity that are current needs in all countries in the Region.

Internationally agreed instruments

With regard to international instruments, in 2008 the 53 Member States in the WHO European Region endorsed the Tallinn Charter on Health Systems, Health and Wealth (EUR/RC58/R4). Soon afterwards the financial crisis broke out, putting the commitments by the Member States to the test and leading to the Regional Committee's resolution on health in times of global economic crisis (EUR/RC59/R3). In 2011, the Regional Committee provided the mandate to strengthen Public Health in the WHO European Region with the Resolution EUR/RC61/R2, calling for the development of a WHO European Action Plan on Strengthening Public Health Capacities and Services to be presented at RC62 as an implementation pillar of Health 2020.[3] The WHO Regional Committee for Europe brought the Human Resources for Health challenges to the forefront with two resolutions (EUR/RC57/R1 and EUR/RC59/R4). These resolutions highlight the need for collaborative efforts to tackle international mobility/migration of health personnel.

Evidence-based, cost-effective interventions

Evidence-based, cost-effective interventions are key to ensuring high levels of effective coverage of core individual and population-based services to attain health improvement, e.g., "best buys" for NCDs and the Stop TB Strategy for MDR-TB control. Evidence-based and cost-effective interventions are built on strong research and innovation that document what has worked better and worse. Sound evidence and knowledge translation empower decision-makers to foster and lead health intersectoral dialogue for improvements in health and well-being.

Comparative advantage of WHO

WHO stands out among partners for its work and position to advice and influence national policies and strategies, for the overall perspective on health systems strengthening and for its convening power in these areas. WHO also has a strong added value providing evidence based policy advice and driving capacity building and peer learning by encouraging networks and sharing of lessons learned between Member States and institutions. Further, WHO Regional Office for Europe is appreciated by Member States for its ability to assess and advise with an understanding that each situation is different and there is no "one size fits all" solution.

[3] EUR/RC62/12 Add.1 and EUR/RC62/9

The health system work will focus on achieving universal health coverage along the consolidated experience but with particular emphasis on people-centred integrated health services delivery and essential public health operations. New activities foreseen for this category include strengthening of health systems to better support NCD and TB Action Plans interventions through activities at country and at regional level. Important shifts have been done in the biennium 2012–13 and the work on information, evidence, research and innovation will mainly consolidate progress against the current streams of work.

The Observatory will continue to provide evidence to reinforce policy dialogue, including on communicable and noncommunicable areas. Preponderance will be given to producing more reactive and actionable evidence, to evidence sharing and more use of new technologies, for example the living HiTs initiative with rolling updates and more dynamic search and compare functions and developing links with online journals.

Country focus

The WHO Regional office for Europe's engagement in Category IV emphasizes country-specific, multicountry and intercountry outputs. During 2014–2015 more emphasis will be placed on providing country-specific support allowing maximum tailoring of activities to country needs and providing opportunities for capacity and institution building through joint work. That is, the strategies, approaches and tools developed during the multi and intercountry activities allowing cross-country learning as well as more efficient use of limited resources will continue as preference whenever feasible.

Category V – Preparedness, surveillance and response

Box 5

Direct contribution to Health 2020:

Priority Area 2: Tackling Europe's major health challenges in communicable and noncommunicable diseases

Priority Area 3: Strengthening people-centred health systems, public health capacity and emergency preparedness

Priority Area 4: Creating supportive environments and resilient communities

1. **Reduce premature mortality in Europe by 2020** – 2. Achieve and sustain elimination of selected vaccine preventable diseases (polio, measles, rubella, prevention of Congenital Rubella Syndrome).
2. **Increase life expectancy in Europe** – Continued Increase in life expectancy at current rate.
3. **Reduce inequities in health in Europe (social determinants target)** – Reduce the gap in health status between population groups experiencing social exclusion and poverty and the rest of the population and 1) % or 2) %– % reduction in the difference in life expectancy between European populations by 2020.
4. **Enhance well-being of the European population** (*to be further elaborated during 2012/2013*)
5. **Universal coverage and "right to health"** – Funding systems for health care guarantee universal coverage, solidarity and sustainability by 2020.
6. **Member States set national targets or goals** – National target setting processes established and targets formulated.

Public health emergencies in the WHO European Region are common and cover natural and manmade (technological) disasters, including increased occurrence of severe extreme weather events, civil unrest or military conflicts and communicable diseases outbreaks. Lessons learnt emphasize the importance of rigorous engagement in health emergency preparedness and risk management processes. Regional efforts include improving influenza surveillance and pandemic preparedness, the full implementation of the International Health Regulations, particularly the national capacity for surveillance and response, and preparedness of the health sector for mass gathering events and humanitarian crises. Laboratory capacity, addressed through programmes in Categories I and V, will be critical in providing support for the rapid detection and response to outbreaks.

The WHO Europe health crisis management framework combines early warning, surveillance and monitoring of infectious diseases, humanitarian and environmental events. It integrates an emergency steering committee, an incident command system, an emergency operations centre and a platform for operations support to countries. Procedures and infrastructure need to be strengthened, maintained and updated as the Organization and countries are to rely more on regional capacity for preparedness, alert and emergency response.

The sixty-first World Health Assembly adopted a resolution to treat the completion of polio eradication as a programmatic emergency. While the European Region has no countries with ongoing transmission of polio virus, the large outbreak in 2010 in central Asia shows the vulnerability of the Region. Until poliovirus is eradicated worldwide, all polio-free regions,

including the European Region, remain at risk of importation. It is therefore essential that the region maintains its efforts to keep its polio-free status.

The WHO Regional Office for Europe provides guidance and evidence-based policy options and technical support to Members States to establish and maintain cost-effective, functional, holistic and risk-based food safety systems that aims to efficiently prevent and control foodborne diseases, including antimicrobial resistance and zoonoses. It contributes to international food safety standards through the Codex Alimentarius Commission.

Key priorities and changes to the portfolio

Current health situation

There is a high demonstrated burden to health attributed to in environmental determinants and food safety. The European Region is highly vulnerable to influenza, including influenza pandemic, and to other respiratory pathogens such as shown by the frequent occurrence of legionnella outbreaks.

In the European Union, Norway and Iceland, 400 000 drug resistant infections are estimated to occur every year, leading to about 25 000 deaths. The situation in the Eastern part of the region is poorly documented although the sparsely available data suggests a similar situation. The figures for drug-resistant tuberculosis are of particular concern. Antimicrobial resistance (AMR) is an emerging health challenge that requires a multisectoral approach (e.g. several sectors of government, private industry, civil society) as well as coordinated actions across a variety of programmes (e.g. food safety, patient safety, health education, health systems, surveillance, essential medicines and pharmaceutical policies).

The region is regularly affected by foodborne and zoonoses outbreaks, some of large size and important consequences such as the *E.coli* (EHEC) outbreak in Germany in 2011. In the latter, the area of health information played a strong role in the response by WHO Europe.

Needs of individual countries

Overall demand from Member States in all the technical areas of Category V is with parts of it delivered through intercountry work and others in response to unexpected emergencies is often not reflected in BCAs. Several Member States have asked for extensions on compliance with the International Health Regulations (2005) core capacity deadlines and strengthening of laboratory and detection and response capacity. Given the interconnectivity of the countries in the Region, strengthening health sector’s capacities for the preparedness, prevention, surveillance and response capacity, incl. environmental emergencies, is of real importance to all 53 Member States in the European Region.

Internationally agreed instruments

Category V encompasses multiple multilateral agreements, including: IHR, Codex Alimentarius, and the renewed agreement for polio eradication are among those guiding the work. In 2011, the Regional Committee for Europe adopted a regional strategic action plan on antibiotic resistance in line with the focus of the World Health Day the same year.

Evidence-based, cost-effective interventions

All technical areas score high on evidence base and cost effective interventions, such as primary prevention through immunization.

Comparative advantage of WHO

Facilitating collaboration with other sectors is important to ensure that policy development supports health is a continuing task of the WHO Regional Office. All technical areas score high on comparative advantage of WHO. A high level of prioritization regarding comparative advantages of WHO applies to polio, influenza, ARO and IHR. WHO Regional Office for Europe adds the particular advantage of linking all category V areas to the wider context of health systems and Health 2020. WHO has a key role as the United Nations lead agency for health and as the sole organization apt to act on international health emergencies and cross border health challenges that go beyond local and regional responsibilities.

Country focus

The new global WHO Emergency Response Framework sets out the required changes and resources that will enable all three levels of the Organization to fulfil their role as health cluster lead agency and as leader in humanitarian and public health emergencies. WHO/Europe supports Member States in preparing for, responding to and recovering from disasters and health crises following an “all-hazard/whole-health” approach. Activities to strengthen preparedness include assessments, capacity-building workshops and trainings, technical support, and documentation. Country assessments will be complemented by capacity-building initiatives at regional and national levels through “Public Health and Emergency Management” training programmes. Emergency preparedness includes technical support to mass gatherings and extreme high visibility/high consequence events in which WHO regional and country offices are increasingly taking a leading role.

WHO provides overall normative guidance for policy development as well as input to national strategic plans for preparedness and response to health emergencies. In general, technical support is provided to those countries that need it most, and in particular for MS requesting extension for IHR core capacity building and development of preparedness plans. In crisis and emergencies, WHO provides direct support to MS and affected areas through the provision of risk assessment, risk communication and response.

Category VI – Corporate services/Enabling functions

Category VI provides the enabling functions and services to the area of governance, country presence, partnerships and communication and includes the organizational leadership and corporate services that are required for the efficient functioning of WHO and effective delivery of the technical programmes. Emphasis in 2014–2015 will be to support the WHO reform implementation in particular contributing to the achievement of its third objective: “an Organization that pursues excellence; one that is effective, efficient, responsive, objective, transparent and accountable”. With 30%, the Category VI’s percentage of the WHO Regional Office for Europe’s total base programme budget is higher than in other regions. This is explained when looking at the specifics of WHO Regional Office for Europe cost drivers in this area:

- 53 Member States, the *largest number of any region*;
- Four official languages affecting translation/publication costs, the *highest of any region*;
- A strengthened oversight function with frequent meetings and an increased membership of the Standing Committee of the Regional Committee (SCRC);
- Copenhagen is an expensive duty station;

- WHO Regional Office for Europe has a strong country presence, with 29 country offices, the *second highest among regions*;
- WHO Regional Office for Europe maintains effective partnerships with all major players in region;
- More focus on communication and dissemination of information than previously.

Table 2: overview of 2012–2013 budgets for functions covered under Category VI by SO12, SO13 and SO13*bis*

	Organization-wide Expected Result	SO12	SO13	SO13*bis*	Total
			(US$)		
12.1	Leadership & Direction / Governance	9 858			**9 858**
12.2/13.5	Country presence	12 838	2 587		**15 425**
12.3	Global Health //Partnerships	3 937			**3 937**
12.4	Multiling / knowledge/ Pub	8 243			**8 243**
13.1	Strategic & Op planning / Monitoring		2 902		**2 902**
13.2	Fin. Practices / Res. mobilization & mgt		5 141		**5 141**
13.3	Human resources policy and practice		100	4 213	**4 313**
13.4	Information systems		1 915	3 856	**5 771**
13.5	Man & Adm support services		7 374		**7 374**
13.6	Security /Building & premise mgt		278	444	**721**
Total		**34 877**	**20 296**	**8 513**	**63 686**

While every effort will be made to achieve further efficiency gains, it will be necessary to increase Category VI by about 5% for 2014–2015 compared to the above to off-set expected cost increases.

Thematic Area 1 – Leadership in health and Strategic Management

The WHO Regional Office for Europe will fully align itself to the global initiative, while building on past achievements to maintain and further strengthen its leadership role in public health in a very politically, socially, economically and geographically diverse region. Partnerships are important elements in the implementation of Health 2020 and in maximizing synergies for programme delivery. Institutionalized relationships with a wide range of partners, (including the European Union, United Nations agencies, subregional networks, global health partnerships, foundations and development agencies, civil society organizations), continues to be the key objective. In 2014–2015, focus will be extended also to country level to create more effective and country specific partnerships. Collaboration with the European Union and its agencies will remain a priority. In this context, WHO Regional Office for Europe now represents WHO globally in maintaining relationships with the European Commission and with that also the management of the WHO Office in Brussels.

Thematic Area 2 – Country Focus

The interim country strategy for the next two years[4] aims to move quickly ahead in creating a beneficial WHO impact in all Member States, i.e., not only where there is an office. In 2014, progress will be evaluated and reported back to the Regional Committee. A longer-term strategy

[4] EUR/RC62/13

will be developed thereafter. However, in the meantime this area contributes to the relative high level of Category VI expenditures compared to other regions. This is mainly due to the large number of countries and Country Offices, relative to the overall size of the budget of the region. The WHO reform foresees to increase country presence globally. Given the large number of countries in the European Region, this may prove to be a challenge, if additional financial resources are not forthcoming.

Thematic Area 3 – Governance and convening

The Regional Office has strengthened the role of its governing bodies over recent years and has increased the membership and meeting frequency of the SCRC to strengthen its oversight and strategic advisory role. In the next biennium, this will be maintained and further institutionalized.

Thematic Area 4 – Strategic policy, planning, resource coordination and reporting

Effective and timely strategic and managerial decision-making have been enhanced by the introduction of regular and comprehensive executive management reports and reviews covering key indicators of budget, resource and technical performance, as well as impediments to implementation. Long-term strategic management, including development of an approach to a sustainable human resource base for the office is one of the cornerstones of the WHO reform and will be a focus for both the current and the next biennium in WHO Regional Office for Europe.

Thematic Area 5 – Strategic communication

Work to further strengthen the Regional Offices media presence has already started with the development of a communications strategy, which includes traditional and new means of communications. The strategy is planned to become fully operational within the 2012–2013 biennium. 2014–2015 will thus focus on sustaining its implementation.

Thematic Area 6 – Knowledge management

The WHO Regional Office for Europe has a strong tradition of publishing, and doing so in four regional languages. The office is also in the process of strengthening its knowledge management, including the use of collaborating centres (see 5.2). Health research, key norms and standards setting work through the Guidelines Review Committee and Ethics Review Committee also sit within this category.

Thematic Area 7 – Accountability and risk management

This is an important area of the management component of the WHO reform. The Regional Office for Europe continues closely working together with the Comptroller, the Office of the Internal Oversight Services, PRP and others to further develop and strengthen the technical evaluation culture as well as the financial control and accountability framework at the Regional Office. Three key initiatives started during 2010–2011, i.e., Programme and Resource Management function, the GSM, and the Compliance function are the backbones of the efforts taken further forward during 2012–2013 and continuing into 2014–2015.

Thematic Area 8 – Management and administration

The Regional Office has achieved considerable savings in this area over the recent years. The office move into the United Nations City in 2013 in a more modern facility will benefit synergies from sharing services with other United Nations agencies. However, the move is not expected to further reduce the cost of administration.

Annex B. Proposed global 2014–2015 outcomes

Category I: Communicable diseases

	Global 2014–2015 Outcomes	EURO 2012–2013 Outcomes (Annex C)
1	Number of people living with HIV on antiretroviral therapy (*HIV/AIDS*)	**4, 34, 35**
2	Percentage of notified tuberculosis patients tested for HIV in settings of high HIV prevalence (*tuberculosis*)	**36**
3	Percentage of population at malaria risk targeted for vector control using an insecticide–treated bednet or protected by indoor residual spraying (*malaria*)	**6, 39**
4	Sustainable dengue prevention and control interventions established in disease–endemic priority countries (*neglected tropical diseases*)	**Nil**
5	Coverage of preventive chemotherapy to control lymphatic filariasis, onchocerciasis, schistosomiasis, soil–transmitted helminthiasis and trachoma (*neglected tropical diseases*)	**33**
6	Number of tuberculosis patients enrolled on MDR–TB treatment annually (*tuberculosis*)	**5, 37, 38**
7	Global average coverage with three doses of DTP vaccines (*vaccine–preventable diseases*)	**1, 28**

Category II: Noncommunicable diseases

	Global 2014–2015 Outcomes	EURO 2012–2013 Outcomes (Annex C)
1	25% relative reduction of blood pressure/hypertension as measured by age–standardized prevalence of raised blood pressure among persons aged 18+ years (*noncommunicable diseases*)	**9, 44, 45**
2	10% relative reduction in the harmful use of alcohol as measured by adult per capita consumption in litres of pure alcohol (*noncommunicable diseases*)	**13, 60**
3	30% relative reduction of tobacco smoking as measured by age-standardized prevalence of current tobacco smoking among persons aged 15+ years (*noncommunicable diseases*)	**15, 58, 59**
4	30% relative reduction in dietary salt intake as measured by age-standardized mean adult (aged 18+) population intake of salt per day (*noncommunicable diseases*)	**9, 14, 19, 57**
5	10% relative reduction in physical inactivity as measured by age-standardized prevalence of insufficient physical activity in adults aged 18+ years (*noncommunicable diseases*)	**9, 57, 61**
6	No increase in adult obesity as measured by age-standardized prevalence of obesity in adults aged 18+ years (*noncommunicable diseases*)	**14, 19**
7	No increase in childhood obesity as measured by age-standardized prevalence of obesity in children aged less than five years (*noncommunicable diseases*)	**14, 19, 57**
8	>80% coverage of multidrug therapy for people aged 30+ years with a 10–year risk of heart attack or stroke ≥30%, or existing cardiovascular disease (*noncommunicable diseases*)	**44, 45**
9	40% relative reduction in stunting as measured by prevalence of low height for age (< -2 SD) in children under 5 (*nutrition*)	**19, 57, 72**
10	Cataract surgical rate as measured by number of surgeries performed per year per million population (*disabilities*)	**Nil**
11	Proportion of countries with comprehensive laws addressing five key risk factors for road safety (*violence and injuries*)	**8, 42, 43**

12	Number of countries with increase in mental health budget as a proportion of health budget (*mental health*)	**7, 40, 41, 55, 56**
13	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)*	**44, 46**

Category III: Promoting Health throughout the life-course

	Global 2014–2015 Outcomes	EURO 2012–2013 Outcomes (Annex C)
1	Reduction in adolescent pregnancies (*sexual and reproductive health*)	**47**
2	>80% children with suspected pneumonia receive antibiotics (*child health*)	**48**
3	>50% babies exclusively breastfed for six months (*maternal and newborn health*)	**11**
4	>50% mothers and babies receive postnatal care within two days of childbirth (*maternal and newborn health*)	**11**
5	>80% of women receive antenatal care at least four times by a skilled provider during pregnancy(*maternal and newborn health*)	**11**
6	>80% pregnant women receive skilled attendance at birth (*maternal and newborn health*)	**11**
7	Reduction in unmet need for contraception is reported (*sexual and reproductive health*)	**49, 50, 53**
8	Number of Member States that are implementing sectoral policies that prevent and/or mitigate environmental and occupational risks (*health and the environment*)	**18, 61, 66, 67, 68, 69, 70, 71**
9	TBD – health service coverage indicator for ageing (*healthy ageing*)	**10**
10	TBD – equity indicator across socioeconomic groups (*social determinants*)	**16, 61, 62, 63, 65**
11	TBD – equity indicator for gender (*gender equity*)	**64, 65**

Category IV: Health Systems

	Global 2014–2015 Outcomes	EURO 2012–2013 Outcomes (Annex C)
1	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*)	**17, 21, 23, 24, 26, 73, 80, 81, 82**
2	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*)	**23, 24, 80**
3	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*)	**25, 75, 76**
4	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*)	**25**
5	Number/proportion of Member States in which a national intervention coverage index of core services is improving (*integrated people–centred services*)	**22, 24, 74, 79**
6	Number of Member States where payment of health care providers is regulated (*integrated people-centred services*)	**Nil**

7	Number of Member States with appropriate accreditation of service providers (*integrated people-centred services*)	**Nil**
8	TBD: indicator for health workforce (*integrated people-centred services*)	**77, 78**
9	Number of Member States implementing appropriate regulatory oversight of medical products (*access to medical products*)	**86**
10	Number of Member States with monitoring systems on price and availability of medicines and medical products (*access to medical products*)	**27**
11	Number of countries using essential medicines list updated in the last five years for public procurement and reimbursement (*access to medical products*)	**87**

Category V: Preparedness, surveillance and response

	Global 2014–2015 Outcomes	EURO 2012–2013 Outcomes (Annex C)
1	Number of Member States conducting or updating a multi-hazard health emergency risk assessment at least every two years (*emergency risk and crisis management*)	**12**
2	Percentage of Member States conducting a national health emergency response exercise at least every two years (*emergency risk and crisis management*)	**52**
3	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*)	**32, 51**
4	Number of Member States meeting and sustaining International Health Regulations (2005) core capacities (*alert and response capacities*)	**3**
5	Percentage of Member States with national emergency risk management plans that include epidemic and pandemic diseases (*epidemic- and pandemic-prone diseases*)	**12, 30, 31**
6	Number of Member States with an active “Safe Hospital Programme” (*emergency risk and crisis management*)	**Nil**
7	Number of Member States with a food safety programme that has a legal framework and enforcement structure (*food safety*)	**2 (TBD), 20, 71**
8	All Member States achieve vaccine coverage levels needed to stop poliovirus transmission (*polio eradication*)	**29**

Annex C. The Regional Office for Europe's outcome and output portfolio – 2012–2013

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
01	1	KPO	I.7	Member States develop, implement, and maintain policies to sustain polio-free status (since 2002) and achieve elimination of measles and rubella in the European Region by 2015 through strengthening the quality of disease surveillance and delivery of immunization services.	(1)Secretariat support to establish a regional process for the verification of measles and rubella elimination (2) Technical and material assistance to Member States for maintaining high quality laboratory-based surveillance systems for measles, and rubella. (3) Policy and strategy guidance to MS for increased access to immunization services with special focus to under-immunized groups and, where needed, conducting supplementary immunization activities. (4) Follow-up monitoring and evaluation of supplementary immunization activities (SIAs).
02	1	KPO	(V.7) TBD	Member States have made an initial assessment of the epidemiological situation of antibacterial resistance, antibiotic usage in all sectors (including food and agriculture) and have established a national coordination mechanism and have developed national action plans based on the seven strategic objectives of the regional plan on the containment of antibiotic resistance.	(1) Technical support provided for AMR assessments, surveillance, and containment in line with WHO and EU strategies, norms and standards. (2) Development of tools and regional data bases for surveillance compatible with EARS-NET for non EU MS. (3) Yearly report on AMR in coordination with ECDC and DG SANCO. (4) Provide technical assistance and tools to MS to improve national programmes in one or more of the seven regional AMR objectives.
03	1	KPO	V.4	In support to national and regional health security, Member States have developed policies and national plans to implement the IHR, including strengthening their core public health capacities for disease surveillance and response, as well as preparedness for epidemic-prone diseases (such as influenza).	(1) Assessment and support to Member States to reach the IHR national core capacity requirements for surveillance and response. (2) Regional and national tools, training, guidelines and plans for disease surveillance, risk assessment, preparedness and response, including pandemic preparedness provided. (3) Policy and technical support in national laboratory networks for quality systems, laboratory diagnoses and biosafety. (4) Sub-regional and regional technical and ministerial meetings. (5) Training of National IHR Focal Points and national staff in systematic hazard detection and risk assessment using WHO training package.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
04	2	KPO	I.1	Member States adopt policies and strategies for strengthening health system and implementing public health approaches for prevention and control of HIV/AIDS, including programmes linked to TB control, drug dependence (including opioid substitute therapy) and sexual and reproductive health, to halt the rise of HIV epidemic in Europe.	(1). Assistance to MS to produce policies, norms, standards, tools and evidence-based interventions in line with WHO Action Plan for HIV/AIDS 2012–2015. (2). Technical support, normative and strategic guidance, and tools provided to link HIV/AIDS surveillance, national policy development, and monitoring and evaluation of evidence-informed interventions with related health services. (3). Policy and strategy guidance to MS to reach universal access for prevention and care, particularly for key populations at higher risk.
05	2	KPO	I.6	Member States adopt policies and strategies for prevention and control of M/XDR-TB through strengthened health systems and public health approaches.	(1) Strategic and technical support to update of National M/XDR-TB Response Plans in 15 MDR-TB burden countries in line with the Regional M/XDR-TB action Plan. (2) Regional green light committee mechanism established to assist Member States for scaling up of MDR-TB treatment. (3) A health system assessment tool for M/XDR-TB developed and implemented in five countries. (4) Technical assistance to Member States to scale up Stop TB strategy and M/XDR-TB response.
06	2	KPO	I.3	Remaining affected Member States are implementing strategies that lead to malaria elimination by 2015 and will sustain malaria-free status.	(1). Normative and technical guidance to MS to achieve MAL elimination within the framework of the Tashkent Declaration. (2). Regional and inter-regional (EURO&EMRO) coordination on MAL elimination and prevention.
07	3	KPO	II.12	Member States apply principles and evidence based interventions according to the European Mental Health Strategy and Action Plan and mhGAP (with the aim of improving mental wellbeing of the population and quality of life of people with mental disorders).	(1) European MNH strategy and Action Plan developed. (2) Member States implement evidence-based activities that improve mental wellbeing of the population across the lifespan and reduce suicides. (3) Community-based mental health service planned in a number of countries. (4) Evidence on safe and effective interventions disseminated. (5) Workforce competency framework developed.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
08	3	KPO	II.11	Evidence- based programming increased in Member States to reduce the burden from violence and injuries.	(1) National prevalence surveys of adverse childhood experiences and elder maltreatment conducted in selected countries. (2) European report on child maltreatment prevention developed and disseminated with an emphasis on social determinants. (3)Policy dialogue workshops held in selected countries to strengthen child maltreatment prevention programmes. (4)Network meeting of national focal points of VIP. (5)Capacity building using TEACH-VIP and a train the trainer approach in selected countries. (6)Regional policy briefing developed based on 2nd Global status report on road safety and policy workshops in selected countries.
09	3	KPO	II.1, 4, 5	Member States adoption of a priority list of evidence-based actions for prevention and control of NCDs consistent with the European NCD Action Plan. These actions include integrating surveillance systems, using fiscal measures, product reformulation and control of marketing to promote healthier consumption, promoting wellness in workplace, managing cardiometabolic risk, and stepwise approaches to cancer control.	(1) Two meetings organized of a broad intersectoral coalition of NCD stakeholders. (2) An integrated system of NCD surveillance is published and implemented. (3) 2–3 guidelines for action across sectors are developed and disseminated (e.g. fiscal, marketing, salt, trans-fats. (4) National plans for NCD are developed or strengthened in pioneer countries. (5) National assessment of health systems and capacity for NCD control conducted with emphasis on a social determinants framework. (6) Continued support to the Health Behaviour in School-aged Children survey international coordination.
10	4	KPO	III.9	An increasing proportion of the older population are covered by public initiatives of healthy aging, disability policy and services in Member States.	(1) Technical assistance to develop, implement and monitor healthy ageing policies using existing and new relevant WHO tools. (2) Develop European Strategy and Action Plan on Healthy Ageing. (3) Technical assistance to develop, implement and monitor policies of long-term care services at the boundary of health and social care systems.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
11	4	KPO	III.3, 4, 5, 6	Evidence-based gender responsive practices for improving maternal, perinatal, newborn, and child health, adopted (or adapted) and implemented by Member States.	(1) Assessment of quality of primary health care for mothers and newborn in selected Member States. (2) Assessment of quality of primary and hospital care for children in selected Member States. (3)Technical assistance to implementation of maternal and perinatal mortality and morbidity audit. (4) Technical assistance to develop and implement comprehensive, gender responsive maternal and child health policies, in line with MDG targets. (5) Focal point meeting on impact of social determinants, inequalities and gender on women's and children's health.
12	5	KPO	V.1, 5	Enhanced preparedness and response capacities of Member States to emergencies and disasters through all-hazard risk management programmes, in line with humanitarian needs and also IHR requirements.	(1) Strategic advice and technical assistance to MS to develop and improve national emergency preparedness plans including the roll out of the toolkit for assessing and monitoring health systems capacities for crisis management . (2) Guidance and tools for disaster risk reduction including mass gathering preparedness, hospital resilience and safety and rollout of the WHO Europe hospital emergency response checklist: An all-hazards tool. (3) Training package and capacity building for "public health and emergency management" including rollout of regional and national training programmes, also in line with IHR procedures and requirements.
13	6	KPO	II.2	Member States have strengthened their national programmes to reduce harmful use of alcohol in line with European Alcohol Action Plan 2012–2020.	(1) Publish a guidance tool including the adopted European Action Plan to reduce the harmful use of alcohol 2012–2020. (2) Give guidance to MS on alcohol prevention by using the new European Action Plan to reduce the harmful use of alcohol 2012 – 2020. (3) Contribute to the implementation of the NCD Action Plan with focus on increased taxation, regulations on promotion of alcohol products and on decreased availability.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
14	6	KPO	II.4, 6, 7	Obesity prevention and control Action Plans, including healthy diet and physical activity, developed and implemented in Member States based on the European Charter to Counteract Obesity Principles.	(1) Progress Rep Implementation Charter Counteracting Obesity with a focus on equity and the SDH. (2) Technical support for Nat Obesity Action Plans. (3) Obesity surveillance system established as a contribution to NCD AP. (4) Database on Nut, PA & Obesity as per NCD AP. (5) Policy tools developed to promote cost-effective interventions on diet, PA and obesity focused on active mobility and Marketing food to Children contributing to NCD AP in accordance with the WHO Set of Recommendations of Marketing of Food to Children and the Global Recommendations on Physical Activity. (6) Policy Tools & technical advice to achieve targets in salt reduction & elimination trans fat. (7) Best-practice manual use of fiscal and price measures to influence diet and PA as part of the NCD AP.
15	6	KPO	II.3	Multisectoral policies and strategies established within Member States to increase the level of implementation of the WHO FCTC by using the MPOWER framework.	(1) Policy tools, including evaluation tool of programmes and policies, with special attention to tax and marketing policies. (2) Technical advice based on latest global and regional evidence. (3) Best practices for strengthening capacity to implement the WHO FCTC. (4) Political support for strengthening of policies and legislation and their enforcement.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
16	7	KPO	III.10	Greater capacity and commitment among Member States to better meeting the right to health and health needs of poor, vulnerable and socially excluded groups (VGs) with particular emphasis on action for migrants and Roma populations and addressing inequities in progress towards the MDGs.	(1) Evidence and resource packages to strengthen the capacity of MS to better understand/meet the health needs of VGs. (2) Reports with analyses on Roma, migrants and VGs' health and health system access produced in partnership with UN agencies. (3) Training package and capacity-building supporting MDG progress for the Roma population, in the context of the decade on Roma inclusion and EU work on Roma. (4) Technical assistance to national authorities to help mainstream Roma health in relevant national policies and programmes and overall advising MSs on health policies and programmes addressing the issue of VGs. (5) Coordination of Office-wide input, particularly to interagency working group for tackling inequities in progress towards the health related MDGs.
17	7	KPO	IV.1	Member States develop comprehensive national (NHP) and sub-national policies, strategies and plans for health and wellbeing based on/or aligned with the Health2020 policy framework and develop capacity to implement whole of government and multi-stakeholder governance processes and mechanisms for Health 2020. All Member States will have endorsed the new policy for Health - Health 2020 at RC 62 in Malta (September 2012).	(1) Health 2020 developed through a participative process and finalized following consultations with MS and key stakeholders. (2)Report of European Review on Social Determinants and Health Divide informing Health 2020 finalized. (3) Report with practical guidance and case studies on good governance for health prepared. (4) Technical support provided to Member States in the form of tools and consultations for developing capacities and processes for developing and implementing Health 2020.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
18	8	KPO	III.8	Member States implement evidence-based intersectoral policies and strategies at regional and national level to meet Parma Declaration commitments with effective new governance for the European Environment and Health Process (EEHP).	(1) Secretariat for the European Environment and Health Process (EEHP) and Regional governance in environment and health, including multilateral agreements. (2)New tools for evidence based policy and strategies including guidelines, policy guidance and advice on multiple environmental exposures and risks. (3) Capacity building tools/activities in MSs for environment and health risk and emergencies assessment and management, climate change and related extreme events in a IHR framework. (4) Technical assistance for implementation of the European Framework for Action on protecting health under a changing climate.
19	9	KPO	II.4, 6, 7, 9	Member States develop, implement and evaluate National plans and strategies for the promotion of appropriate nutrition in accordance with the WHO European Action Plan for Food and Nutrition Policy, prioritizing the areas of nutritional status surveillance and monitoring of the population with a focus on children.	(1) Progress Report on the Implementation of the 2nd FNAP and development of the 3rd WHO European Region Food and Nutrition Action Plan in line with the Global Strategy on Diet and Physical Activity and the Global Strategy on Infant and Young Child Nutrition. (2) Issue reports and publications with the nutritional status surveillance data on a Regional basis every 2 years with inclusion of the SDH. (3) Technical Assistance to Member States for the implementation of the National Surveillance Systems. (4) Set of implementation indicators developed to evaluate nutrition policies. (5) Policy summary & scientific review produced for the MS Nutrition Action Networks. (6) Policy tools to assist MS in implementation of priority actions in nutrition. (7) Support provided to MS in food security emergencies. (8) Capacity building mechanisms development for the health workforce and recommendations for breastfeeding, complimentary feeding and infant nutrition are delivered.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
20	9	KPO	V.7	Member States enhance their capacities and resource allocations for addressing food safety, food-borne diseases and food hazards.	(1) Strengthen the partnership with FAO, EC, EFSA and ECDC and other relevant organizations (e.g. OIE and the WB) on food safety issues. (2) Promote surveillance of food-borne disease and contamination in the food chain, e.g. through subregional GFN activities. (3) Coordinate Codex-related activities at the regional level in collaboration with FAO and WHO HQ, including Codex Trust Fund issues, such as joint FAO/WHO sub-regional capacity activities funded by CTF. (4) Provide support in times of food safety emergencies impacting on the Region. (5) Support the strengthening of food safety risk communication.
21	10	KPO	IV.1	Member States have applied a systematic approach to governance with the aim of strengthening health systems by developing, evaluating and supporting alignment to national and/or sub-national health plans and strategies and by assessing the performance of their health system.	(1) Training courses to strengthen core competencies for health governance, health systems strengthening and NHP and sub-national health plan development. (2) Good practice guidelines on health systems governance and NHP development. (3) Health Systems Performance Assessment Toolkit. (4) Case studies on Health Policy Analysis Units. (5) Assessment of MS capacities/institutions in evidence-informed policy development. (6) Tallinn Charter follow-up learning activities. (7) WHO/EURO support package for Health Systems Strengthening.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
22	10	KPO	IV.5	Member States improve the performance of public health services and operations by developing, implementing and evaluating evidence-informed public health policies.	(1) European Action Plan for Strengthening Public Health Capacities and Services 2020. (2) WHO Europe Self-Assessment Tool for Evaluation of Public Health Capacities and Services, incl. health promotion, health protection and disease prevention. (3) Review of Public Health policies and instruments. (4) Sub-regional Public Health strengthening products: (i) Review and assessment of national mechanisms for financing and human resources for PHS and developing recommendations for actions, (ii) Training of trainers on PHS planning, management, monitoring and evaluation, (iii) Standards and procedures for accreditation of PHS, (iv) Policy Dialogue of NIS on PHS strengthening for improved NCD prevention and control.
23	10	KPO	IV.1, 2	Increased quality of and capacity for health situations analysis, including collection, use of standards, analysis and dissemination of health information in Member States.	(1) ICD-10 web-based training delivered in different languages. (2) Guidance &technical support for the integration of health information systems provided. (3) Guidance for assessments &quality improvement of health information &statistics provided to MS. (4) Standards for improving availability, quality &comparability of health information in MS.
24	10	KPO	IV.1, 2, 5	A common European health information system agreed and framework established jointly with the EC for harmonized health information and evidence used for decision making at regional and Member State levels.	(1) A framework for a common European Health Information System developed and roadmap for action agreed jointly with the EC. (2) An integrated health information platform with databases, analytical reports and other info products developed.
25	10	KPO	IV.3, 4	Member States implemented health financing policies to make progress towards, or sustain existing achievements of, universal health coverage, with attention to minimizing the negative effects of the financial crisis on the health sector and ensuring that financing arrangements are well aligned to priority health care and public health services.	(1) Reports on health financing, universal coverage and lessons learned from the response to the global economic crisis. (2) Policy briefs on health financing & system institutional arrangements to better address priority health issues, with a particular focus on TB/MDR-TB and NCDs. (3) Technical assistance for strengthening MS institutional capacity to address priority health financing issues.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
26	10	KPO	IV.1	Member States request and use policy briefs and evidence syntheses for the translation of evidence into policy at country level AND participate in capacity building workshops and in the development of tools for evidence informed policy.	(1) Increased number of joint policy briefs produced with stakeholders. (2) Increased number of HEN syntheses in response to MS demands and establishment of EVIPNet Europe. (3) Identification of countries for networks and organization of initial multi-country training workshops.
27	11	KPO	IV. 10	Member States improve equitable access to good quality medical products (medicines, vaccines, blood products) and technologies.	(1) Networking and technical guidance on medicines pricing, supply and reimbursement and health technology assessment policies. (2) Policy guidance and networking of medical products regulatory authorities. (3) Policy guidance for improving the prescribing and use of medicines. (4) support for WHA plan of action on public health, innovation and intellectual property. (5) Policy development and support to national programmes for safe blood and clinical technologies. (6) Guidance on risk assessment and management strategy for vaccine safety/quality. (7) Development of WHO regional strategic plan on medical products and technologies.
28	1	OPO	I.7	Member States able to strengthen immunization systems in the context of health systems strengthening in order to maximize equitable access of all people to vaccines of assured quality, including new or underutilized immunization products and technologies, and to integrate other essential family and child health interventions with immunization.	(1) Technical assistance, information, tools, norms and standards, provided to strengthen decision-making for programme strategies and policies. (2) Support provided to strengthen programme management. (3) Tools and technical assistance provided to improve programme data management. (4) Technical support provided to improve access to and utilization of immunization services. (5) Technical and material support provided for evidence based decisions to accelerate introduction of new vaccines and technologies. (6) Technical guidance, training, and supplies provided to strengthen surveillance of diseases preventable by new vaccines. (7) Support provided to strengthen management of vaccines and supplies.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
29	1	OPO	V.8	Member States maintain high quality surveillance and high coverage with polio vaccine to maintain polio-free status leading to global polio eradication.	(1) Document wild poliovirus containment achieved. (2) Policy and technical support provided to MS to ensure capacity to sustain polio-free status. (3) Technical and material support provided to maintain AFP epidemiological and laboratory based surveillance. (4) Normative guidance, policy and technical support provided MS in shifting from OPV to IPV. (5) Normative guidance and technical and material support provided for supplementary immunization activities conducted in high-risk MS (to importations of WPV).
30	1	OPO	V.5	Member States equipped to carry out communicable diseases surveillance and response, including laboratory, as part of a comprehensive surveillance and health information system.	(1) Normative guidance and tools provided for development of surveillance policies and strengthening data management systems. (2) Technical assistance to MS to develop lab capacity and policy support for conf. of targeted diseases. (3)Standard tools for data management and support for transition to case-based surveillance. (4) Updated reg. guidance on flu Surv. (5) Tech. asst. to MS to strengthen ILI and SARI surv. (6) Quality assessment and capacity building for NICs. (7) Dis. burden est. to inform vacc policy in priority MS. (8) Support for surv. of other comm. dis.
31	1	OPO	V.5	Member States able to detect, assess, respond and cope with major epidemic and pandemic-prone diseases in collaboration and partnership with the international community (e.g. influenza, meningitis, yellow fever, hemorrhagic fevers, plague and smallpox) with effective prevention, detection, surveillance, preparedness and intervention tools, methodologies, practices, networks and partnerships.	(1) Technical assistance provided for the revision of pandemic preparedness national and regional plans. (2) Intercountry and multi-country workshops and training provided to promote the use of WHO technical norms and standards. (3) Examples of good practice in pandemic planning provided. (4)Regional guidance on early warning and risk assessment for a pandemic developed. (5) WHO EURO/ECDC European Pandemic Indicators revised.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
32	1	OPO	V.3	Member States and the international community implement effective and timely responses to declared emergency situations due to epidemic and pandemic prone diseases.	(1) At time of public health events which may constitute a public health emergency of international concern, offer of specific expertise and technical support in order for MS to provide a timely and effective response, particularly to emergency situations caused by epidemic and pandemic prone diseases (2) WHO maintains operational, every day and on a 24 hours basis, the IHR Contact Point for the European Region and supports timely sharing with MS of information related to potential acute public health risks in the region.
33	1	OPO	I.5	Member States possess policies, increased technical capacity and effective collaborations to control and prevent neglected, tropical and zoonotic diseases.	(1) Assistance to priority MS to produce policies, strategies and tools to control and prevent neglected, tropical and zoonotic diseases (NTD). (2) Normative guidance and assistance to strengthen institutional capacities for decision-making related to NTD. (3) Assistance to promote partnership, mobilize resources and involve communities to control and prevent NTD. (4) Assistance to ensure country stocks of drugs for treatment of NTD. (5) Operational research assistance on issues of direct relevance to NTD.
34	2	OPO	I.1	Member States progress towards optimizing HIV, STIs and viral hepatitis (B&C) prevention, diagnosis, treatment and care outcomes and progress towards building strong and sustainable systems for HIV, STIs viral hepatitis prevention and control.	(1) Provide leadership and policy guidance and tools to build consensus to promote client centred service delivery particularly for key populations. (2) Monitor service availability and coverage. (3) Strengthen capacity of MS, patient groups, CBOs and NGOs to deliver services. (4) Report progress towards elimination of mother to child HIV transmission. (5) Strengthen MS capacity and provide tools to collect, collate, analyse and use strategic information. (6) Assist MS to avoid interruption in supply of medicines, diagnostics and other commodities. (7) Develop practical quality improvement tools for HIV prevention. (8) Assist MS to monitor and improve the quality of services. (9) Normative, strategic and technical support provided and tools prepared to support national STI and viral hepatitis prevention and control programmes.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
35	2	OPO	I.1	Member States reduce vulnerability and structural barriers to accessing HIV, STIs viral hepatitis and other essential services (including through addressing social determinants of health).	(1) Provide MS evidence-based policy and build consensus to address legal and regulatory barriers to prevention treatment and care. (2) Liaise with patient groups, CBOs & NGOs to promote human rights. (3) Support Member States in reviewing policies, ,strategies and legal, regulatory barriers . (4) Assist MS to establish and enforce social protection policies and practices. (5). Policy guideance and technical assistance for strengthening community systems for higher quality and more effective diagnosis, treatment and care. (6) Assist MS to address gender-related barriers, reduce vulnerability.
36	2	OPO	I.2	Member States through national and international partnership adopted the measures to identify and address determinants of TB and improved collaborative TB/HIV activities.	(1) Minimum package of tools, norms, standards, and evidence-based interventions for cross border TB control and care developed and disseminated among Member States. (2) Framework for intersectoral collaboration developed and piloted in addressing at least one TB determinant. (3) Impact of determinants on TB and M/XDR-TB prevention and control documented and monitored. (4) Technical assistance to collaborative TB/HIV activities provided. (5) One Regional workshop for countries in Eastern Europe to promote and coordinate interventions addressing TB and M/XDR-TB determinants.
37	2	OPO	I.6	MS provided equitable and universal access to quality assured laboratory diagnosis and quality medicines for treatment of TB.	(1) Technical assistance on drug management, using WHO norms, tools, and evidence-based interventions, provided to High TB priority countries (2) Technical assistance to high TB priority countries provided in ensuring quality TB laboratory network and adoption of new technologies for early TB diagnosis in line with WHO policies and standards.
38	2	OPO	I.6	Member States monitor progress in TB prevention and control and use surveillance data for improving TB services.	(1) Monitoring framework for Berlin follow-up finalized. (2) Trends of TB, M/XDR-TB and TB/HIV measured and recorded on annual basis. (3) Monitoring and surveillance report launched annually.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
39	2	OPO	I.3	Member States certify malaria elimination through normative and technical guidance and engage in this process.	(1) Normative and technical guidance to eligible MS on prevention of re-introduction and certification of malaria elimination. (2) Assistance to eligible MS to sustain political commitments, mobilize resources and involve communities to attain MAL elimination goals. (3).Normative assistance to eligible MS to promote and coordinate operational research on malaria elimination.
40	3	OPO	II.12	Member States develop and implement best practices based on international good evidence and innovative services in mental health.	(1) Evidence produced to raise awareness in the Member States on the role of SD and inequalities of MNH. (2) Case studies and best practices documented and disseminated.
41	3	OPO	II.12	Member States implement activities to improve the quality of life and social inclusion of children with Intellectual Disabilities and their families.	(1) Report on achieved progress in the Member States with regard to addressing quality of life of children with intellectual disabilities. (2) Seminar designed and implemented for users of MNH service families on addressing discrimination.
42	3	OPO	II.11	Member States increase capacities and resources to address the burden of violence and injuries.	(1) Activities linked to the Decade of Action for Road Safety with technical support provided to countries for developing national road safety policy and advocating for higher priority. This would consist of policy workshops based on the results of the global status report survey . (2) Advocacy activities linked to the WHA resolution on child injury prevention by a) questionnaire survey of focal points and with national profiling b) national policy dialogues to develop policy further based on these baseline assessments.
43	3	OPO	II.11	Member States improve and offer care and rehabilitation for injured and disabled people proportionately to need.	(1) Reports on improving trauma care and rehabilitation disseminated. (2)Training workshops held using TEACH-VIP curriculum with an emphasis on improved equity and access to trauma care. (3) Assessments of disability in selected Countries. (4) Advocacy for disability with the launch of the World report on disability-workshops with policy dialogues will be held in selected countries.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
44	3	OPO	II.1, 8, 13	Member States progressively adopt and adapt evidence-based interventions for primary and secondary prevention of NCDs within their primary health care systems.	(1) Action research projects (including health systems components) initiated in pioneer countries on the above, with a view to documenting effects of intervention.
45	3	OPO	II.1, 8	Member States develop and progressively implement European Regional guidance for cardio-metabolic risk assessment and management.	(1) European review conducted of the control of diabetes and cardiovascular disease (ICP). (2) Case studies and best practices documented (MC). (3) Consensus meeting organized (ICP). (4) Guidance tested in countries (MC).
46	3	OPO	II.13	Member States develop and implement national cancer control programmes with an emphasis on the early detection of breast, cervical and colorectal cancers developed.	(1) European review of national cancer control plans and/or cancer programmes conducted (ICP). (2) Case studies and best practices documented (MC). (3) Consensus meeting organized (ICP). (4) Guidance tested in countries (MC).
47	4	OPO	III.1	Member States competent in developing, implementing and monitoring adolescent health programmes using a whole-of-society perspective.	(1) Member States applied a whole-of-society perspective to conduct an analysis of adolescent health programmes, including school health services. (2) National multisectoral plans developed to address adolescent health and development priorities. (3) WHO tools to support quality measurement and capacity building of health personnel to deliver adolescent friendly services, adapted in Member States. (4) Continued support to Schools for Health in Europe Network.
48	4	OPO	III.2	Member States equipped to implement evidence based interventions for child health and development.	(1) Technical advice on incorporating child health interventions in health systems approach to meet MDG 4. (2) Support for use of IMCI tool to improve primary health care for children. (3) Consultation to develop indictors for child well-being and interventions for child protection. (4) Child rights approaches in care introduced. (5) Package with gender responsive tool on how to achieve MDG 4 developed.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
49	4	OPO	III.7	Research capacity strengthened in Member States and new evidence on sexual and reproductive health available.	(1) Capacity building of national experts in operational research in collaboration with HRP/WHO HQ. (2) Supporting development and implementation of the research projects in reproductive health focusing on social determinants of health.
50	4	OPO	III.7	Member States have adapted and implemented tools for accelerating progress in achieving universal access to sexual and reproductive health.	(1) Technical advice in adaptation of tools for improving sexual and reproductive health. (2) Capacity building of national experts in implementation of tools and achieving universal access to quality sexual and reproductive health services. (3) Promoting lessons learnt and experience in Member States through Entre Nous magazine.
51	5	OPO	V.3	In times of acute and chronic crises, response and recovery actions (including health cluster coordination) mobilized and integrated into the multi-sector emergency response strategies of affected Member States [Response] (RER 5.7).	(1) Emergency response and recovery operations mobilized, including rapid health needs assessments and humanitarian Health Cluster coordination.
52	5	OPO	V.2	Member States are better equipped to establish effective partnership mechanisms for collaboration and capacity development in health emergency and disaster risk management.	(1) Regional and sub-regional partnerships for capacity development to manage health emergencies and disaster risk management are established (Public health and emergency management PHEM network), in line with WHO and UN norms and procedures, including the IHR procedures and requirements. (2) Regional monitoring of disaster risks and health emergency preparedness of MSs. (3) Regional network of disaster management and emergency medicine focal points established and maintained jointly with partners. (4) Technical support provided to MSs for preparing health systems for mass gathering events through WHO tools and expert advice. (5) Strengthened WHO institutional readiness through emergency procedures for the regional office, trained expert teams for rapid deployment and a regional emergency operations centre (EOC) as coordination and health information sharing hub.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
53	6	OPO	III.7	Gender responsive evidence-based policies and interventions promoting safer sex and tackling the social and individual consequences of unsafe sex adapted and implemented.	(1) Technical guidance on adaptation and implementation of gender responsive evidence-based policies and interventions promoting safer sex and tackling the social and individual consequences of unsafe sex including NCDs as per European NCD Action Plan. *Due to an undetected error in the planning the two Outcomes have the same outputs and should be considered as one. The Outputs that were foreseen under 54 are captured under Outcome 46*
54	6	OPO		Universal access to appropriate, evidence-based interventions for screening and clinical preventive services is facilitated by health systems.	
55	6	OPO	II.12	Member States have implemented drug dependence treatment including opioid substitution therapy based on WHO guidance.	(1) Continue current on assessment of country situation with focus on drug dependence treatment. (2) Technical guidance on opioid substitution therapy and expansion of existing service to all part of the country including penitentiary institutions.
56	6	OPO	II.12	Member States have implemented comprehensive health interventions within their prison system.	(1) Give guidance to Member States on prison health issues with focus on illicit drugs, mental health, and communicable diseases. (2) Facilitate the role of the public health system to take responsibility of prison health and secure close links to the civil system. (3) Annual meetings with Member States and international partners to exchange best practice. (4) Relevant publications on prison health issues including an update of the prison health guide and on prison health stewardship.
57	6	OPO	II.4, 5, 7, 9	Member States have strengthened the capacity of their health workforce with a focus in the Primary Health Care sector in the areas of diet and physical activity to deliver evidence based interventions according to the European Charter on Counteracting Obesity, the Food and Nutrition Policy Action Plan and the Action Plan for the Implementation of the European Strategy on Noncommunicable Diseases.	(1) Policy summary on ensuring nutrition as an integral part of PHC. Report on effectiveness of nutrition and physical activity related interventions in the PHC setting. (2) Web-based training package aimed at policy makers for the development of nutrition and physical activity programmes for PHC in line with the Alma-Ata Declaration. (3) Cost-effectiveness study on the provision of nutrition advice in the primary care settings with a focus on equity.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
58	6	OPO	II.3	WHO FCTC ratified by remaining non-ratified countries.	(1) Assessment report on policies and legislation in place vs. WHO FCTC obligations, incl. recommendations on the improvement of the legal framework for WHO FCTC ratification and start of its implementation (2) Political support and technical advice to facilitate the ratification process and start of treaty implementation. (3) Policy tools adopted for evaluation of programmes and policies with special attention on taxation and marketing policies
59	6	OPO	II.3	Member States have established or strengthened National surveillance systems of tobacco consumption and exposure to tobacco smoke built on sustainability, standardization and comparability across countries and use data for policy making in line with the WHO FCTC.	(1) Capacity building and technical support to implement youth and adult surveys in countries. (2) Capacity building and technical support to use survey data for evidence based policy making in line with WHO FCTC. (3) Developing a tobacco control database as part of the integrated NCD surveillance system.
60	6	OPO	II.2	Member States have established national alcohol surveillance systems that are built on sustainability, standardization and comparability across Member States and use data for the European Alcohol Information System on Alcohol and Health.	(1) Capacity building ant technical support to MS and yearly national counterpart meetings to discuss monitoring and evaluation. (2) Collect data from MS in 2012 by using the European Survey on alcohol. (3) Include data in the European Information System for Alcohol and Health. (4) Use survey results for policy making by producing reports including a European Status report on alcohol and health in 2013.
61	6	OPO	II.5 & III.8, 10	Multisectoral health and wellbeing strategies and plans developed and capacity for health promotion and health equity strengthened at the local level in Member States in line with Health 2020 principles and approaches. Completion of Phase V of the Healthy Cities Programme.	(1) Development of guidance and tools on local/urban health leadership, health literacy, equity, healthy ageing and healthy urban planning. (2) Ensuring local governments input in the development of Health 2020. (3) Strategic management and leadership of WHO healthy cities networks and organizing annual Healthy cities conference. (4) Expanding healthy cities in countries of the Region that are not currently involved Members of the network. (5) Evaluation of Phase V (2009–2013) WHO Healthy Cities Network. (6) Participation and support of 2012 WHD European and global activities

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
62	7	OPO	III.10	Improved capacity and uptake for governance for action on the social determinants of health and health inequities within the Health 2020 Policy Framework and consistent to WHA 62.14.	(1) Normative guidance, analytical tools, evidence syntheses/policy briefs to support MS to implement/ review multi-stakeholder approaches to addressing SDH & health equity. (2) Capacity Building Programme to strengthen know how and skills to implement whole of government and society approaches to SDH/ Equity. Including exchange of promising practices and innovations in policy formulation, investment, delivery and accountability for health equity. (3) Normative guidance on incorporating a gender, SDH, human rights, equity focus into health systems, PH programmes & development agendas.
63	7	OPO	III.10	Member States systematically use analyses of social & economic determinants and health inequalities to inform the development, implementation, monitoring and evaluation of health policies & programmes.	(1) Guidance for Member States on collecting and assessing evidence on social determinants and equity including gender. (2) Capacity building programme for systematic use of disaggregated data and diverse methods and approaches: 2.1 Intercountry mixed-methods 5 day workshop (using 2009 KISH event as model). (2.2) Targeted technical assistance for country-specific products (2.3) Capacity building workshops (as requested and appropriate) on use of specific tools and approaches such as equity focused Health Impact Assessment and or linked to ICP/multi-country work as part of the SDH/Equity Solutions lab. NB: For Outputs 2.2–2.3 these will tailored to each country context where CS mode.
64	7	OPO	III.11	Greater capacity and commitment in Member States to apply a gender approach in the development and implementation of health policies and programmes, as per WHA Resolution 60.25.	(1) Evidence on the impact of gender inequities in health produced & disseminated: policy briefs, fact sheets, thematic reviews. (2) Capacity of WHO staff built on translating evidence and guidelines into policy and action. (3) Technical input into EURO main regional initiatives on gender equity. (4) Capacity building for MS on how to translate evidence & guidelines on gender inequities into policy & action (training, technical advice and adaptation of tools). (5) Strengthen the network of national focal points. (6) Monitoring the implementation of the WHO gender strategy.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
65	7	OPO	III.10 11	Greater capacity and commitment in Member States to apply a human rights-based approach in the development and implementation of health policies, plans and programmes, including a specific focus on populations experiencing poverty and social exclusion.	(1) Adaptation of HQ developed analytical tool for piloting in EURO MS. (2).Develop EURO-specific information and training material on human rights and health and the HRBA to development. (3) Support technical units and country offices in their work with MS on health rights-related aspects. (4)Targeted support to technical units and country offices on non-discrimination issues, in particularly in the context of women's, migrant and Roma health. (5) Participation in joint collaboration efforts with strategic partners on improving the adherence and enjoyment of health rights in Europe.
66	8	OPO	III.8	Evidence-based strategies and WHO norms and guidelines addressing main environmental health risk factors (air and water pollution, noise, chemicals) adopted in the MS.	(1) Guidelines on noise and housing, water and sanitation, environmental health risks prepared all in line with WHO norms and standards. (2) Monitor through Environment and Health Information System (ENHIS). (3) Assessment of the evidence of the health impacts of environmental determinants and risk factors such as air pollution, asbestos, industrial contamination and waste. (4) Policy and strategic guidance to Member States for evidence based national actions.
67	8	OPO	III.8	Inequalities in environmental health risks identified and addressed by national policies/actions.	(1) Assessment of international and country-specific inequalities in Environment and Health (EH) risks. (2) Review of approaches and policies for the reduction of inequalities in EH risks. (3) Identification and analysis of case studies of environmental health inequalities and environmental justice, including addressing the economic dimension and cost of inaction. (4) Normative and policy guidance provided to Member States for addressing inequalities.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
68	8	OPO	III.8	Capacities, tools and resources enhanced in Member States for addressing environmental health security and emerging risks.	(1) Development of training material, technical guidance and expert networks to provide enhanced support for environment and health risk assessment according to WHO and other relevant norms and standards. (2) Development of a WHO position on nanotechnology and health. (3) Development of a WHO position on energy and health. (4) Development of national and sub regional programs addressing occupational health policies and selected occupational risks.
69	8	OPO	III.8	Intersectoral approaches to addressing environmental determinants of health implemented in Member States (e.g. in transport, built environment, workplaces).	(1) Member States supported to fulfil their obligations under legally-binding multilateral agreements related to the sustainable water management and the protection and promotion of human health through different exposure routes. (2) Development of technical guidance, tools, evidence and good practices in for addressing health issues through transport and urban development policies. (3) Policy guidance and recommendations on the implementation of HIA (health in impact assessment) and engagement of the health authorities in sectoral policies in MSs, including through the implementation of legal instruments such as Environment and Strategic Impact Assessments.
70	8	OPO	III.8	Prevention of health effects of climate change and other global changes and extreme events enhanced and sustainable public health measures and green developments promoted in Member States.	(1) Partnerships: UN European climate change and SD partnership, in collaboration with HQ (e.g. social dimension). EU adaptation Clearinghouse (with EC/EEA). EEA. WMO and others. (2) Tools and methods for low carbon health care. Health impact assessment of climate change. Economic damage and adaptation costs. National health adaptation strategy development. Development of health action plans and flood and cold wave prevention. Run simulation exercises. Linking climate change with infectious diseases. (3) Country adaptation pilot projects. (4) Research and innovation (5) Information platform. (6) Capacity development and training workshops in countries.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
71	9	OPO	V.7 & III.8	Strengthened systems for surveillance, prevention and control of food-borne diseases and food hazards in the MS.	(1) Support the development of national intersectoral (PH, agriculture, veterinary sector) food safety systems that have a whole-food chain and risk-based approach. (2) Support the strengthening of national surveillance systems for food-borne disease and contamination in the food chain. (3) Promote and support MSs' participation in Codex activities. (4) Support the strengthening of alert & response systems for food safety emergencies in the MSs and provide technical support to the countries at times of food safety emergencies, in line with WHO and other relevant norms and standards and in partnership with other relevant regional organizations. (5) Support the strengthening of food safety risk communication in MSs. (6) Food safety aspects included in national approaches to address and contain antibiotic resistance.
72	9	OPO	II.9	Member States develop, implement and evaluate intersectoral strategies for the substantial reduction of under nutrition concurring for the progressive elimination of stunting in the Region.	(1) National Plans for the reduction/elimination of stunting interacting with policies to alleviate inequity. (2) National intersectoral coordination mechanisms in place. (3) Technical Assistance to Member States for the implementation of the National Plans. (4) Policy summary & scientific review produced to support evidence-based actions.
73	10	OPO	IV.1	Member States have strengthened their institutional capacity to coordinate donor assistance and promote integrated systemic approaches to health systems strengthening.	(1) Analytical guidance on development of SWAPs for strengthening government capacity and leadership, harmonization/alignment around NHP budget, monitoring framework, joint reviews, dialogue mechanisms increased use of GVT systems by external partners. (2) Analytical reports/guidance on JANS, IHP and utilizing the health system funding platform (HSFP). (3) TA to GF HSS applications, Seminar on HSS and GF for WHO staff and consultants, Cooperation on development of tools for HS assessments. (4) Production of analytical reports and guidance on strengthening synergies between disease program.

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
74	10	OPO	IV.5	Member States have strengthened their institutional capacity to gather and assess evidence, and formulate, implement and evaluate, evidence- informed policies to improve the performance of primary health care services, with a particular focus on the prevention and management of non-communicable diseases.	(1) Guidance reports developed to assist MSs to design and implement evidence-informed policies in primary care. (2) Platforms provided to enable experience sharing, international comparisons, synthesis of experiences and translation of global and regional initiatives in primary health care into national context. (3) Technical contributions made to strategic partnerships in primary health care at global, regional and national level. (4) Indicators and benchmarks developed and piloted for assessing PHC performance vis-à-vis PH priorities.
75	10	OPO	IV.3	Member States have improved their reporting on national health accounts (NHA) and strengthened their capacity to generate evidence on resource flows, the costs and effects of interventions, equity in the finance and receipt of health services, and the extent and distribution of catastrophic and impoverishing levels of health spending.	(1) New version of the System of Health Accounts finalized and agreed with international counterparts for standards on international reporting. (2) Capacity building support to MSs through NHA regional and sub-regional networks, which provides the platform to share experience and improve data collection and health expenditure estimates. (3) Technical support to countries in conducting analysis on (i) catastrophic and impoverishing expenditure on health, (ii) equity in the finance and delivery of services, (iii) cost-effectiveness of interventions.
76	10	OPO	IV.3	Member States have strengthened their capacity to gather and assess evidence, and formulate, implement and evaluate, evidence-informed health system financing policies to improve and sustain financial risk protection, equity in finance and the distribution of resources and services, access to care, efficiency, and transparency.	(1) Training courses in health financing policy and health system strengthening with a focus on the follow-up to WHR2010 and the new DSP strategy. (2) Technical briefs to document good practices in health system strengthening (and health financing in particular) to support experience sharing through the Knowledge, Experience and Expertise Bank, expertise Bank process and technical policy briefs

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
77	10	OPO	IV.8	Member States have strengthened their knowledge base on the health workforce at the country, regional and international levels.	(1) Technical consultations and capacity building on Joint data collection on HRH (incl. validation, meta data analysis, etc). (2) Technical consultations and guidance on HRH information systems and HRH Observatories. (3) WHO tools for monitoring and evaluation of HRH. (4) Updated country profiles on HRH. (5) Min data set and guidance for monitoring health workforce migration to be used by Member States. (6) Networks of national focal points, experts and WHO CCs maintained. (7) Publications: production, translation and dissemination.
78	10	OPO	IV.8	Member States have strengthened their capacity to monitor and analyse health workforce dynamics, and to formulate, implement and evaluate evidence- informed health workforce policies, strategies, and plans.	(1) Regional HRH Strategy, with a supporting package of relevant WHO tools, guidelines for the implementation of the WHO Global Code of Practice, developed. (2) Building sub-regional, regional and inter-regional platforms and other mechanisms for shared learning, research and capacity building (technical consultation, multi-stakeholders policy dialogues). (3) WHO evidence-based tools for improving the quality of health professionals' education, including accreditation system, to be used by Member States, including recommendations on transformative scale up education. (4) Technical guidance and advocacy to strengthen nursing and midwifery at country and regional levels. (5) Publications (develop, translate and disseminate). (6) Partnerships and technical networks.
79	10	OPO	IV.5	Member States have enhanced the quality and safety of health care services, through an integrated approach that focuses on the patient, the provider and the service.	(1) Technical support to implementing interventions for patient safety and quality of care at various levels of health services across the Region. (2) Tools to improve quality of care delivery, service satisfaction and reduction of health care related adverse events . (3) Capacity building of sub-regional networks through dedicated sub-regional health centres (blood safety, transplant safety, quality of care and patient safety).

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
80	10	OPO	IV.1, 2	Member States utilize the information and analytical products provided by EURO to Member States for planning, monitoring and evaluation of health situation and inequalities at country level.	(1) A Health Info Strategy for WHO and MS developed and presented at the RC62. (2) Biannually updated quality EURO health information DB's (HFA family) available for situation and trend analyses to support policy decision making in MS and WHO. (3) Improved content, functionality and display capabilities of HFA DB systems to increase their use. (4) Enhanced analytical outputs, including reports and other dissemination and communication products based on HFA DBs.
81	10	OPO	IV.1	Member States utilize Knowledge Management methods and tools for the collection, storage and dissemination of their information.	(1) Development of EURO Knowledge Management Strategy and development of guidance for countries on e-health.
82	10	OPO	IV.1	Member States will use (i) evidence on their own and other health systems. (ii) thematic and comparative evidence on key themes. (iii) Evidence on comparative performance. (iv) ongoing evidence updates and dissemination tools to mobilize and "translate" evidence to their own context. to assess and evaluate policy options. to support better decision making. and to strengthen reform processes.	(1) Country monitoring - series of HiT profiles, pilot on-line updating. (2) Analysis - key studies, case studies and policy briefs reviewing and generating evidence on policy relevant issues. (3) Performance assessment - analysis on the policy uses and abuses of data and a series of domain reports and methodological papers. (4) Dissemination - tools to transfer knowledge whether in print (briefs, summaries, articles). face to face (policy dialogues, presentations). or electronic (web).
83				Merged into Outcome 82.	
84				Merged into Outcome 82.	
85				Merged into Outcome 82.	

Out-come	SO	Type	Cat. 2014–2015	2012–2013 EURO outcome portfolio	2012–2013 EURO output portfolio
86	11	OPO	IV.9	Member States have improved capacity in regulation and quality assurance for medical products (medicines, vaccines, blood products) and technologies.	(1) Assessment, technical guidance and capacity building on the regulation of medical products and technologies. (2) Technical support for implementation of Medicines Prequalification programme. (3) Capacity building for quality improvement of blood services and clinical transfusion practice. (4) Dissemination to and adoption of vaccine related norms and standards by national regulatory authorities. (5) Support for national policies for injection safety and health care waste management.
87	11	OPO	IV.11	Member States have improved capacity and developed policies for the rational use of medical products (medicines, vaccines, blood products) and technologies.	(1) Technical guidance, tools and networking on improving prescribing and use of medicines, including on antibiotics (2) Capacity building and technical guidance on HTA for better use of medicines and technologies. (3) Promoting best practices in management of clinical technologies, including blood and transplant safety.

List of abbreviations

AC	Assessed contributions. These are the financial amounts that all Member States are obliged to contribute, based on an assessment key determined by the United Nations. When the World Health Assembly passes the appropriation resolution, it decides how AC funds should be used – for the current and previous Programme Budget, the 13 Strategic Objectives (SOs) were the appropriation sections for these funds.
AMR	Antimicrobial Resistance
BASE	Base programme segment of the budget. WHO has exclusive strategic and operational control over the activities concerned, and over the choice of means, location and timing of implementation. The Organization can ensure a balanced growth across the different strategic objectives, reflecting overall health priorities, and an even distribution across major offices.
BCA	Biennial Collaborative Agreement
CBO	Community-based organization
CCS	Country Collaboration Strategies
CF	Core functions of the WHO
CF1	Providing leadership on matters critical to health and engaging in partnerships where joint action is needed
CF2	Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge
CF3	Setting norms and standards, and promoting and monitoring their implementation
CF4	Articulating ethical and evidence-based policy options
CF5	Providing technical support, catalysing change and building sustainable institutional capacity
CF6	Monitoring the health situation and assessing health trends
CIS	Commonwealth of Independent States
CISID	Centralized information system for infectious diseases
CTF	Codex Trust Fund (food safety)
CVCA	Core voluntary contributions account. This is a mechanism to receive, allocate and manage resources that are provided to WHO from donors and which are flexible at Programme Budget (across SO1-11) or SO level.
DALY	Disability-adjusted life year

DG SANCO	European Commission Directorate General for Health and Consumers
EARS-Net Database	An interactive database that provides information on the occurrence and spread of antimicrobial resistance in Europe
EC	European Commission
ECDC	European Centre for Disease Prevention and Control
EEA	European economic area
EFSA	European Food Safety Authority
EHEC	Enterohaemorrhagic E. coli is a bacterium that can cause severe food-borne disease.
EMRO	WHO Regional Office for the Eastern Mediterranean
EOC	Emergency operations centre
EURO	WHO Regional Office for Europe
EVIPNet	Evidence-informed policy-making network
FAO	Food and Agriculture Organization of the United Nations
FCTC	WHO Framework Convention for Tobacco Control
Flu Surv	Influenza surveillance
GAVI	The GAVI Alliance (formerly the “Global Alliance for Vaccines and Immunization”) is a public-private global health partnership committed to saving children’s lives and protecting people’s health by increasing access to immunization in poor countries.
GDO	Geographically dispersed office
GF	The Global fund to Fight AIDS, Tuberculosis and Malaria
GPW12	WHO General Programme of Work for the period 2014–2019
GSM	Global Management System
Health 2020	New European framework strategy for health and well-being
HEN	European Health Evidence Network
HFA	Health for All
HFA DBs	Health for All Databases
HiTs	Health Systems in Transition

HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
HRBA	Human rights-based approach
HRH	Human resources for health
HRP	United Nations Development Programme/ United Nations Population Fund/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction
HSFP	Health Systems Funding Platform (of the GAVI Alliance)
HSS	Health systems and services
ICD	International Classification of Diseases
ICP	Intercountry programme. This is a means of delivering technical assistance to countries
IHP	International Health Partnership
IHR	International Health Regulations
ILI	Influenza-like illness
IMCI	Integrated management of childhood illnesses
JANS	Joint Assessment of National Health Strategies and Plans
KPO	Key Priority Outcome. These are outcomes in the Regional Office's outcome portfolio, which are given particular attention in terms of monitoring, management, and resourcing
LRTAP	Convention on Long-range Transboundary Air Pollution
M/XDR-TB	Multi and extensively drug-resistance tuberculosis
MAL	Malaria
MC	Multicountry - a mode of delivering technical assistance to countries
MDGs	Millennium Development Goals (Eight United Nations development targets to be achieved by 2015)
MDG1	Eradicate extreme poverty and hunger
MDG2	Achieve universal primary education
MDG3	Promote gender equality and empower women
MDG4	Reduce child mortality
MDG5	Improve maternal health

MDG 6	Combat HIV/AIDS, malaria and other diseases
MDG7	Ensure environmental sustainability
MDG8	Develop a global partnership for development
MDR TB	Multi-drug resistant tuberculosis
MEA	Multilateral environmental agreements
mhGAP	Mental Health Gap Action Programme
MNH	Mental health
MPOWER	Measures, set out in the WHO FCTC, to assist in country-level implementation of effective interventions to reduce the demand for tobacco
MS	Member State of WHO
MTSP	Medium-term Strategic Plan 2008–20013
NCD	Noncommunicable disease
NCD AP	Action Plan for the Global Strategy on the Prevention and Control of Noncommunicable Diseases
NGO	Nongovernmental organization
NHP	National health policy
NIS	Newly independent States
NTDs	Neglected tropical diseases
Nut	Nutrition
OCR	Outbreak and crisis response. These activities are governed by acute external events. The resource requirements are normally significant and difficult to predict and budgeting is therefore an uncertain process.
OECD	Organization for Economic Co-operation and Development
OIE	World Organization for Animal Health
OPO	Other Priority Outcome
OWER	Organization-wide Expected Results. These are part of the MTSP2008-2013 results chain
PA	Physical activity
PB	WHO biennial Programme Budget
PHC	Primary health care

PHEM	Public health and emergency management
PHS	Public health services
RC	WHO Regional Committee for Europe
SARI surv	Severe Acute Respiratory Infections surveillance
SCRC	Standing Committee of the WHO Regional Committee for Europe
SDH	Social Determinants of Health
SO	Strategic objectives, as set out in MTSP208-2009:
SO1	Communicable diseases
SO2	HIV/AIDS, Tuberculosis and Malaria
SO3	Chronic non communicable conditions
SO4	Child, adolescent, maternal, sexual and reproductive health, and ageing
SO5	Emergencies and disasters
SO7	Risk factors for health
SO8	Healthier environment
SO9	Nutrition and food safety
SO10	Health systems and services
SO11	Medical products and technologies
SO12	WHO leadership, governance and partnerships
SO13	Enabling and support functions
SO13bis	The part of SO13 that is financed through the post-occupancy charge, which is included as a programme direct cost within all strategic objectives and appears in work plans as an integral component of the standard staff cost. These costs are separated out and explicitly shown in Annex 1 of the PB2012-2013. This is done in order to avoid double accounting.
SPA	Special programmes and collaborative arrangements. These are activities that are fully within WHO's results hierarchy and over which WHO has executive authority. The activities in this budget segment, however, are undertaken in collaboration with partners and thus the magnitude of associated operations is determined by the special nature of the activity and the joint strategic decisions of the collaboration.
SWAPs	Sector-wide approaches
TB	Tuberculosis

TEACH-VIP	A comprehensive injury prevention and control curriculum
THE PEP	The Pan-European Programme on Transport and Health
UN	United Nations
UN City	Shared facilities for all UN organizations in Copenhagen. WHO will move into these new premises early 2013.
UNECE	United Nations Economic Commission for Europe
UNEP	United Nations Environment Programme
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
VCS	Specified Voluntary Contributions. Earmarked voluntary funding contributions with strict restrictions on use imposed by the donor.
VG	Vulnerable group
VIP	Violence and injury prevention
WB	World Bank
WHA	World Health Assembly
WHO	World Health Organization
WHO CC	WHO Collaborating Centre
WMO	World Meteorological Organization
WPV	Wild poliovirus