World Health
Organization

REGIONAL OFFICE FOR Europe

Draft Twelfth
WHO General Programme of Work

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…Health is a state of complete physical, mental and social well-being and

not merely the absence of disease or infirmity.

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

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

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

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

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

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

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

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

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

(CONSTITUTION OF THE WORLD HEALTH ORGANIZATION)

EXECUTIVE SUMMARY

To be added

DRAFT FOR DISCUSSION BY THE 2012 REGIONAL COMMITTEES

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

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

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

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[1] Document A65/5 Add.1.

World Health Organization

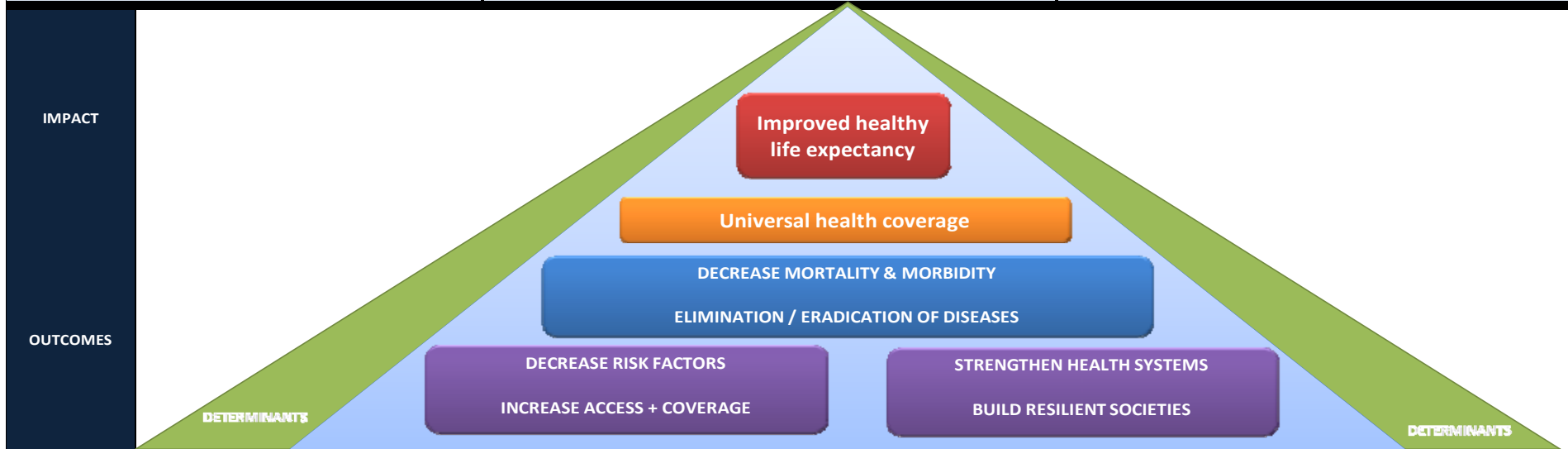## TWELFTH GENERAL PROGRAMME OF WORK 2014–2019 - DRAFT STRATEGIC OVERVIEW

MISSION

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

Principles, values and fundamental approaches

- Equity and social justice
- Global solidarity
- Gender equality
- Emphasis on countries and populations in greatest need
- Multilateralism
- Due consideration to the economic, social, and environmental determinants of health
- Science and evidence-based
- Public health approach

WHO's core functions

- Providing leadership
- Shaping the research agenda
- Setting norms and standards
- Articulating policy options
- Providing technical support and building capacity
- Monitoring and health trends

Criteria for priority-setting

- Current health situation
- Existence of evidence-based, cost-effective interventions
- Needs of countries for WHO support
- Internationally agreed instruments
- WHO's comparative advantage

IMPACT

Improved healthy life expectancy

OUTCOMES

Universal health coverage

DECREASE MORTALITY & MORBIDITY

ELIMINATION / ERADICATION OF DISEASES

DECREASE RISK FACTORS

INCREASE ACCESS + COVERAGE

STRENGTHEN HEALTH SYSTEMS

BUILD RESILIENT SOCIETIES

DETERMINANTS

DETERMINANTS

CATEGORIES & PRIORITIES

Communicable diseases	Noncommunicable diseases	Promoting health through the life course	Health systems	Preparedness, surveillance and response
• HIV/AIDS; tuberculosis; malaria • Neglected tropical diseases (including vector-borne diseases) • Vaccine-preventable diseases	• Heart disease, cancers, chronic lung diseases, diabetes (and their major risk factors tobacco use, unhealthy diet, physical inactivity, harmful use of alcohol) • Mental health • Violence and Injuries • Disabilities (including blindness and deafness), and rehabilitation • Nutrition	• Maternal and newborn health • Adolescent sexual and reproductive health • Child health • Women's health • Healthy ageing and health of the elderly • Gender and human rights mainstreaming • Health and the environment • Social determinants of health	• National health policies, strategies, and plans • Integrated people-centred services • Regulation and access to medical products	• Alert and response capacities • Emergency risk and crisis management • Epidemic- and pandemic-prone diseases • Food safety • Polio eradication

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CORPORATE SERVICES

- Leadership in health
- Country presence
- Management and administration
- Governance and convening
- Strategic policy, planning, management and resource coordination
- Strategic communications
- Knowledge management
- Accountability and risk management

CHAPTER 1

SETTING THE SCENE

New political, economic, social and environmental realities

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

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

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

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

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

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

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

- A continuing economic downturn with consequent decreases in public spending has implications for all countries. At a macroeconomic level, austerity and low demand in the OECD countries may have an impact on growth worldwide. Reductions in public spending risk creating a vicious cycle with a negative impact on basic services, low health and educational attainment and high youth unemployment. At the opposite end of the age spectrum, those retiring from work face the spectre of impoverishment and ill health in old age.

- By 2050, 70% of the world's population will live in cities. Rapid unplanned urbanization is a reality, particularly in low-income countries and emerging economies. Urbanization brings opportunities for the provision of health services and the promotion of health, but also carries direct threats and significant risks of exclusion and inequity. It also brings into play new institutional actors – most notably powerful city administrations with resources that can be tapped for better health. While migration between countries can offer benefits to both the countries from which migrants leave and to those to which they migrate, this is by no means guaranteed and many migrants are exposed to increased health risks in their search for economic opportunity.

- Falling fertility in many developing countries and the demographic dividend that accrues from a larger working population in proportion to the very young and very old has boosted economic growth in many parts of the world. For many countries this presents a vital opportunity, particularly in relation to adolescent health. Real potential to fuel the engine of growth for the future will be lost in the absence of efforts to increase youth employment. Recent events in different parts of the world have shown how chronic unemployment combined with a lack of economic and political rights and any form of social protection can link to outrage and uprising. More broadly, the long-term impact of the economic downturn in both rich and poor countries puts the social contract between governments and their citizens under ever-increasing pressure.

- The global environment is equally under pressure. Key planetary boundaries (such as loss of biodiversity) have been surpassed; and others soon will be. In many parts of the world, climate change will increasingly jeopardize the fundamental requirements for health, including clean urban air, safe and sufficient drinking-water, a secure and nutritious food supply, and adequate shelter. Competition for scarce natural resources will increase. Most people and governments accept the scientific case for sustainable development. They recognize too that health contributes to its achievement, benefits from robust environmental policies and is one of the most effective ways of measuring progress. Nevertheless, progress at global and national level in creating institutions and policies that are better able to ensure a more coherent approach to social, environmental and economic policy has been disappointingly slow.

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

A changing agenda for global health

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

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

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

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

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

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

Unfinished business

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

Innovation and technology

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

Health care systems: financial sustainability

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

Health care systems: ensuring access

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

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

Preparing for the unexpected

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

The institutional landscape for global health

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

The changing role of ministries of health

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

Health and the global agenda

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

Global goals post-2015

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

Engagement with other stakeholders

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

More effective development support

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

Health and security

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

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

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

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

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

CHAPTER 2

THE ROLE OF WHO

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

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

Enduring principles, values and approaches

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

Box 1. Constitution of the World Health Organization: principles

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
>
> The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.
>
> The health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest cooperation of individuals and States.
>
> The achievement of any State in the promotion and protection of health is of value to all.
>
> Unequal development in different countries in the promotion of health and control of diseases, especially communicable disease, is a common danger.
>
> Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.
>
> The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.
>
> Informed opinion and active cooperation on the part of the public are of utmost importance in the improvement of the health of the people.
>
> Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

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

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

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

- In line with the principle of equity and social justice, WHO will continue to give emphasis where needs are greatest. Whilst WHO's work will continue to be relevant to all Member States, the Organization sees health as being central to poverty reduction. The analysis in Chapter 1 points to the fact that the greatest absolute number of poor people are now citizens of middle-income and emerging economies. The focus is therefore not only on countries, but on poor populations within countries.

- WHO is and will remain a science and evidence-based Organization with a focus on public health. The environment in which WHO operates is becoming ever more complex; however WHO's legitimacy and technical authority lies in its rigorous adherence to the systematic use of evidence as the basis for all policies. This also underpins WHO's core function of monitoring health trends and determinants at global, regional and country level.

- The review of health governance issues points to the need for negotiated solutions to shared international health problems, particularly in instances of interaction between health and other sectoral interests (such as trade, migration, security and intellectual property). In addition, the capacity to convene and facilitate the negotiation of binding international agreements distinguishes WHO from most other health actors. A commitment to multilateralism remains a core element of WHO's work .

- WHO will continue to be both a normative agency that produces a range of guidelines, norms and standards that benefit countries collectively, as well as a provider of technical support to individual Member States.

- As a public health agency, WHO continues to be concerned not with the purely medical aspects of illness, but with the promotion of health as a positive outcome of all policies.

A strategic response to a changing environment

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

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[1] The Political Declaration at the World Conference identified five action areas in which WHO was requested to support Member States:
1. Improved governance for health and development
2. Participation in policy-making and implementation.
3. Reorientation of the health sector towards promoting health and reducing health inequities.
4. Global Governance and collaboration.
5. Monitoring progress and increasing accountability

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

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

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

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

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

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

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

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

CHAPTER 3

PRIORITIES 2014–2019

Introduction

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

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

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

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

CRITERIA FOR PRIORITY SETTING AND PROGRAMMES IN WHO

1. The current health situation including: demographic and epidemiological trends and changes, urgent, emerging and neglected health issues; taking into account the burden of disease at the global, regional and/or country levels.

2. Needs of individual countries for WHO support as articulated, where available, through the country cooperation strategy, as well as national health and development plans.

3. Internationally agreed instruments which involve or impact health such as declarations and agreements, as well as resolutions, decisions and other documents adopted by WHO's governing bodies at the global and regional levels.

4. The existence of evidence-based, cost-effective interventions and the potential for using knowledge, science and technology for improving health.

5. The comparative advantage of WHO, including:
(a) capacity to develop evidence in response to current and emerging health issues;
(b) ability to contribute to capacity building;
(c) capacity to respond to changing needs based on ongoing assessment of performance;
(d) potential to work with other sectors, organizations, and stakeholders to have a significant impact on health.

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

- HIV/AIDS
- Tuberculosis
- Malaria
- Neglected tropical diseases
- Vaccine-preventable diseases

- Heart disease, cancers, chronic lung diseases, diabetes (and their major risk factors: tobacco use, unhealthy diet, physical inactivity, and harmful use of alcohol)
- Mental health
- Violence and injuries
- Disabilities (including blindness and deafness) and rehabilitation
- Nutrition

- Maternal and newborn health
- Adolescent sexual and reproductive health
- Child health
- Women's health
- Healthy ageing and health of the elderly
- Gender and human rights mainstreaming
- Health and the environment
- Social determinants of health

- National health policies, strategies, and plans
- Integrated people-centred services
- Regulation and access to medical products

- Alert and response capacities
- Emergency risk and crisis management
- Epidemic- and pandemic-prone diseases
- Food safety
- Polio eradication

Categories

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

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

- **Category 1: Communicable diseases** includes a *limited* number of communicable diseases, specifically HIV, tuberculosis, malaria and vaccine-preventable diseases. Cancers and other chronic diseases caused by or associated with viruses are included in category 2, sexually transmitted diseases in category 3 as part of sexual and reproductive health, and epidemic-prone communicable diseases in category 5.

- **Category 2: Noncommunicable diseases** and conditions covers *all* noncommunicable diseases and their associated risk factors and includes work on mental health, disabilities (including blindness and deafness from all causes), prevention of violence and injuries, and nutrition.

- **Category 3: Promoting health through the life-course** brings together strategies for promoting health and well-being throughout critical periods from conception to old age. It is concerned with health as an outcome of all policies and with health and the environment, and includes leadership, and mainstreaming and capacity building on the social determinants of health, gender and human rights.

- **Category 4** covers all the main building blocks of health systems: service delivery, human resources, financing, information systems, medical products, vaccines and technologies, and leadership and governance as well as health systems research.

- **Category 5: Preparedness, alert and response** covers the health response to acute and chronic events with public health significance caused by disease outbreaks, antimicrobial resistance, environmental threats, natural disasters and conflict. It includes all elements of emergency risk management: prevention, preparedness, surveillance, response and early recovery. In terms of specific diseases, the category includes polio; a range of diseases with the potential to cause outbreaks, epidemics or pandemics (such as influenza, several zoonoses, viral encephalitis and hepatitis) and food-borne diseases.

Cross-cutting priorities

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

Social determinants of health

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

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

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

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

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

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

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

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

[2] The Oslo Ministerial Declaration (2007).

Priorities

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

HIV

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

Tuberculosis

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

Malaria

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

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

Neglected tropical diseases

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

The road map for accelerating work to overcome the impact of neglected tropical diseases[1] sets out a detailed timetable for the control and, where appropriate, elimination and eradication of the 17 specific diseases in this group. Over the next six years, partnerships with manufacturers will be important in maintaining drug supplies, although in the longer-term there will need to be a shift from donation to generic manufacture. Sustaining the current momentum for addressing these diseases requires not only commodities and financing but also political support. In this regard, neglected tropical diseases cannot be seen as a health issue alone. They are inextricably linked with health as a human right, with poverty reduction and with effective governance.

Vaccine-preventable diseases

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

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

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

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

The growing burden of **noncommunicable diseases** will have devastating health consequences for individuals, families and communities; it threatens to overwhelm health systems; and is inextricably linked to poverty reduction and economic development. WHO will focus primarily over the next six years on combating the four primary noncommunicable diseases[1] and their major risk factors.[2] Cited as one of the greatest overall global risks by the World Economic Forum, failure to act on noncommunicable diseases in the short-term will lead inexorably to massive cumulative output losses, estimated at about US$ 47 trillion by 2030, from the four primary noncommunicable diseases and mental health disorders alone.

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

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

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

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

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[1] Cardiovascular disease, cancers, chronic lung diseases, diabetes.
[2] Tobacco use, unhealthy diet, physical inactivity, and harmful use of alcohol.

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

Risk factors

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

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

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

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

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

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

Nutrition

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

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

Mental health

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

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

Violence and injuries

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

Disabilities and rehabilitation

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

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

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

Maternal and newborn health: the first 24 hours[1]

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

Adolescent sexual and reproductive health

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

Child health: ending preventable child deaths

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

Women's health

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

Healthy ageing and health of the elderly

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Emergency risk and crisis management

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

Epidemic- and pandemic-prone diseases

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

Food safety

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

Polio eradication

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

CHAPTER 4

ENABLING FUNCTIONS AND CORPORATE SERVICES

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

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

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

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

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

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

Leadership in health

WHO plays a leadership role in health governance and in influencing governance in other sectors in the interests of health through its interactions with a wide range of stakeholders at global, regional and country levels. These include United Nations funds, programmes and specialized agencies; other intergovernmental and parliamentary bodies; regional political and economic integration organizations; development banks and other providers of official development assistance; philanthropic foundations; a wide range of partnerships, with interests in global health, including those hosted by WHO; as well as civil society organizations and nongovernmental organizations, and selected private commercial organizations. In addition, work in this area is concerned with internal coordination, across all levels of the Organization, so that WHO can present consistent and cogent positions in support of global health. Finally, it covers the management, oversight and facilitation of partnerships that are hosted by WHO.

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

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

Strategic policy, planning, management and resource coordination
This component is about leadership of the Secretariat. It covers the role of the senior managers – through mechanisms such as the global policy group – in ensuring coherence, synergy and alignment between the different parts of the Secretariat, including the oversight and direction of WHO reform. It also encompasses strategic planning, budget management, performance assessment, resource

mobilization, and reporting at all three levels. Of particular importance is the development, negotiation and implementation of new approaches to financing designed to increase the predictability, flexibility and sustainability of WHO's financing.

Strategic communications

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

Knowledge management

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

Accountability and risk management

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

Management and administration

This component covers the core administrative services that underpin the effective and efficient functioning of WHO: finance, human resources, information technology, and operations support. It is a particular priority to ensure the adequacy of the financial control framework (as a specific aspect of risk management), such that expenditure is properly authorized and recorded, account record keeping is accurate, assets safeguarded and liabilities are correctly quantified, along with accurate and timely financial reporting. In a context of austerity in many donor countries, WHO needs to have systems in place that allow it to state, with confidence and on time, how all monies that have been invested in the Organization have been used and what their use has achieved.

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

CHAPTER 5

RESULTS CHAIN

Introduction

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

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

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

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

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

A third challenge is managerial. A budget structure based on mutually exclusive categories with links to organizational structure is required for the costing of outputs and for resource allocation across

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

Making a difference

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

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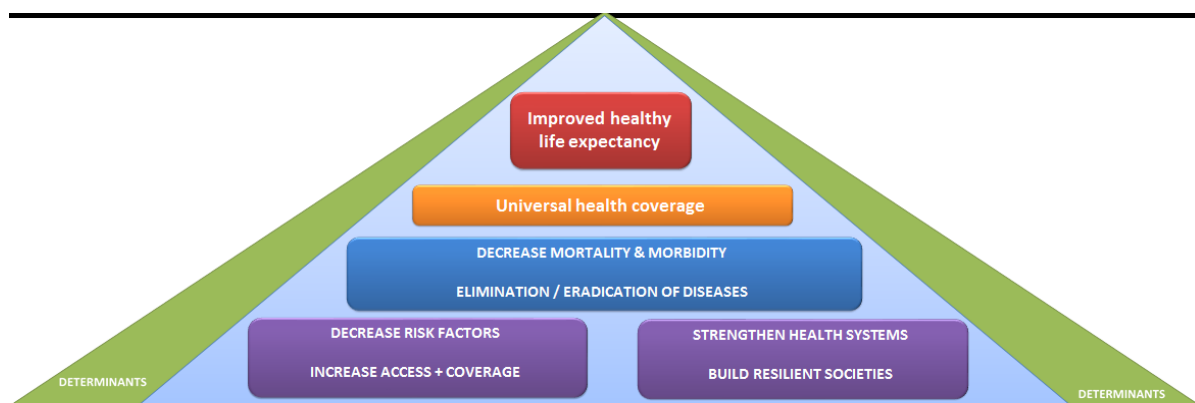
IMPACT

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

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

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

well as protecting increasing numbers of people from catastrophic financial consequences when they fall ill. Universal coverage maintains and improves health, but it also helps people escape from poverty and decreases inequity. It is therefore central to the work and the achievements of WHO.

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

Reducing mortality, morbidity, eradication and elimination of diseases

In addition to healthy life expectancy and universal health coverage, measures are needed to show the combined impact of work on overall rates of mortality and morbidity. In the case of noncommunicable disease an overall goal has been agreed (a 25% reduction in global mortality from noncommunicable between 2010 and 2025). For communicable diseases, reduction in child deaths is a good indicator of work in category 3 as well as of an overall reduction in these diseases. Some cause-specific measures of impact are also needed to measure progress. Finally, at this level some specific diseases are targeted for eradication or elimination within the period 2014–2019.[1]

- Reduction in **childhood mortality**… *post-Millennium Development Goal target/rate of reduction to be defined*

- Reduction in **maternal mortality**… *post-Millennium Development Goal target/rate of reduction to be defined*

- Progress toward 2025 global target of reducing **global mortality from noncommunicable diseases** – *rate of decline/target for 2019 to be defined*

- *Aggregate measures needed for **other noncommunicable conditions** such as mental health, disabilities, violence and injuries*

- Reduce overall number of **AIDS** deaths and reduce new pediatric HIV infections

- Reduction of global **tuberculosis** mortality rate in 2015 compared with 1990

- Reduce number of **malaria** deaths – *target to be defined*

- Aggregate measures needed to track reductions in **neglected tropical diseases**

- Complete the eradicate of poliomyelitis and dracunculiasis

- Elimination by 2015 of rabies in the Region of the Americas and of schistosomiasis in the Eastern Mediterranean Region;

- Elimination of measles, leprosy and neonatal tetanus globally.

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

OUTCOMES

Reduction of risk and access to services[1]

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

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

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

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

Health systems

- Number/proportion of Member States in which a **national intervention coverage index of core services** is improving

- Number/proportion of Member States that: (i) have a **national health sector strategy** with goals and targets; (ii) conduct an annual multi-stakeholder review; and (iii) produce a health sector performance assessment report to inform annual reviews

- Number/proportion of Member States in which the percentage of households with **catastrophic out of pocket expenditure**: (i) are below XX%; and (ii) where the percentage in the poorest quintile of households is not greater than in the richest quintile (*to be used in measuring progress on UHC*)

- Number/proportion of Member States in which the percentage **of households impoverished** due to paying out of pocket for health services is below XX%

- Number of Member States where payment of **health care providers is regulated**

- Number of Member States with appropriate **accreditation of service providers**

- Number of Member States implementing appropriate **regulatory oversight of medical products**

- Number of Member States with monitoring systems on **price and availability of medicines** and medical products

- Number of countries using **essential medicines list** updated in the last five years for public procurement and reimbursement

- Number of Member States that are implementing sectoral policies that prevent and/or mitigate **environmental and occupational risks**

- *TBD: indicator for health workforce*

- Number/proportion of Member States in which the coverage **of birth and death registration**, with reliable cause of death, is improving among Member States with coverage less than 90%

- Number of Member States with a **food safety programme** that has a legal framework and enforcement structure

- Number of countries with an increase in **mental health budget** as a proportion of health budget

- Proportion of countries with comprehensive **laws** addressing five key risk factors for **road safety**

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

- Number of Member States with an active **'Safe Hospital Programme'**

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

- *TBD - equity tracer indicator for women?*

Resilience

- Percentage of Member States with national **emergency risk management plans** that include epidemic and pandemic diseases.

- Number of Member States meeting and sustaining **International Health Regulations (2005) core capacities**.

- Number of Member States conducting or updating a **multi-hazard health emergency risk assessment** at least every two years.

- Percentage of Member States conducting a **national health emergency response exercise** at least every two years.

- Percentage of Member States delivering a basic package of **emergency** health services to affected populations within 10 days of a major emergency

Social, economic and environmental determinants

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

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

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

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

CHAPTER 6

RESOURCES

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