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Draft proposed WHO programme budget 2016–2017: the European Region's perspective

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Draft proposed WHO programme budget 2016–2017: the European Region's perspective

This paper elaborates the European Region's perspective on the global draft proposed WHO programme budget 2016–2017 (PB 2016–2017) and should thus be read in conjunction with document EUR/RC64/23.

The Regional Committee is invited to comment and advise on the strategic orientations presented and the budget proposed.

After approval of the final PB 2016–2017 by the World Health Assembly in May 2015, and on the basis of this regional perspective, a regional implementation plan for PB 2016–2017 will be presented to the 65th session of the Regional Committee in September 2015. The plan will include detailed outcomes and outputs, providing further means for accountability at the regional level and, hence, could be regarded as a new iteration of the "contract" between Member States and the Regional Office.

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Executive summary

1. The draft programme budget 2016–2017 (PB 2016–2017) in document EUR/RC64/23 is presented for consideration by all regional committees in 2014 in order to allow regional input into the programme priorities, results and deliverables proposed for the work of the Organization and the setting of budget levels by major office and category or programme area.

2. The European regional perspective on the global PB 2016–2017 is fully integrated into the global programme budget document. It includes greater detail and analysis of how the WHO Regional Office for Europe plans to implement PB 2016–2017, to be approved by the World Health Assembly in May 2015. Consideration of this document provides an opportunity for European Member States to give additional guidance on the planned work of the Regional Office in the next biennium.

3. The document describes the main process and outcome of the bottom-up planning exercise, which initially resulted in a budget greater than that of 2014–2015; this was subsequently reduced to the level of 2014–2015; US$ 218 million for base programmes. While the overall budget is the same as that for 2014–2015, its components and development process are fundamentally different from those of previous years. This includes significant shifts among categories and programme areas, which are described in this document. Given the instruction to reach a zero-growth budget, not all activities and programmes resulting from the bottom-up planning exercise could be accommodated, and some had to be dropped or postponed.

4. The document presents the technical content of the Regional Office's planned work for 2016–2017, including the country priorities established during bottom-up planning, specific regional orientations in each of global categories 1 to 6 and considerations in terms of resourcing the planned work in the Region.

5. After approval of the final PB 2016–2017 by the World Health Assembly in May 2015, a regional implementation plan for PB 2016–2017 will be presented to the 65th session of the Regional Committee (RC65) in September 2015. The plan will contain detailed outcomes and outputs, providing a further means for accountability at regional level, and hence could be regarded as a new iteration of the "contract" between Member States and the Regional Office. The first "contract" was established for the 2012–2013 biennium in document EUR/RC61/Inf.Doc/10, "The programme budget as a strategic tool for accountability: a proposed 2012–2013 pilot trial for WHO reform." Performance in realizing the terms of this contract is assessed in document EUR/RC64/18, "WHO Regional Office for Europe performance assessment report 2012–2013," and the lessons learnt in that biennium were considered in preparing the Regional Office's contribution to PB 2016–2017.

Developing the WHO programme budget 2016–2017: bottom-up planning in the context of WHO reform

6. PB 2016–2017 was developed in the context of WHO reform, which had a major impact on the planning process and its outcome. The results chain defined in the Twelfth General Programme of Work is used again in PB 2016–2017, with certain elements revised and improved on the basis of lessons learnt in 2014–2015 and 2012–2013. The objective of PB 2016–2017 is to present measurable objectives that accurately reflect the work of WHO's Secretariat and the impact of that work in the countries WHO serves.

7. Of potential consequence for PB 2016–2017 is the output of the global working group on strategic budget allocation, established at the 134th session of the Executive Board in January 2014. In order to clarify its mission, the working group has been renamed the strategic budget

space allocation working group. It is expected to present a draft proposal for a new allocation mechanism to the Executive Board in January 2015, which may inform the budget ceilings in PB 2016–2017. As this work is not yet completed, 2014–2015 figures were used to establish budget envelopes by major office.

8. The "financing dialogue", begun in 2012–2013 and continued into 2014–2015, strongly affects how PB 2016–2017 is formulated and implemented. The concept of a "fully funded programme budget" indicates that actual funding and implementation follow the plans set out in programme budgets much more closely, addressing the issue of "funding alignment", as frequently stated at past meetings of WHO governing bodies. While PB 2014–2015 is a "transition biennium" in this respect, it is expected that the groundwork laid in its preparation will result in much closer alignment of Member States' priorities in PB 2016–2017 and the actual work that will be funded through the financing dialogue.

9. Matrix management has been a challenge for WHO, as it has also been for many other large organizations, both public and private. Nonetheless, the latest attempt to use a matrix approach in planning as part of WHO reform – the category and programme area networks – was successful in the preparation of PB 2016–2017. These networks, composed of designated focal points at country, regional and global levels, have been a cornerstone in the development of globally coherent objectives. The Regional Office for Europe participated actively in the networks and benefited from them through an increased role in setting global objectives and by knowledge-sharing opportunities. It is expected that the networks will continue to play an important role in implementation, monitoring and reporting on PB 2016–2017.

10. Bottom-up planning was conducted in the European Region, as in all regions, on a very tight timeline during the months of April and May 2014. The process was built on existing planning resources, such as national health policies, strategies and plans, governing bodies' commitments, biennial collaborative agreements (BCAs) and operational plans for 2014–2015. The exercise was launched through a communication from the Regional Director to all Member States, seeking their collaboration and input in defining the priorities for WHO's work at country level during 2016–2017. The priorities were selected from among the programme areas in the Twelfth General Programme of Work.

11. Input was received from all 29 countries in the Region with BCAs, where the process was led by the WHO country representative, and from about one third (8/25) of countries without WHO representation (largely western European countries without BCAs). The bottom-up process involved, not only for countries but also for the Regional Office, intercountry programmes. The process overall could be considered successful in identifying country priorities and global and regional public goods.

12. For both regional and country work, the process required costing of human and financial resources required for each budget centre (country office or regional division). Thus, detailed costing formed an integral part of bottom-up planning. In line with the WHO reform, this is the first time that a global exercise has been conducted in preparation of the programme budget; in the past it had been done in the context of operational planning, well after the programme budget had been approved by the World Health Assembly.

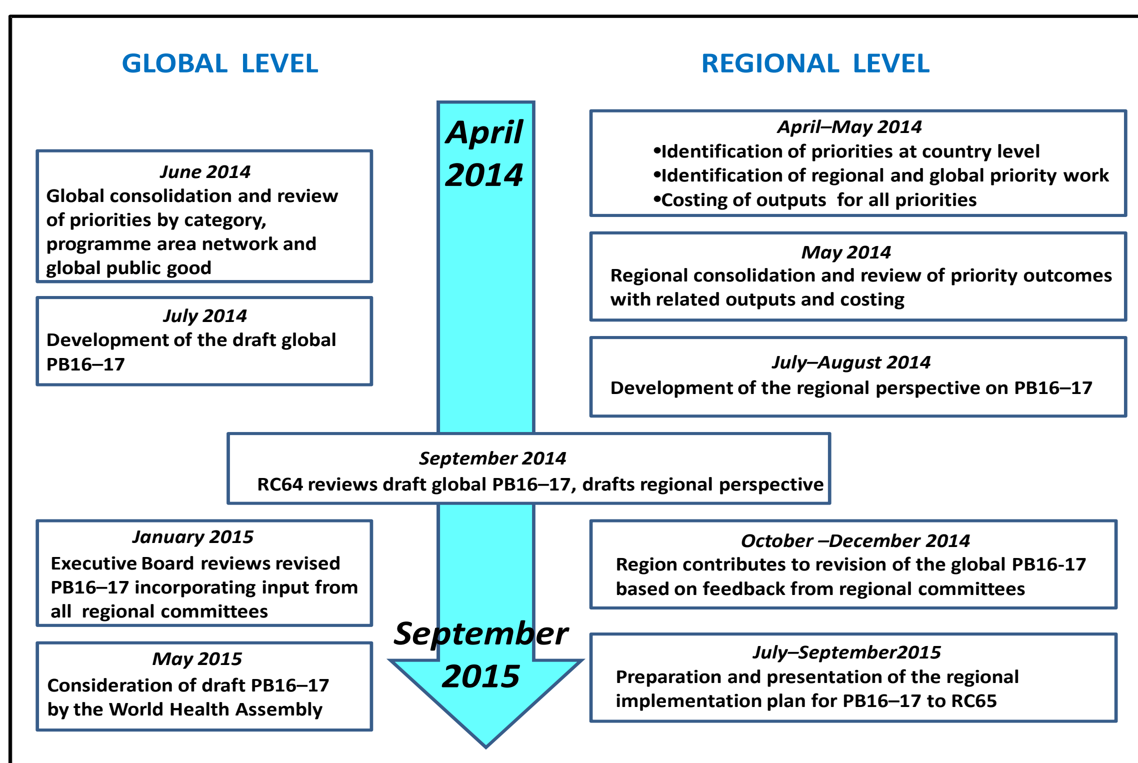
13. Preparation of PB 2016–2017 included the costing of existing commitments in the form of resolutions approved by both global and regional WHO governing bodies. For the global proposed PB 2016–2017, forecasting the full programmatic and budgetary implications of recent Health Assembly resolutions has yet to be completed, in particular for strengthening the regulation of medical products, for hepatitis and for antimicrobial resistance (resolutions WHA67.6, WHA67.20 and WHA67.25, respectively). At regional level, the budgetary implications of draft resolutions presented to the 64th session of the Regional Committee

(RC64) in documents EUR/RC64/11 Add.1, EUR/RC64/12 Add. 1, EUR/RC64/14 Add.1, EUR/RC64/15 Add.1 (totalling US$ 22.4 million) are considered in the proposed PB 2016–2017 for the Regional Office, as are previous governing bodies commitments. Further details of the costs of resolutions will be presented in 2015.

14. The results of the bottom-up exercise in the Regional Office for Europe were collated for strategic review at regional level prior to submission at global level. The review determined that the Regional Office should shift its budget so that a minimum of 40% is allocated to country level. This budget distribution contrasts with that resulting from the bottom-up process, which followed the historical proportion of 27–28% going to country level. The shift is due to a high-level strategic orientation to strengthen country-level work in the Region.

15. This document is the next step in the process of developing the European Region's portion of the programme budget. Fig. 1 below depicts the entire process.

Fig.1. Development of the global PB 2016–2017 from the European perspective



Country priorities

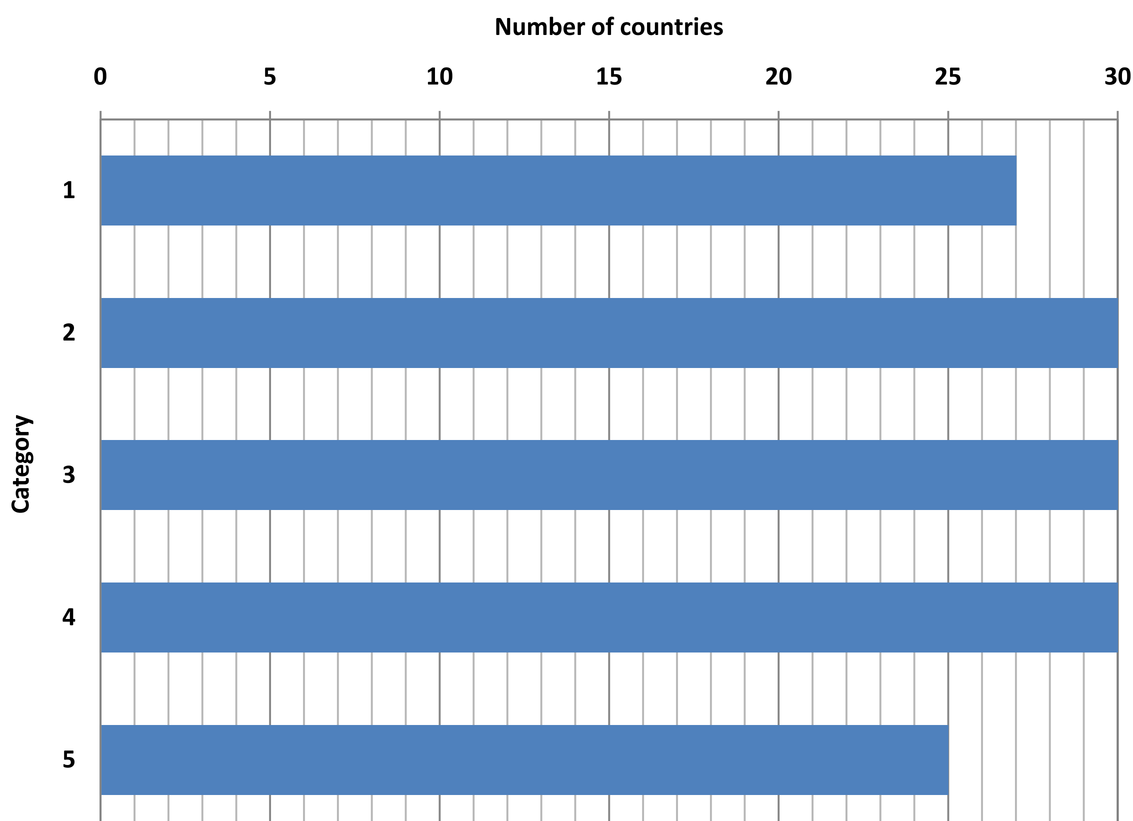
16. The objective of bottom-up planning with countries was to determine the priority health outcomes for WHO's collaboration with countries during the period 2016–2017. In the planning launch communication to Member States, the Regional Office asked all Member States to identify 10 priorities from the outcomes of the Twelfth General Programme of Work, for the purpose of determining the Secretariat's work. The priority outcomes are aligned with Health 2020.

17. In Member States with a country presence, heads of WHO country offices led the exercise from the Secretariat side, in collaboration with the ministry of health and relevant

stakeholders. The priorities presented below are those initially received from the Member States. Heads of WHO country offices in collaboration with technical staff at regional level have made an initial costing of outputs, based on an assessment of the resources (human and financial) required to achieve given outputs in a given location, to arrive at the proposed PB 2016–2017 budget for discussion by the Regional Committee.

18. Fig. 2 and Fig. 3 show the categories and programme areas, respectively, defined as priorities by Member States with BCAs for 2016–2017. Categories 2 (Noncommunicable diseases), 3 (Promoting health through the life-course) and 4 (Health systems) were identified as the highest priorities; every BCA country in the Region chose priority outcomes in these three categories.

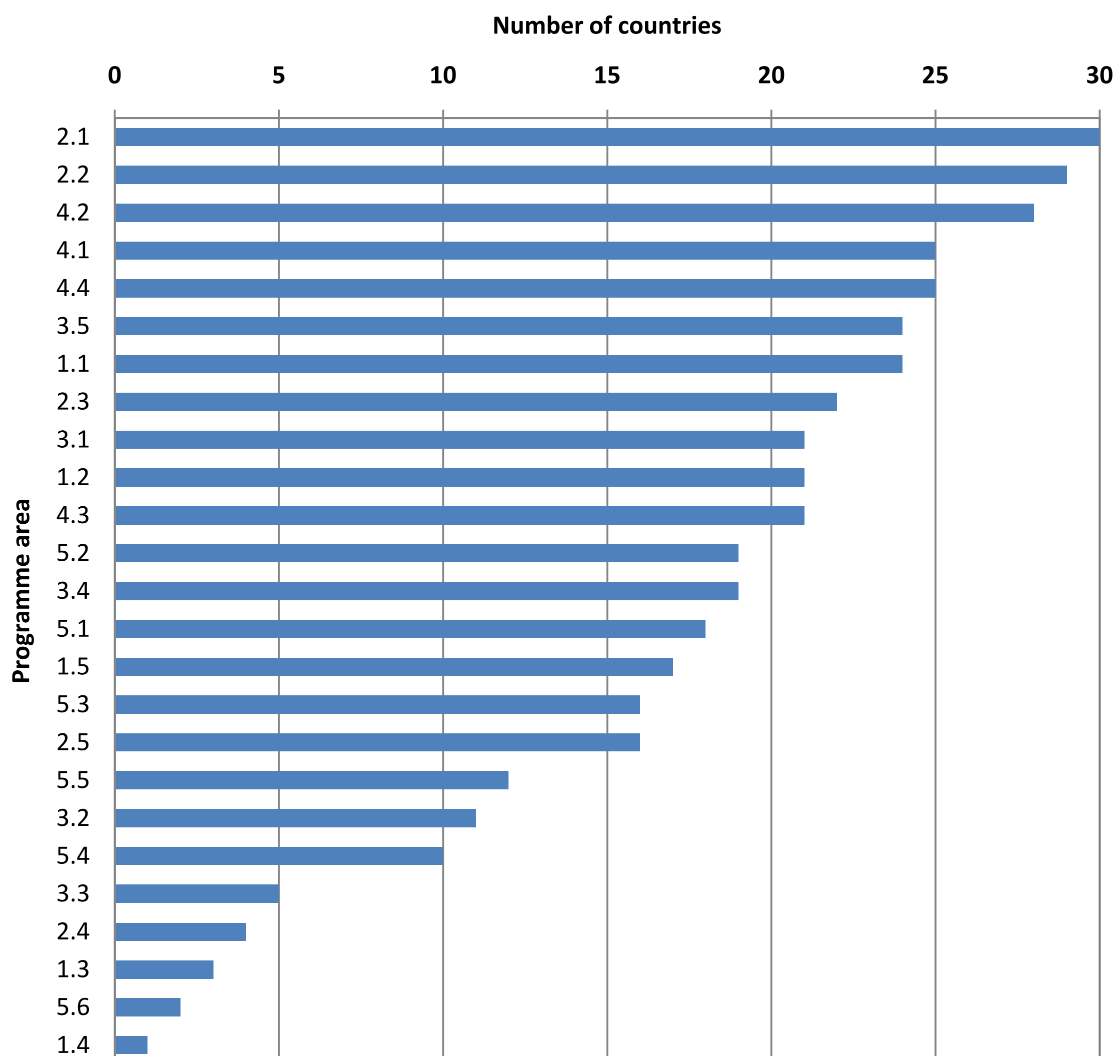
Fig. 2. Frequency of categories cited as priorities by BCA countries



19. Programme area 2.1 (Noncommunicable diseases (NCDs)), followed by 2.2 (Increased access to services for mental health and substance use disorders) and 4.2 (Policies, financing and human resources are in place to increase access to people-centred integrated health services) were most frequently chosen as priorities by Member States (Fig. 3).

20. Programme areas 1.3 (Malaria), 5.6 (Outbreak and crisis response) and 1.4 (Neglected tropical diseases) were the least frequently prioritized programme areas. Most malaria and neglected tropical disease programmes are delivered through an intercountry mode and are therefore reflected in the regional public goods priorities. As the activities in outbreak and crisis response are governed by acute external events, budgeting is uncertain, as reflected in country priority setting.

Fig. 3. Frequency of programme areas cited as priorities by BCA countries

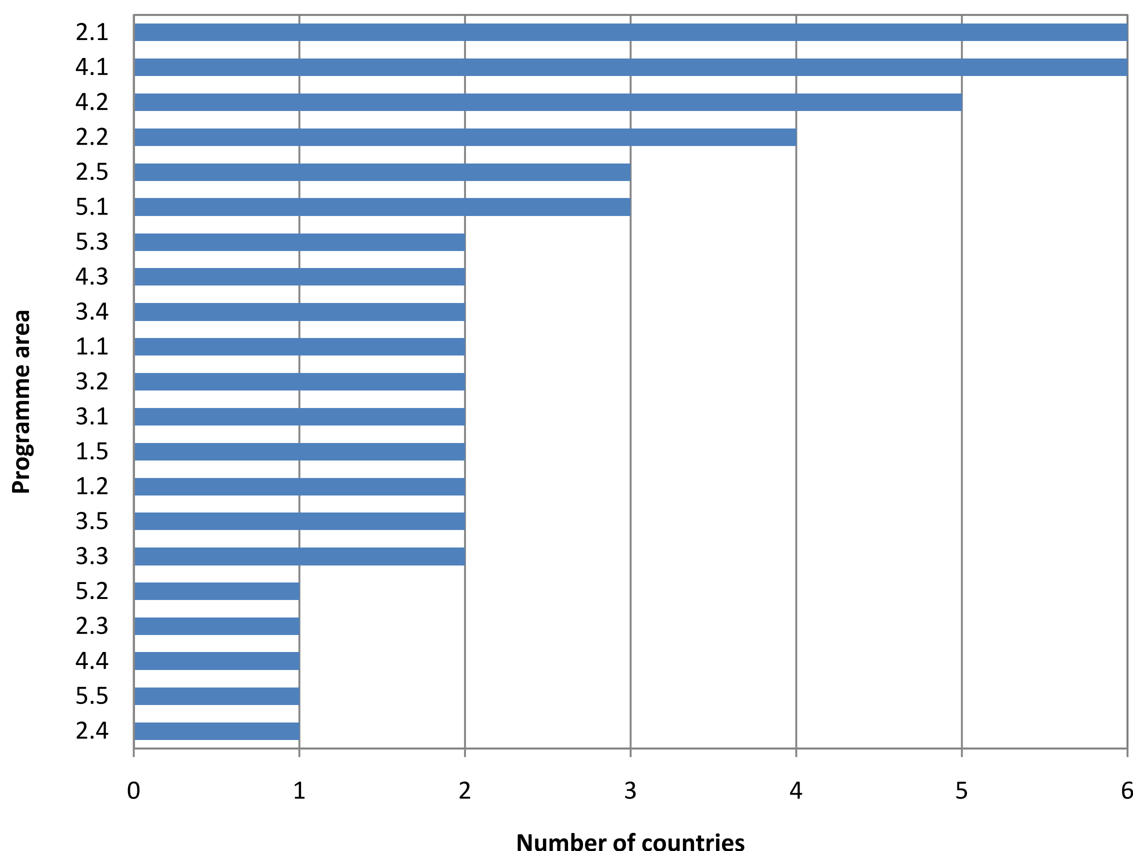


Engagement with non-state actors

21. Countries without BCAs indicated priorities for PB 2016–2017 both directly and in accordance with existing and planned country cooperation strategies (see Fig. 4). As in BCA countries, programme area 2.1 (NCDs) was the highest priority, followed by 4.1 (National health policies and plans) (Fig. 3). Unlike in BCA countries, the outputs were not costed separately but were included as part of regional public goods, as technical assistance to these countries is provided mostly through the intercountry mode.

22. Country priorities should be considered in relation to intercountry work. The Regional Office for Europe's business model is characterized by a high level of skill and technical capacity both at the Regional Office and in European institutions and public services. Therefore, common needs of countries are often addressed through Region-wide (or intercountry) and multicountry approaches, which supplement direct country support as expressed in BCAs. This implies that total country investment is comprised of country budget allocations and part of the budget allocated to the regional level.

Fig. 4. Frequency of programme areas in priority-setting by countries without a BCA



Health 2020

Global developments

23. Defining and setting strategic health priorities for 2016–2017 for the European Region is guided by Health 2020 – the European policy framework for health and well-being (resolution EUR/RC62/R4), a common policy framework for action to promote health and well-being for people in the Region. Health 2020 was designed as a value-based, evidence-informed policy and strategy that would continue to promote the health and well-being of the people of the European Region while at the same time would address the inequalities in health that scar the Region. Fulfilling the promise and potential of the Health 2020 vision and approach had implications for the work of the whole Regional Office at both technical and country levels.

24. Operational planning for the 2014–2015 biennium served as an important opportunity for aligning the work of the entire Regional Office with Health 2020. Emphasis has been given to supporting and accelerating implementation of Health 2020 through all aspects of operational planning for 2014–2015, which allowed for more integrated work across divisions, especially at country level. Furthermore, these revised programming modalities contributed specifically to the objectives of WHO reform. This work will continue during operationalization of PB 2016–2017.

25. Both BCAs and country cooperation strategies are important instrumental components, which facilitate understanding of how a country intends to promote the Health 2020 vision in the national context and how the Regional Office can support those efforts, both at the strategic

level and with specific technical approaches. In 2016–2017, the Regional Office will continue to support Member States in developing new national health policies aligned with Health 2020 or in updating existing ones; at the same time, it will support countries in their policy development efforts in thematic areas, such as a multisectoral NCD strategy, a public health policy or strategy and national plans for health systems strengthening. The Office will also support countries in building capacity for whole-of-government approaches and in establishing and running multisectoral committees.

26. In 2014–2015, the Regional Office has prepared detailed road maps for next steps in the strategic implementation of Health 2020 in each country. Based on lessons learnt from this biennium, this work will continue in 2016–2017.

The Regional Office for Europe's business model

27. In 2016–2017, the Regional Office will maintain a strong focus on technical assistance to countries, matching their needs as effectively and efficiently as possible. Three modes of operation are contemplated: intercountry (when all Member States are involved), multicountry (when a specified set of countries takes part) and country-specific (when only one country participates).

28. The Regional Office for Europe business model is as follows:

- The intercountry mode addresses the common needs of countries through Region-wide approaches, leverages the capacity of the limited number of technical staff at regional level, including geographically dispersed offices (GDOs) to address needs across various countries, and is effective when these countries have common objectives.
- When an objective is relevant for only a limited number of countries, a multicountry model may be used, again making optimal use of the resources that exist at regional level within the Secretariat.
- When the objectives are specific to the needs and circumstances of an individual country, the country-specific mode of operation is the chosen mode of delivery via the WHO country office. Country-level work is planned with the Member State concerned and is covered by a BCA specifying the impact to be achieved, expected outcomes and specific deliverables.
- The Regional Office-specific business model pools technical staff to meet considerable demands and challenges. Technical staff at the Regional Office and the GDOs carry out a substantial part of the work at country level, thus backing up the country offices, many of which have no or only limited technical capacity in given programme areas.

29. This model has been in place for two biennia. The main change for 2016–2017 is actual allocation of budget to the country level to a level of 40%, up from 27–28% in previous biennia. This change does not, however, necessarily mean an increase in staff at country offices but rather an increased focus of Regional Office staff on country work.

Regional budget overview

30. The overall global and regional budgets for 2016–2017 remain stable at 2014–2015 levels. After the Regional Office for the Americas, the Regional Office for Europe has the smallest share of the global base programmes budget, 7%. The proposed allocation represents a 10% increase as compared to the Regional Office's expenditures in 2012–2013.

31. Bottom-up planning included an assessment of the human and financial resources required to achieve given outputs in given locations (countries or the Regional Office). When determining the cost of priority outcomes, which were later translated into budgets, countries and regional divisions were requested to keep reasonably close to PB 2014–2015 levels. Nevertheless, once all planned costs were tallied, they totalled US$ 266.5 million, which was US$ 41.5 million or 18% over the level of 2014–2015. This difference can be accounted for by increased demand from Member States linked to the capacity to deliver, by standard cost increases (notably for staff) and partly by existing commitments from previous regional committees.

32. In order to respect the request from WHO's global governing bodies that PB 2016–2017 be equal to PB 2014–2015 at global level and in the absence of an approved strategic resource allocation mechanism, the Global Policy Group agreed that all major offices should have 0% growth. Preparing the budget for the Regional Office for Europe for 2016–2017 entailed reconciling the bottom-up planning priorities and costing with the global requirement to set budgets at the same level as PB 2014–2015. To achieve this, the following steps were taken:

(a) specific projects or initiatives were removed, which were still uncertain or under negotiation; these represent requests from Member States to implement projects in individual countries. While such requests are fully in line with WHO's overall priorities and respond to clear needs in a given country, the expected role for WHO in implementation is a challenge due to budget envelopes;

(b) once step (a) was completed then an overall reduction was made, respecting the proportions determined in the bottom-up process.

33. When decisions were made to remove projects in order to accommodate the given budgetary envelope, the advantages of WHO in implementing these programmes as compared with other health stakeholders present in the area were considered.

34. The elements that were removed are summarized in each category section below. The combination of steps (a) and (b) ensured that the proposed PB 2016–2017 includes all the major programmes and initiatives that the Regional Office is reasonably certain will be implemented in 2016–2017 while at the same time respecting the priority assigned to individual programme areas and categories during the bottom-up process and in the review of regional public goods.

35. Before the final version of the programme budget is adopted, there may be scope for accommodating some of the omitted programmes, so that the needs expressed by Member States and the priorities identified as regional public goods can be appropriately addressed during the implementation process.

36. Table 1 shows areas of strategic emphasis for 2016–2017 in relation to the current allocated PB 2014–2015. In line with country priority-setting, categories 2, 3 and 4 receive the largest share of all the technical categories of the Regional Office's proposed PB 2016–2017, with Health 2020 providing the overall framework and context.

37. In comparison with PB 2014–2015, the Regional Office's support to countries for combating the emerging epidemic of NCDs in 2016–2017 will require more emphasis and resources for category 2. Similarly, the Office's work to strengthen institutional capacity in emergency risk and crisis management and to establish a GDO for preparedness for humanitarian and health emergencies in Turkey will also require more budget, with a resulting 9% increase in category 5.

38. In relation to governance and management (category 6), the Regional Office will focus on implementing the recommendations of the Joint Inspection Unit in 2012[1] to strengthen WHO country presence, as well as on implementing reform-related initiatives. These will require an increase in resources in 2016–2017.

39. The 11% decrease in category 4 is due almost entirely to the need to arrive at a stable overall budget for 2016–2017; that is, removing large country-specific projects or initiatives still under negotiation. Category 4, however, continues to represent the largest share of the Regional Office's budget for technical categories (18%). Despite some fiscal limitations, the Office's work on Health 2020 at country level will be a priority, supported by work on social determinants in category 3. The multisectoral mechanisms at country level and the Health 2020 United Nations Interagency Task Force on the Prevention and Control of NCDs led by WHO at regional level lend further weight to this effort.

40. Polio eradication and outbreak and crisis response were not part of bottom-up priority-setting and were later determined at global level. The polio eradication budget is determined by the endgame strategies of the Global Polio Eradication Initiative, while the budget for outbreak and crisis response is fixed at the 2014–2015 allocated budget level. This resulted in an overall 5% increase in PB 2016–2017 for emergencies.

41. Details of the budgets for each programme area are included in each category description under the section below on "Regional orientations for 2016–2017" and are summarized in the Annex.

42. There is a notable shift of US$ 26.5 million (12%) in the base budget to country level in 2016–2017 as compared with 2014–2015, in accordance with the strategic decision described previously. This reflects strengthened, intensified country work for implementing Health 2020, aligned country priorities and regional policies and strategies put in place by the Regional Office, following approval by the Regional Committee, in the past two biennia. It is expected that a considerable portion of the Regional Office's country work will be delivered by technical staff in Copenhagen and the GDOs. The proposed country-level budget therefore includes, in quantitative terms, the full support provided to countries by the Regional Office, in addition to any amount directly budgeted in the country work plans.

43. Analysis of 2012–2013 income and expenditures (Table 2) shows that the Regional Office was successful in raising and implementing resources at nearly 100% of its approved programme budget. The high level of expenditure in 2012–2013, however, indicates that some priorities will have limited budget space to grow in both 2014–2015 and 2016–2017, as the approved budget of US$ 225 million represents an increase of only 10% over expenditure in 2012–2013.

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[1] Review of management, administration and decentralization in the World Health Organization, report by the Joint Inspection Unit. Geneva: World Health Organization; 2013 (EB132/5 Add.6; http://apps.who.int/gb/ebwha/pdf_files/EB132/B132_5Add6-en.pdf).

Table 1. Proposed PB 2016–2017 as compared with the allocated PB 2014–2015 by category

Category	2014–2015 allocated budget				2016–2017 proposed budget				Increase/decrease 2016–2017 vs 2014–2015 (%)
	Countries	Region	Regional Office for Europe total		Countries	Region	Regional Office for Europe total		
			Total	%			Total	%	
1. Communicable diseases	11.7	18.9	**30.6**	13%	13.5	16.1	**29.6**	13%	–3%
2. Noncommunicable diseases	9.7	23.1	**32.8**	14%	16.9	19.2	**36.1**	16%	10%
3. Promoting health through the life course	7.3	32.8	**40.1**	18%	10.3	27.7	**38.0**	17%	–5%
4. Health systems	12.3	32.5	**44.8**	20%	13.5	26.5	**40.0**	18%	–11%
5. Preparedness, surveillance and response	3.3	12.4	**15.7**	7%	6.8	10.2	**17.0**	7%	9%
6. Corporate services / enabling functions	17.9	36.1	**54.0**	24%	27.8	29.2	**57.0**	25%	6%
Subtotal	62.3	155.7	**218.0**	96%	88.8	129.2	**218.0**	95%	0%
Emergencies	3.6	6.4	**9.9**	4%	2.1	8.3	**10.4**	5%	5%
Total	65.9	162.0	227.9	100%	90.9	137.5	228.4	100%	0%

Table 2. Past programme budgets, income and expenditure in the Regional Office for Europe

	Approved / proposed programme budget	Funds available (plus projected) for biennium	Funds available after first 6 months	Funds available as % of World Health Assembly-approved budget	Expenditure	Expenditure as % of World Health Assembly-approved budget	Expenditure as % of funds available/ projected
2010–2011	261.9	223.0	185.8	85%	199.0	76%	89%
2012–2013	213.0	213.0	160.4	100%	204.0	96%	96%
2014–2015[a]	225.0	*225.4*	147.3	100%	47.2	21%	21%
2016–2017[b]	228.4	*161.1*		*71%*			

[a] For 2014–2015, funds available = actual available, projected voluntary contributions and corporate funds projected to the level of 2012–2013. Expenditures are actual expenditures as of 1 July 2014.
[b] For 2016–2017, available funds are a projection based on current donor commitments and negotiations and the same level of corporate funding as in 2012–2013.

Financing: prospects and challenges

44. In the past two biennia (2010–2011 and 2012–2013), the Regional Office's financial resources were characterized by a high level of programmatic earmarking (only about half of the available funds were fully or highly flexible) and little flexibility to fund staff costs. Of the voluntary contributions, 70% were raised at regional level, and these were often less predictable than multiyear agreements and grants agreed at the global level.

45. Although less funding was available for 2012–2013 than the previous biennium (Table 2), the financial resources were at the level of the approved programme budget; that is, the programme budget appeared to be fully funded. This overall financial picture, however, masked serious funding shortfalls for some programmes and overfunding for others as well as poor alignment of resources with activity and staff costs. These were direct consequences of unpredictability and a lack of flexible funds. These issues were not specific to the Regional Office for Europe: the financial resources of all WHO major offices were characterized by the same lack of predictability, flexibility and alignment with results. The financing dialogue begun during the past biennium aimed to improve the quality of financing and to address these issues.

46. Although it is too early to evaluate the impact of the financing dialogue on financing for 2014–2015, several encouraging trends can be seen, such as a higher level of firm funding projections at the global level, the willingness of some Member States to consider reallocating their funds to underfunded areas and greater transparency, through the new programme budget web portal that provides a basis for well-informed decisions by contributors.

47. In addition, and in line with WHO reform, coordinated resource mobilization is expected to contribute to better alignment of funding with needs and a move away from a programme- or project-specific approach. More efficient resource mobilization and a corporate strategic approach towards contributors and donors are expected to lead to a fully funded PB 2016–2017. Tools are available at the three levels of the Organization and across categories to increase the transparency of committed financial resources and those in the pipeline.

48. At this stage, it is premature to estimate the total resources for 2016–2017, which will depend on the impact of the financing dialogue, the donor environment and other factors. Initial estimates of the funds that the Regional Office may expect in 2016–2017 indicate that approximately 71% of the proposed programme budget is potentially secured; thus, the budget and the aim of reaching 100% overall funding for PB 2016–2017 would seem to be realistic. The estimate is based on existing commitments, negotiations under way and the assumption that the level of corporate funding will be the same as in 2012–2013. Of the projected resources, 42% are voluntary contributions, with a similar level of projected funding for technical categories (15–20%). Category 4 (Health systems) is projected to receive the most voluntary contributions (32%); mostly for large, country-specific projects and GDOs.

49. The GDOs allow the Regional Office to scale up its activities in specific technical areas based on strong financial support from the respective host countries. Support is typically pledged for several biennia, thus providing sustainable resources for high-priority programme areas. Currently there are three fully functioning GDOs in the Region: the WHO Barcelona Office for Health Systems Strengthening (Barcelona, Spain), with an annual budget of US$ 1.8 million; the WHO European Centre for Environment and Health (Bonn, Germany), with an annual budget of US$ 4.5 million); and the WHO European Office for Investment for Health and Development (Venice, Italy), with an annual budget of US$ 1.7 million.[2] Three new GDOs are in various stages of planning and negotiation and are expected to be fully operational

[2] Including €150 000 from San Marino

in 2015–2016: one for primary health care (Almaty, Kazakhstan), with an annual budget of US$ 2 million); one for preparedness for humanitarian and health emergencies (Istanbul, Turkey), with an annual budget of US$ 2 million; and one for NCDs (Moscow, Russian Federation) with an annual budget of US$ 4.4 million.

50. In the coming biennium, continuing requests are expected from individual Member States to implement large-scale projects in individual countries. While such requests are in line with WHO's overall priorities and reflect a clear need in those countries, the role expected of WHO for implementation will be difficult to fulfil owing to budget envelopes. As noted above, many such projects were removed from the bottom-up planning results in order to arrive at a zero-growth budget for 2016–2017. As this is a common problem in most WHO regions, a suitable mechanism is being sought for such projects at global level; the decision is pending better understanding and clarification of the role and function of WHO in implementing these projects. Often, WHO is asked not only to provide technical assistance but also to manage and administer the large amounts of funds required for the overall project, whereas WHO is only one of the implementing entities. This management function is clearly not part of WHO's core functions; however, it is often a condition set by donors and hence the only way to implement a technical programme or provide assistance in a country.

Regional orientations for 2016–2017

51. The substantial technical content of PB 2016–2017 is described under each category, with a description of the main challenges and priorities in the category for the biennium, the specific health outcomes (and indicators), outputs (and indicators) and deliverables. Each category also includes a budget table by programme area and major office.

52. The regional contribution to the global outcome and output indicators has not yet been elaborated but will be included in future versions once the global indicators are closer to finalization. In the meantime, the narrative covers major regional challenges and orientations. The budget tables are supplemented by a description of projects and activities that were not included, in order to arrive at an overall stable budget for 2016–2017 (as described above).

Category 1. Communicable diseases

1.1 HIV/AIDS

53. An increasing number of countries are adopting evidence-informed policies for preventing HIV among key populations. Harm reduction interventions and programmes in national HIV plans to prevent sexual transmission nevertheless remain a challenge for many countries in the Region. The Regional Office will continue to provide technical assistance to Member States to support HIV prevention, diagnosis, treatment and care, especially for key populations, and for removing the legal and social barriers that prevent access to services.

54. Emphasis will be given to promoting equal access to life-saving antiretroviral therapy, coordinated and integrated service delivery, prevention of mother-to-child transmission of HIV and measures to better manage co-infections, such as tuberculosis and hepatitis. Under the aegis of the global health sector strategy on HIV/AIDS 2016–2020, a revised regional HIV/AIDS action plan will be implemented to support national programmes. Partnership with The Global Fund to Fight AIDS, Tuberculosis and Malaria will allow WHO to significantly strengthen the technical assistance it provides to Member States.

55. Technical support will also be provided for the development and implementation of coordinated, multisectoral national strategies for the prevention, diagnosis and treatment of viral

hepatitis according to the local epidemiological context and in line with resolution WHA67.6 of the World Health Assembly. Implementing a full set of actions in response to Member States' needs in this area would require additional core budget allocation.

56. The above work will be carried out in the context of an overall reduction in the budget space allocated for the HIV/AIDS programme area in 2016–2017 as compared with 2014–2015, which will require scaling down and reprioritization of activities. This reduction is a result of bottom-up planning, as many countries did not cite HIV/AIDS as a high priority.

1.2 Tuberculosis

57. Building on achievements made during implementation of the "Consolidated action plan to prevent and combat multidrug- and extensively drug-resistant tuberculosis [M/XDR TB] in the WHO European Region 2011–2015", the Regional Office will continue to provide technical assistance to Member States in achieving universal access to diagnosis and treatment, thus interrupting the transmission of M/XDR TB in the Region.

58. Specifically, the Regional Office will support Member States in scaling up quality diagnosis, strengthening mechanisms for cross-border TB control and care, improving the drug supply, working in partnership and enhancing civil society engagement and assessing and addressing health systems challenges and the social determinants of TB, in line with Health 2020.

59. While the focus will be on countries with a high prevalence of TB and M/XDR TB, the Regional Office will also assist countries with a low TB burden in developing strategies for moving towards TB elimination and for improving the diagnosis and treatment of TB in migrants and other high-risk groups.

60. The "post-2015 global TB strategy", endorsed by World Health Assembly resolution WHA67.1, requires adaptation and implementation at regional and national levels. Technical support will be given to Member States to further reduce TB mortality, improve early detection of all forms of TB and improve treatment success rates. This will require expansion of TB diagnostic capacity at country level (laboratory capacity and quality assurance), enhancing TB monitoring and surveillance systems, improving management techniques, introducing new TB drugs, ensuring active pharmacovigilance, avoiding secondary drug resistance and boosting integration of TB services into health systems.

1.3 Malaria

61. Elimination of malaria from the European Region by 2015, in keeping with the 2005 Tashkent Declaration, is well on track. Remarkable progress has been made, from 90 000 cases in the mid-1990s to 37 cases in 2013. Armenia, Kazakhstan and Turkmenistan have been declared malaria-free and Georgia, Kyrgyzstan and Uzbekistan have no cases and are in the phase of preventing reintroduction; Azerbaijan, Tajikistan and Turkey are still pursuing elimination.

62. In 2016–2017, the focus will be on completing elimination, providing certification and preventing reintroduction. The main planned activities are maintaining effective vector control and malaria surveillance, including timely responses to outbreaks after importation. To achieve this, the Region has contributed to and will follow the Global technical strategy for malaria control and elimination 2016–2025: accelerating progress towards elimination, which will be discussed at the 136th session of the Executive Board in January 2015 and submitted for consideration to the Sixty-eighth World Health Assembly in May 2015. The global strategy will be implemented regionally within the regional Health 2020 framework.

1.4 Neglected tropical diseases (including re-emerging vector-borne diseases)

63. New vector-borne diseases are emerging in the WHO European Region and diseases considered to have been eliminated are returning. Population movements, rapid urbanization, ecological, climatic and environmental changes, and interruption of actions to prevent and control transmission are central to this renewed public health problem.

64. Recent data document the increasing geographical spread of insect vectors. The incidence and distribution of vector-borne diseases such as leishmaniasis, Crimean–Congo haemorrhagic fever, tick-borne encephalitis, West Nile fever, Lyme disease and imported Chagas disease are increasing significantly, particularly in the southern part of the Region.

65. Although the overall budget allocation for this area is decreasing, the Regional Office will continue to provide technical assistance to Member States to reduce the risks of re-emergence of vector-borne infectious diseases by focusing on areas such as disease surveillance and integrated vector control, as well as overall implementation of the *Regional framework for surveillance and control of invasive mosquito vectors and re-emerging vector-borne diseases 2014–2020*.

66. Other neglected tropical diseases for which technical support to countries may be requested in 2016–2017, particularly in central Asia, the Caucasus and the Balkans, include tick-borne diseases (Lyme borreliosis, Crimean–Congo haemorrhagic fever, tick-borne encephalitis), rabies and soil-transmitted helminths (Ascaris, whipworm, hookworm).

1.5 Vaccine-preventable diseases

67. The "European Vaccine Action Plan 2015–2020" calls for activities at regional level that include sustaining regional measles and rubella elimination and supporting global elimination activities within the *Global Vaccine Action Plan 2011–2020*. Strong vigilance, high political commitment, sufficient resources and implementation of key strategies to close immunity gaps and conduct supplemental immunization activities all have a direct impact on reducing the numbers of un- or under-immunized infants, children and adolescents and removing barriers to immunization. While the impact of immunization is a core part of the life-course approach, further work is needed to address issues in adulthood, closing immunity gaps resulting from past immunization practices and maximizing the benefits of immunization prior to the onset of immunosenescence (the gradual deterioration of the immune system due to ageing). This work closely interacts with programme areas in category 4 (Health systems).

68. Planned activities for 2016–2017 include:

- providing assistance to Member States for updating and modifying policies and strategies on vaccine-preventable diseases and immunization in line with global and European vaccine action plans;
- advocacy to broaden the stakeholder base supporting immunization;
- improving the quality and availability of the evidence required for decision-making.

69. Member States have clearly indicated the need for more support in managing and responding effectively to public concern about vaccine effectiveness and safety. The programme will continue to support national immunization technical advisory groups in formulating evidence-based policies and will create opportunities to exchange experience and foster interaction with the European Technical Advisory Group of Experts on Immunization. Technical assistance will be provided to establish or enhance surveillance of vaccine-preventable diseases or other monitoring systems.

70. In order to arrive at the above figures within a zero-growth budget for 2016–2017 as compared with 2014–2015, activities and projects from the bottom-up planning exercise costing about US$ 6.6 million could not be accommodated in category 1. Notably, a full set of actions to support Member States in developing and implementing coordinated, multisectoral national strategies for the prevention, diagnosis and treatment of viral hepatitis and sexually transmitted infections are not included in the above budget for programme area 1.1. Some scaling down and reprioritization will be required in the technical support provided to Member States for HIV/AIDS. Programme areas 1.2 (Tuberculosis) and 1.5 (Vaccine-preventable diseases) will have decreased allocations as compared with the bottom-up planning, implying reprioritization of activities at both country and regional levels.

Table 3. Proposed PB 2016–2017 for category 1 (Communicable diseases) by programme area (compared with PB 2014–2015), US$ million

	2014–2015 allocated budget			2016–2017 proposed budget			% increase / decrease 14–15 to 16–17
	Countries	Region	Regional Office for Europe Total	Countries	Region	Regional Office for Europe total	
1.1 HIV/AIDS	1.9	3.8	5.6	1.4	3.2	4.6	–17%
1.2 Tuberculosis	7.1	3.9	11.0	8.3	2.7	11.0	0%
1.3 Malaria	0.2	1.1	1.3	0.2	1.1	1.3	–5%
1.4 Neglected tropical diseases	0.0	0.7	0.7	0.0	0.6	0.6	–13%
1.5 Vaccine-preventable diseases	2.6	9.4	12.0	3.6	8.5	12.1	1%
Total category 1	11.7	18.9	30.6	13.5	16.1	29.6	–3%

Category 2. Noncommunicable diseases

2.1 Noncommunicable diseases and risk factors

71. Among the WHO regions, the European Region has the highest proportional burden of NCDs: cardiovascular diseases, cancer, respiratory diseases and diabetes (the four major NCDs) together account for 77% of the burden of disease and almost 86% of premature mortality. Premature death (before age 60 years) or living with an NCD or related disability in the long term has socioeconomic consequences and constitutes a double burden to sustainable social and economic development. Thus, a major increase in the budget is planned for the programme area. The focus of the Regional Office with regard to NCDs in 2016–2017 will be:

- development and strengthening of multisectoral plans on NCDs by supporting knowledge networks and actions across sectors in countries. By 2017, countries should have prioritized the prevention and control of NCDs in national health planning processes and development agendas;
- development and strengthening of capacity to control NCDs at primary care level;
- tangible progress in NCD-related outcomes set out in the global monitoring framework and in the context of Health 2020.

72. The Regional Office for Europe will provide technical support for interventions among high-risk populations, particularly for cardio-metabolic risk assessment and management and early detection and management of cancer. This will enable countries to ensure universal

coverage of their populations with the interventions listed in Appendix 3 of the *Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020*. A people-centred approach will ensure coordination, integration and high-quality implementation of population interventions and individual health services. Member States will receive support for strengthening their capacity for essential NCD services, including primary prevention, early detection and disease management at the primary care level.

73. The Regional Office is updating the NCD integrated database to monitor risk factors. Countries will be supported in developing an integrated surveillance system in line with Health 2020 targets and indicators and the global monitoring framework for NCDs. Moreover, countries will receive training in the use of their data for policy-making and for identifying good practices, challenges, trends and priorities.

Alcohol

74. Alcohol is one of the leading risk factors for NCDs in the European Region. The Regional Office will continue to support implementation of the *European action plan to reduce the harmful use of alcohol 2012–2020*. The focus will be on marketing, pricing and availability, but the Regional Office will also provide guidance on early identification and brief interventions in primary health care. Sharing of good practices among Member States is facilitated by a new timeline database, which provides information such as alcohol policy, information campaigns and recent studies. A new method for calculating alcohol-attributable death rates will be used to monitor trends and differences among Member States over time.

Tobacco

75. The WHO European Region has the highest prevalence of smoking among adults and the highest rate of smoking-related mortality of all the WHO regions. Although 50 countries in the Region have ratified the *WHO Framework Convention on Tobacco Control*, its implementation remains poor. The main focus of the Regional Office is full implementation of the Convention after ratification and implementation of stronger policies, use of knowledge networks and action across sectors. By 2017, countries should have prioritized implementation of the Convention as key to the prevention and control of NCDs and should reach the global voluntary target by 2025.

76. The Regional Office will provide technical support to countries for full implementation of the Convention in strong cross-sectoral partnerships, as part of Health 2020 priority actions. The Office will also provide technical advice for tobacco control capacity-building and institutional strengthening in countries for sustainable tobacco control policies and related health outcomes.

2.2 Mental health and substance abuse

77. Mental disorders contribute 19% to the European disease burden and about 30% of all years lived with disabilities. The mental health programme will work with Member States towards implementation of *The European Mental Health Action Plan* by providing support for the development of national strategies and policies; improving the role of primary care for the diagnosis and treatment of common mental disorders; establishing community teams to treat and prevent the deterioration of people with complex mental disorders; and providing residential facilities and occupational opportunities for community integration.

78. Progress will be monitored through appropriate indicators. The programme will work closely with other international agencies and with professional and representative nongovernmental organizations to coordinate progress and disseminate good practice to meet the objectives of the Action Plan.

79. Substance abuse and especially use of injected drugs are major sources for the spread of blood-borne diseases in the European Region. The Regional Office gives guidance on opioid substitution therapy and collects information on treatment. The Regional Office targets special settings, such as prisons, and provides guidance on prison health governance.

2.3 Violence and injury prevention

80. Injuries and violence remain the leading causes of death among people aged 5 to 45 years in the European Region and are an important cause of health inequality; the rates in low- and middle-income countries being 2.4 times higher than that in high-income countries. More positively, there have been decreases of 24% in mortality rates from all injuries and 28% from road crashes in the past decade. Through regional and national activities, the Regional Office will support Member States in building health systems capacity, improving surveillance and developing evidence-informed programming and policy in the areas of road safety, child injury prevention and interpersonal violence prevention, with a focus on preventing child maltreatment. These efforts will contribute to achieving the regional targets of a 30% reduction in road crash deaths and a 20% reduction in child homicides by 2020. A draft resolution and policy "Investing in children: the European child maltreatment prevention action plan 2015–2020" to be considered by RC64, will underpin most of the deliverables for violence prevention in 2016–2017.

81. The above work will be carried out in the context of an overall 16% reduction in the budget space allocated for violence and injury prevention in 2016–2017 as compared with 2014–2015. This reduction is due to greater emphasis on other NCDs.

2.4 Disabilities and rehabilitation

82. Disability is a concern for the WHO European Region, as the prevalence in Member States ranges from 4% to 21%, and 6–10 person-years are lived with disability by every 100 people. This number is set to increase with the ageing of the population and the rising prevalence of NCDs and injuries in the Region. Disability is an area that reflects the core values of the Regional Office in terms of social justice, rights, equity and governance; Health 2020 provides a valuable framework for delivery. The Regional Office will work at regional and national levels to support countries in implementing the *WHO global disability action plan 2014–2021: better health for all people with disability* through technical guidance and capacity development within the limits of a 30% reduction of the programme budget in this area in 2016–2017 as compared with 2014–2015.

2.5 Nutrition

83. The rising rates of physical inactivity among children and adolescents in the Region are alarming. Analysis of the *Global Burden of Disease Study 2010* shows that dietary factors are the most important risk factors undermining health and well-being in every Member State in the Region. Healthy diets can also prevent other forms of malnutrition, such as micronutrient deficiency, particularly among vulnerable groups. In the European Region, the focus will be on implementation of the *Vienna Declaration on Nutrition and Noncommunicable Diseases in the context of Health 2020*, with special attention to equity and governance.

84. Despite the situation in the Region, the budget for this programme area is planned to decrease by 21% in 2016–2017 due to competing priorities (NCDs). The Regional Office will work with Member States to implement the "European Food and Nutrition Action Plan 2015–2020" and the forthcoming European strategy for physical activity and health in line with the global and European NCD frameworks by:

- analysis of policy development and implementation in Member States: impact assessment across sectors (for example: economic tools to promote healthy diets; marketing of foods high in fat, sugar and salt; salt reduction; elimination of trans-fats; promotion of breastfeeding and appropriate complementary feeding; prevention of childhood obesity and promotion of physical activity) as outlined in Health 2020;
- country profiles, policy briefs and technical advice to achieve targets in salt reduction, elimination of trans-fats, elimination of childhood obesity, promotion of breastfeeding and maternal nutrition, reduction of physical inactivity, counselling and early identification of NCDs related to poor diet and lack of physical activity;
- tools and actions to reduce inequalities in diet and physical activity, to guide behaviour change, to eliminate trans-fats, to control marketing of foods to children and to report on policy adoption.

85. In order to arrive at the above figures within a zero-growth budget for 2016–2017 as compared with 2014–2015, activities and projects from the bottom-up planning exercise costing about US$ 5.6 million could not be accommodated in category 2. Notably, limited support will be provided to countries for capacity-building events, establishing national surveys and implementing action plans and country-specific projects in several programme areas of category 2. In order to give greater emphasis to the NCD programme area, the budgets of the remaining four programme areas of category 2 will be reduced as compared with 2014–2015.

Table 4. Proposed PB 2016–2017 for category 2 (Noncommunicable diseases) by programme area (compared with PB 2014–15), US$ million

	2014–2015 allocated budget			2016–2017 proposed budget			%
	Countries	Region	Regional Office for Europe Total	Countries	Region	Regional Office for Europe total	increase / decrease 14–15 to 16–17
2.1 Noncommunicable diseases	4.1	10.6	14.7	11.1	9.7	20.8	41%
2.2 Mental health and substance abuse	1.8	3.8	5.6	2.9	2.2	5.1	–9%
2.3 Violence and injuries	2.9	6.2	9.2	2.2	5.5	7.7	–16%
2.4 Disability and rehabilitation	0.7	0.1	0.7	0.4	0.1	0.5	–30%
2.5 Nutrition	0.2	2.4	2.6	0.3	1.8	2.1	–21%
Total category 2	9.7	23.1	32.8	16.9	19.2	36.1	10%

Category 3. Promoting health throughout the life-course

86. Work on the life-course approach to health promotion and disease prevention is an integral part of the Health 2020 policy framework and 2016–2017 will see integration of global strategies for health throughout the life-course with the regional objectives, values and principles laid out in Health 2020.

87. Category 3 has many links to other WHO programmes, such as those on communicable diseases and NCDs, vaccines, nutrition and integrated people-centred health services for reducing maternal and child mortality and morbidity. Additionally, work in this category, comprising support of health throughout the life-course and cross-cutting issues such as the social determinants of health, health and environment, gender, equity and human rights, contributes to and benefits from work in all the other categories, in line with Health 2020. In

particular, work in this category is intrinsically linked to developing multisectoral national health policies and introducing whole-of-government and whole-of-society approaches for health and well-being. Analysis and monitoring of these cross-cutting areas across WHO programme areas and in countries will be key to fulfilling the global call for equity and rights in the post-2015 agenda.

3.1 Reproductive, maternal, newborn, child and adolescent health

88. Further improvement of the health of children and adolescents in the European Region will require a shift towards a whole-of-government approach and comprehensive policies to ensure equitable distribution of health and well-being for these groups. Although measures for protecting and improving children's and adolescents' health and development are already in place throughout the Region, much more can be done to promote better health and well-being and reduce inequalities. Evidence demonstrates that investment in children and adolescents, including the crucial first three years of life, yields economic and social benefits well beyond improved health outcomes.

89. The Region includes countries with the lowest rates of infant and child mortality in the world; yet the highest rate of death for children under five years is 25 times higher than that in countries with the lowest rate. In the Region, half of deaths during the first five years occur during the first month of life. The determinants of adolescent health are now much better understood: the social values and norms of the immediate family, peer groups and school environments can expose adolescents to risk as well as protect them. The challenge for policy is to balance risk and protection in favour of well-being and away from behaviour that may undermine health.

90. In 2016–2017, the focus will be on supporting countries to use the "Investing in children: the European child and adolescent health strategy 2015–2020" in drafting or revising national policies. Improving access to quality services is still an important focus, as is improvement of health information systems.

91. The indicators of sexual and reproductive health for the European Region, such as the maternal mortality ratio, the number of unsafe abortions and the adolescent birth rate, have all improved; however, huge differences remain between and within countries in maternal health, family planning and sexual health. Inequalities in sexual and reproductive health start during adolescence, with disparate access to health education, information and youth-friendly services. Improved access to information and services for sexual and reproductive health is one of the main principles of Health 2020.

92. The quality of antenatal, hospital and postpartum care for mothers and newborns in the European Region is diverse, ranging from over-medicalization and high rates of interventions such as caesarean sections to lack of access to emergency care, resulting in high maternal morbidity and mortality rates.

93. A major task for the Regional Office in 2016–2017 will be preparation of a regional strategic document linking the latest trends and research data, while seeking to ensure universal access to sexual and reproductive health for all. This will require particular attention to marginalized and vulnerable people.

3.2 Ageing and health

94. The WHO European Region has the highest median age in the world. Many countries are ageing rapidly, the group of people aged 80 years and older growing the fastest. Policy initiatives for ageing have been spreading quickly in Europe and ageing is increasingly

addressed as a cross-cutting policy issue, bringing together different parts of government and a broad range of stakeholders, thus applying a key principle of Health 2020.

95. The demand for Regional Office support to Member States for healthy ageing policies has grown correspondingly. In 2016–2017, work will continue to focus on supporting countries in designing or reviewing national ageing strategies, policies and action plans, in particular on the basis of the *Strategy and action plan for healthy ageing in Europe, 2012–2020*. The work takes into account differences in the capacity of the health and social systems of Member States to provide support to ageing populations and the large differences between and within countries in the wider social determinants of healthy, successful ageing.

96. The Regional Office will continue to provide tools and to exchange good practices with regard to age-friendly, supportive environments and to cooperate in health systems reforms to put in place better coordinated, integrated care and to improve the quality of and access to services for the elderly.

97. Monitoring of progress in healthy ageing policies, examples of good practice and exchanges of international policy to provide evidence for broader policies are lagging behind other fields of health policy. Work will therefore continue on devising systematic approaches for the exchange of evidence on policy in 2016–2017.

98. Owing to the budget reduction for this programme area (a decrease of 8% compared with 2014–2015), an important deliverable is in question: a comprehensive review of healthy ageing policy developments in Member States in 2017. This would involve monitoring the implementation of the *Strategy and action plan for healthy ageing in Europe, 2012–2020*, supported by an expert meeting open to all Member States.

3.3 Gender, equity and human rights mainstreaming

99. Advancing the Health 2020 strategic objectives for improving health for all, reducing health inequalities and improving leadership and participatory governance for health will not be possible without inclusion of gender, equity and human rights issues in WHO support provided to countries to implement Health 2020.

100. Member States will be supported through: (a) the application of the gender, equity and human rights component of the Health 2020 implementation package into health policies; (b) gender, equity and human rights integration into Health 2020 road maps; and (c) the mainstreaming of gender, equity and human rights throughout the work of the Regional Office, including the monitoring and evaluation framework. Gender, equity and human rights issues have proven to be a good entry point for intersectoral collaboration in health policy. Therefore, documenting good practices in setting up such policies will be at the centre of the Regional Office's work in 2016–2017. Special attention will be paid to health outcomes resulting from gender inequality and violation of human rights, such as gender-based violence and sexual and reproductive health issues.

101. A 17% reduction in the programme budget allocation for this area in 2016–2017 from that in 2014–2015 will effect the capacity of the Regional Office to support countries in implementing projects on gender- and rights-based approaches for improved health equity and better governance for health and to meet WHO's interagency commitments under the United Nations system-wide action plans on gender equality and human rights and the *"Rights Up Front" Action Plan*. At the same time, this area is at the heart of Health 2020 and is therefore a priority in all work on this policy. Consequently, less direct investment will be required for programmes in this field, as the relevant objectives form part of the implementation of Health 2020.

3.4 Social determinants of health

102. A key approach to promoting health, closing gaps in opportunities to be healthy and reducing the risks and consequences of poor health is systematic action on social determinants. Social determinants of health are found in all major policy domains of government and cut across all programme areas. The Regional Office provides support tailored to the needs and priorities of Member States to: (a) strengthen health sector capacity at all levels; (b) improve decision-making systems; and (c) promote engagement with other sectors to improve implementation and monitoring of common actions on social determinants of health and equity.

103. In many countries, certain population groups face barriers in accessing health services and suffer avoidable inequities in their health status. The Regional Office responds with technical assistance to promote the health of these groups, including a continued focus on Roma populations in 2016–2017 through a tailored capacity-building programme for health professionals and Roma civil society representatives.

104. The planned 8% budget reduction for this programme area would limit the Regional Office's ability to support the vulnerability and health programme (migrants and Roma) and the South-eastern Europe Health Network for health and inclusive growth.

3.5 Health and the environment

105. The environmental determinants of health are estimated to account for approximately 20% of all mortality and up to 25% of the total burden of disease, much of which is unevenly distributed among geographical, demographic, sociocultural and socioeconomic subgroups. This generates large costs, consumes important resources, prevents the attainment of optimal health and well-being and undermines social and economic development. The Regional Office will continue to address environment and health in the framework of the European Environment and Health Process (EHP), for which the Office has served as the EHP Secretariat since 1989. The EHP provides an intersectoral platform to present, explain and advocate for Health 2020.

106. The Regional Office helps its Member States and partners to understand and navigate the complexities of environment and health and to identify policies and actions in different sectors, nationally and internationally, that benefit the environment and human health, underpinned by the best available evidence. WHO will seek evidence to support changes in consumption patterns, promote environmentally friendly developments in other sectors and provide guidance to address new and emerging issues, particularly those related to climate change.

107. In 2016–2017, the Regional Office will conduct assessments, devise tools and strengthen capacity to monitor and address air pollution, climate change, water and sanitation, chemical safety, noise pollution, housing, health in transportation, population exposure in contaminated areas and environment and health in emergencies (in collaboration with category 5). At national level, the Regional Office will support Member States in meeting commitments under the EHP and in relevant multilateral environmental agreements. Preparation for the Sixth Ministerial Conference on Environment and Health will be a major undertaking.

108. In order to arrive at the above figures within a zero-growth budget for 2016–2017 as compared with 2014–2015, activities from the bottom-up planning exercise costing about US$ 3.6 million could not be accommodated in category 3. Notably, capacity to support countries in all programme areas of category 3 will be reduced.

Table 5. Proposed PB 2016–2017 for category 3 (Promoting health throughout the life-course) by programme area (compared with PB 2014–2015), US$ million

	2014–2015 allocated budget			2016–2017 proposed budget			% increase / decrease 14–15 to 16–17
	Countries	Region	Regional Office for Europe Total	Countries	Region	Regional Office for Europe total	
3.1 Reproductive, maternal, newborn, child and adolescent health	3.6	3.4	7.0	3.5	3.5	7.0	0%
3.2 Ageing and health	0.1	1.4	1.5	0.4	1.0	1.4	–8%
3.3 Gender, equity and human rights mainstreaming	0.2	1.2	1.4	0.1	1.1	1.2	–17%
3.4 Social determinants of health	1.0	6.5	7.5	1.8	5.1	6.9	–8%
3.5 Health and the environment	2.4	20.3	22.7	4.5	17.0	21.5	–5%
Total category 3	7.3	32.8	40.1	10.3	27.7	38.0	–5%

Category 4. Health systems

109. Category 4 encompasses a broad range of areas: the transformation of health care and public health services towards people-centred, coordinated, integrated health systems; whole-of-government and whole-of society processes for preparing new intersectoral national policies for health as outlined in Health 2020; and health information, evidence, research and innovation.

110. As an umbrella policy framework, Health 2020 recommends action across government and society for health and well-being, including health systems strengthening, which is one of the four priorities for action. Health 2020 puts forward a vision for improving the performance of health systems through innovative approaches that strengthen core health system functions, with renewed efforts to define people-centred solutions and health financing arrangements that are resilient to economic downturns.

111. Support in the complex areas of category 4 is sought increasingly by Member States because of pressures on national budgets as a result of the economic crisis and austerity measures and also because of recognition of the leverage of the broader determinants of health on health outcomes and inequities.

4.1 National health policies and plans

112. Member States in the European Region strengthen their national health policies and strategies in order to give direction and coherence to efforts to improve health. In recent years, 42 countries have defined broader goals and objectives for health systems in their national health strategies and plans; 31 Member States measured health system performance with a comprehensive package of indicators at system level; and at least 20 Member States performed systematic reviews of health systems performance with different formats. Some performance reviews were explicitly associated with national health strategies and plans, while others were conducted individually, such as health system performance assessments.

113. In 2016–2017, increased demand is expected for support in implementing Health 2020, reflecting the fact that many countries are embarking on whole-of-government and whole-of

society approaches to develop new intersectoral national policies for health. With a decreased programme budget for this area in 2016–2017, it will be a challenge to respond to the demands of Member States to increase support.

114. The Regional Office supports development and implementation of intersectoral national health policies, strategies and plans, including for health policy development and strategic and technical leadership on governance for health and health equity, in particular on the social determinants of health, gender, human rights and vulnerability. The Regional Office also coordinates the WHO European Healthy Cities Network and the Regions for Health Network.

115. The Office provides strategic advice to policy-makers seeking to align policies with Health 2020 and develop national and subnational health policies, strategies and plans in intersectoral, whole-of-government and whole-of-society approaches. Member States receive technical assistance for capacity-building in conducting the entire policy cycle, from development through implementation and monitoring, to assessment and application of lessons learnt for the next round of development.

116. Member States in the European Region are at different stages on the path to universal health coverage, but they share the objective of improving health and financial risk protection by making progress towards this goal and sustaining gains achieved. The recent economic downturn raised awareness of the health and social consequences of gaps in coverage even in the most developed countries of the Region.

117. Further priorities are to obtain new evidence on financial protection in the European Region in order to contribute to global reporting on universal health coverage and to support work on policies at country level. This includes estimation using standard WHO methodology as well as new and innovative approaches to make financial protection indicators more relevant for high-income countries. Technical work on health systems strengthening for universal health coverage will also build on lessons learnt from pilot assessments of health systems challenges for better NCD outcomes. Health systems bottlenecks will be analysed to improve coverage and health outcomes.

4.2 Integrated people-centred health services

118. Ageing populations with multiple comorbid conditions, emerging and re-emerging diseases and chronic diseases are challenges to health services in all countries in the WHO European Region. The increasing numbers of health and social providers results in fragmentation and disorientation of patients and their families. The competence of health workers and future cadres must be continuously improved to ensure high-quality services. Most Member States have begun to meet these challenges by improving the coordination of providers and integrating services; however, sustainability is frequently an issue.

119. In response to this situation, the Regional Office will pursue the following strategic directions: management of health services to provide accessible services; ensuring the inclusiveness of services throughout the life-course; coordination and integration among providers; and continuous performance improvement to ensure high-quality service delivery. These directions will be based on the principles and values of a primary health care approach and universal health coverage in the framework of Health 2020.

120. In 2016–2017, the Regional Office will develop a regional framework for action towards coordinated, integrated health services delivery to operationalize the *WHO Global Strategy on People-centred and Integrated Health Services*, revitalize the primary health care approach to scale up interventions for universal health coverage and address challenges in the provision of health services that impede better outcomes for NCDs and M/XDR TB.

121. The Regional Office will conduct a mid-term assessment and continuously implement the *European Action Plan for Strengthening Public Health Services and Capacity* and the 10 essential public health operations (EPHOs) in Member States. In order to strengthen EPHOs, emphasis will be placed on supporting public health assessments in countries, strengthening public health workforce capacity (EPHO 7), supporting organizational transformation and improving financing for public health services (EPHO 8) and improving communication for public health and social mobilization (EPHO 9). Revitalizing public health as part of health systems transformations in countries facing austerity will be a priority.

122. As regards human resources for health, the Regional Office will assist Member States in strengthening knowledge about the health workforce at country, regional and international levels, with a focus on “brain drain” and migration. This evidence will inform formulation, implementation and evaluation of health workforce policies, strategies and plans that will contribute to achieving universal access, in line with Health 2020. The four main areas of work in the Region in 2016–2017 will be support to Member States in implementing the *WHO Global Code of Practice on the International Recruitment of Health Personnel*, training human resources for health information systems and for health observatories, transforming the education of health professionals and strengthening nursing and midwifery.

4.3 Access to medicines and health technologies and strengthening regulatory capacity

123. Medicines policies are critical for setting direction and creating a balance between access and cost–effectiveness. Many new therapies are becoming available, but at the same time these products put pressure on health systems, sometimes because of the complexity of their use and generally because of their high prices. Systems and processes are required to help manage the supply and demand of medical products, including optimizing the entry of new medicines to meet growing demand. Countries require support in defining policies for optimal use of generic medicines and the appropriate use of medicines in general. Excessive pharmaceutical expenditure continues to be a key issue in most countries of The Organisation for Economic Co-operation and Development and emerging countries, presenting decision-makers with significant challenges and dilemmas for future sustainability. Optimizing systems to ensure the best value for funds spent on medical products is important; there is currently substantial waste and inefficiency in many countries. All of these issues are reflected in Member States’ increasing demand for WHO support in this programme area.

124. The Regional Office will support Member States in advocating, networking and technical guidance to improve access to essential, quality medicines, moving towards universal health care. Health systems will be strengthened by improving drug policy, pricing and reimbursement, including health technology assessment; promoting convergence in regulation and strengthening regulatory capacity in non-European Union countries, emphasizing compliance with good manufacturing practices; and capacity-building for inspection and pharmacovigilance systems. In addition, surveillance of consumption of antimicrobial medicines will continue, in accordance with the *European strategic action plan on antibiotic resistance*, along with other relevant medicines utilization studies, to provide evidence for policy-making. Innovative approaches to promote prudent use of antimicrobial medicines will be explored, with better monitoring and evaluation of medicines use, including pharmacovigilance systems. Innovation in partner collaboration will be a priority to improve the affordability of medicines and health technologies.

4.4 Health systems information and evidence

125. While the European Region is probably the most data-rich region of WHO, lack of harmonization of data collation, analysis, interpretation and use for policy-making and lack of

integration of health information systems at national level pose a challenge for implementation of Health 2020 and for monitoring its targets and indicators.

126. The Regional Office's main strategic direction for 2016–2017 will be enhancing and harmonizing systematic collation and analysis of evidence for use in policy-making in the context of Health 2020, by fully integrating health information systems at national level. This will require harmonized health information strategies.

127. The Regional Office has launched the European health information initiative with seed funding from the Ministry of Health, Welfare and Sports of the Netherlands, and this will be the main programme thrust for 2016–2017. The initiative will be extended throughout the Region to form a single, integrated health information system for Europe. It is the "umbrella" for all activities in this area, including work on indicators for new areas of Health 2020, such as cultural determinants of well-being and governance. The "autumn school" on health information and evidence for policy-making will be an annual feature in 2016–2017, providing strong support to Member States in building capacity for monitoring Health 2020. Updating the Health for All database will continue to be a priority; currently, more than 90% of countries reply to data requests. The Regional Office health information portal ("one-stop shop") launched in 2014 will be evaluated and refined during the biennium and a European health report 2015 will be prepared for early 2016. It will probably attract much media interest, in view of experience with the previous report, which became the most frequently downloaded and requested publication of the Regional Office in 2013.

128. Technical support will continue to be provided for assessing and improving health information at country level, especially in central Asian and eastern European countries, where a new health information network – Central Asian Republics Health Information Network (CARINFONET) – was launched in 2014. Country and regional e-health activities will be extended, with support to countries for developing national e-health strategies and for identifying technological solutions for improving health management and developing interoperability standards. The regional knowledge translation network – the Evidence-informed Policy Network (EVIPNet) – will continue to be extended and a new series of the Health Evidence Network (HEN), on health and migration, will be launched. The European Advisory Committee on Health Research (EACHR) will continue to operate.

129. In order to arrive at the above figures within a zero-growth budget for 2016–2017 as compared with 2014–2015, activities and projects from the bottom-up planning exercise costing about US$ 16 million could not be accommodated for category 4. Notably, human resources capacity will not be available to meet the increasing demands of Member States and to implement several large country-specific and cross-cutting projects.

Category 5. Preparedness, surveillance and response

130. This category covers strengthening of institutional, international and country capacity for the prevention, preparedness, response and recovery required for all types of hazards, risks and emergencies that pose a threat to human health. The capacity for health in emergencies includes that required by the *International Health Regulations* (*2005*) and that are specific to natural disasters and conflicts.

131. This category includes WHO's contribution to rapid, effective, predictable response operations in acute and protracted emergencies due to any hazard with health consequences. This category also includes the provision of guidance and technical support to countries with epidemic- and pandemic-prone disease and for sustaining polio-free status.

Table 6. Proposed PB 2016–2017 for category 4 (Health systems) by programme area (compared with PB 2014–2015), US$ million

	2014–2015 allocated budget			2016–2017 proposed budget			% increase / decrease 14–15 to 16–17
	Countries	Region	Regional Office for Europe Total	Countries	Region	Regional Office for Europe total	
4.1 National health policies, strategies and plans	4.1	12.2	16.3	4.4	8.1	12.5	–23%
4.2 Integrated people-centred health services	6.4	7.6	14.0	5.3	7.1	12.4	–11%
4.3 Access to medicines and health technologies and strengthening regulatory capacity	0.6	4.4	5.0	1.2	4.1	5.3	5%
4.4 Heath systems information and evidence	1.1	8.3	9.4	2.6	7.2	9.8	4%
Total category 4	12.3	32.5	44.8	13.5	26.5	40.0	–11%

5.1 Alert and response capacities

132. The demand from Member States for WHO technical assistance in this area is high. Although existing capacity in the Region is generally strong, many countries are not consistently applying the *International Health Regulations* (IHR) (*2005*) and there are gaps in multisectoral coordination. Few extension requests to further develop and strengthen core capacity are expected from Member States during 2016.

133. Work in this area will therefore focus on supporting Member States to maintain and strengthen their IHR (2005) core capacity. Given the limited budget allocation for this area of work and the resource constrains, however, emphasis will be given to supporting Member States in addressing specific challenges, such as at ports, airports and ground crossings, and in risk communication. In the limited number of countries that require further core capacity strengthening, work will focus on developing national policies and strategies, strengthening laboratory capacity through the "Better labs for better health" initiative and enhancing outbreak response capacity.

134. The Regional Office will continue to conduct event-based surveillance and risk assessment for all 55 States Parties to the IHR (2005) in the Region and to further improve understanding and use of WHO event-based surveillance procedures and systems. Coordination of international response and provision of surge capacity to countries in need during public health events of international concern will continue, in cooperation with the European Commission and its agencies.

5.2 Epidemic-prone and pandemic-prone diseases

135. Maintaining surveillance and response capacity in the Region is crucial for early detection and containment of epidemic- and pandemic-prone diseases. In the western part of the Region, most countries have robust surveillance and response systems; however, in the eastern and south-eastern parts, sustainable systems for surveillance of severe infections due to influenza and other respiratory pathogens are weak or nonexistent. Few Member States have reached the WHO targets for seasonal influenza vaccination of at-risk groups and access to

pandemic vaccine is limited. Several Member States still do not have WHO-recognized national influenza centres.

136. Regional Office activities at both regional and country levels will focus on improving preparedness and response for seasonal influenza and on preparing for the next influenza pandemic or other emerging respiratory pathogen, such as the Middle East respiratory syndrome coronavirus. This will include supporting pandemic preparedness and building capacity for surveillance, laboratory analysis and outbreak response. WHO will also support estimates of the burden of disease, vaccination programmes and clinical management of severe diseases caused by influenza virus. The work of WHO in coordination with the European Commission and the European Centre for Disease Prevention and Control through the WHO EuroFlu network will be crucial in sustaining national and regional influenza surveillance and response capacity, as part of the global influenza surveillance and response system.

137. The aim of work on outbreak response and pandemic preparedness in countries will be to build generic capacity to prepare and respond to influenza or any emerging respiratory pathogen in humans. Partnership in the Pandemic Influenza Preparedness (PIP) Framework allows the Regional Office to intensify its support to Member States; however, as the framework is implemented during the 2014–2015 biennium outside the core programme budget envelope, additional core budget space will be necessary for implementation, monitoring and reporting of related activities.

138. Antimicrobial resistance is a growing global health threat that affects the entire WHO European Region. While progress is being made in decreasing certain types of resistance in health care settings in the western part of the Region (such as Methicillin-resistant *Staphylococcus aureus*), new resistant strains are emerging. In the eastern part of the Region, the tools to measure current and new trends in resistance are poorly developed, whereas the western part has well-established surveillance networks. The *European strategic action plan on antibiotic resistance 2011–2016* promotes the establishment of surveillance networks for the entire Region and support to countries in building national capacity and structures.

139. After the mapping of country capacity and definition of follow-up activities, work will be accelerated to implement and meet the objectives of the European strategic action plan. Implementation of the new global action plan on antimicrobial resistance will also increase awareness of antimicrobial resistance, which is expected to raise demand for technical support from Member States. An increased budget envelope as compared with 2014–2015 will be required for full implementation of a comprehensive set of actions in line with the expected need and demand.

140. The Regional Office will continue to build country capacity, support implementation of national plans and develop national networks for surveillance of antimicrobial resistance. Progress in all countries in the Region in addressing cross-border antimicrobial resistance and the threat to global health security will be tracked. Regional data reporting through the Central Asian and Eastern European Surveillance on Antimicrobial Resistance (CAESAR) network will be expanded and regional data on trends and the effect of interventions on antimicrobial resistance will be published periodically.

5.3 Emergency risk and crisis management

141. Member States in the Region are increasingly confronted with public health risks associated with natural disasters, conflicts and other humanitarian emergencies, often affecting millions of people. The Regional Office's work on preparedness will focus on providing support to countries, in an all-hazard approach, on developing national preparedness plans and strengthening their emergency and risk management capacity. Work on readiness and response

will include maintaining and mobilizing rapid response teams to fulfil WHO's critical functions in humanitarian emergencies, assessing countries' health systems capacity for crisis management, evaluating the resilience of hospitals to disasters, mapping health capacity and vulnerability, training in public health and emergency management and supporting health systems planning for mass gatherings.

5.4 Food safety

142. Throughout the Region, better intersectoral collaboration is needed between public health and the agriculture and veterinary sectors to respond to public health risks at the animal–human interface. In the newly independent states and in countries of south-eastern Europe, capacity must be built to strengthen food safety systems in order to better prevent and control foodborne diseases, which represent a significant public health burden. The involvement of these groups of countries in the work of the Codex Alimentarius Commission should be increased.

143. Activities in this area will be guided by WHO's global strategic approach to promote food safety in the Region, with the involvement of the FAO/WHO Codex Regional Coordinating Committee for Europe. Priorities will include promoting the work of the Codex in the Region, including supporting country participation and coordinating Codex-related activities; promoting collaboration between the agriculture, animal health and human health sectors for addressing food-related zoonotic diseases and the food safety aspects of antimicrobial resistance; and supporting national capacity building in food safety and management of zoonotic risks at the animal–human interface.

5.5 Polio eradication

144. Endgame strategies of the Global Polio Eradication Initiative guide work in this programme area. To ensure that the objectives of the global *Polio Eradication & Endgame Strategic Plan 2013–2018* are met, the Regional Office will support Member States in completing introduction of inactivated poliovirus vaccine, with withdrawal of all stocks of trivalent oral polio vaccine and introduction of bivalent vaccine, monitoring vaccine uptake and vaccine management, conducting surveillance for any safety issues, including risk management of the newly introduced products and concurrent use of bivalent vaccine with other vaccines and follow up of any issues faced by national immunization programmes. These activities will be delivered in close collaboration with programme areas 1.5 and 4.3. Technical support will be given for licensing and post-marketing surveillance of new products containing inactivated poliovirus or bivalent oral polio vaccine.

145. In 2016–2017, the Regional Office will continue to support the Regional Certification Commission in estimating the risk for outbreaks after introduction of polioviruses and will use its oversight capacity to monitor and support national authorities in biocontainment or destruction of type-2 viruses at vaccine production, research, diagnostic or vaccine utilization level. Additional activities will be initiated to prepare national polio certification committees for the biocontainment of remaining poliovirus types, an essential step towards global certification of polio eradication. Long-established activities such as support to Member States for maintaining highly sensitive surveillance for polio, annual accreditation of national and regional polio laboratories, provision of laboratory supplies and proficiency testing panels, monitoring surveillance performance and polio outbreak simulation exercises will continue.

5.6 Outbreak and crisis response

146. The Regional Office will help Member States to respond in an effective, timely manner to acute and protracted emergencies with public health consequences in the Region and also globally in case of massive response activities.

147. A well-trained, experienced core staff will be available to respond, in collaboration with national health authorities and key partners, to the emergency health needs of populations within the requirements of the WHO Emergency Response Framework. In addition to its core work of leading or co-leading the health cluster and addressing the main health gaps or duplications in response work, the Regional Office will develop,, monitor and report on the health cluster sectoral response plan, actively raise funds and support countries in the transition from emergency response to early recovery.

148. In order to arrive at the above figures within a zero-growth budget for 2016–2017 as compared to 2014–2015, activities from the bottom-up planning exercise costing about US$ 6 million could not be accommodated in category 5. Notably, actions in programmes such as antimicrobial resistance and capacity building for alert and response, including IHR (2005) core capacity, will not fully respond to the expected demand of Member States. Full implementation of the pandemic influenza preparedness framework will require an increase in the budget envelope.

Table 7. Proposed PB 2016–2017 for category 5 (Preparedness, surveillance and response) by programme area (compared with PB 2014–2015), US$ million

	2014–2015 allocated budget			2016–2017 proposed budget			% increase / decrease 14–15 to 16–17
	Countries	Region	Regional Office for Europe Total	Countries	Region	Regional Office for Europe total	
5.1 Alert and response capacities	1.0	4.3	5.3	2.1	3.2	5.3	–1%
5.2 Epidemic- and pandemic-prone diseases	0.9	5.0	5.9	1.4	2.7	4.1	–30%
5.3 Emergency risk and crisis management	1.1	2.5	3.6	3.0	3.5	6.5	81%
5.4 Food safety	0.3	0.6	0.9	0.3	0.8	1.1	23%
Subtotal Emergencies	3.3	12.4	15.7	6.8	10.2	17.0	9%
5.5 Polio eradication	1.1	5.8	6.9	1.4	6.0	7.4	7%
5.6 Outbreak and crisis response	2.4	0.6	3.0	0.7	2.3	3.0	0%
Subtotal	3.6	6.4	9.9	2.1	8.3	10.4	5%
Total category 5	6.9	18.7	25.6	8.9	18.5	27.4	7%

Category 6. Corporate services/enabling functions

149. While the nature of the work in category 6 is expected to be similar to that in 2014–2015, the budget required will increase by 5% due to two main factors: (a) an increase in country presence in the form of additional WHO representatives and a small number of administrative officers in non-European Union countries (in line with the recommendations of the Joint Inspection Unit) and (b) strengthening management through the recruitment of key experts. The WHO representatives fall under programme area 6.1, the administrative officers under 6.4 and senior management under 6.3.

6.1 Leadership and governance

150. This programme area covers crucial elements of the Regional Office's services to and relations with its Member States, namely the Regional Director's office, the heads of country offices, the governing bodies and partnerships. These elements, together with the technical leaders in regional divisions, comprise the public health leadership of the Regional Office. The priorities set out in categories 1 to 5 are therefore the de facto leadership priorities for 2016–2017, within the framework of Health 2020.

151. The Regional Office's leadership is accountable for implementing and reporting on WHO reform in the Region, which will remain a high priority in 2016–2017. The Office will continue to implement the various aspects of WHO reform through respective regional policies, processes and initiatives, in close collaboration with WHO headquarters and as per the reform results framework considered by the 134th session of the Executive Board in January 2014.

152. A key focus for 2016–2017 will be strengthening country offices in non-European Union countries by appointing 10 new WHO representatives and additional administrative officers in three country offices, in line with reform to strengthen the internal control framework and supported by a decision of the Global Policy Group in 2014. This decision builds on recommendations of the Joint Inspection Unit presented to the 132nd session of the Executive Board in 2012. The 2016–2017 biennium will also see the roll out of more country cooperation strategies in the European Region and the development of a regional country strategy in line with the global strategy.

153. Working in partnership is at the heart of Health 2020 and the Regional Office's work. Thus, the Office will continue to foster a wide variety of partnerships in and beyond the health field at regional and country levels, such as United Nations agencies, European Union institutions, global health organizations and non-state actors, with the ultimate aim of promoting policy coherence.

154. In the area of effective governance, the Regional Office will support Member States in preparing for effective participation and engagement in the work of the WHO governing bodies at regional and global levels. The aim will be to help delegations understand both the technical content and relevant procedures. This area also includes organization of sessions of the WHO Regional Committee for Europe and its subcommittees, for which the Regional Office serves as the Secretariat and provides logistical and administrative support. In 2016–2017, multilingualism will continue to be a priority for the Regional Office, to allow Member States access to information in a form that is most easily accessible to them.

6.2 Transparency, accountability and risk management

155. In keeping with global reform's strong emphasis on transparency and accountability, the Regional Office sees this as a major focus for 2016–2017. Significant achievements were made in 2014–2015, including implementation of the global internal control framework, increased compliance measures and improved audit response. In 2016–2017, compliance with the financial rules and regulations will continue to be a priority for the Regional Office. Additional resources will be directed to improving financial compliance at country level.

156. By the end of the 2016–2017 biennium, full application of a comprehensive risk management framework is foreseen in the Regional Office and in country and geographically dispersed offices.

157. During the next biennium, the Regional Office will continue to actively participate in the global evaluation network, in response to the evaluation policy endorsed by the 131st session of the Executive Board in May 2012 and any future direction provided by the WHO's governing

bodies. This will include planning future evaluations of certain programme areas and implementation and monitoring of recommendations made in previous evaluations in the Region.

6.3 Strategic planning, resource coordination and reporting

158. Programme area 6.3 remains a key element of WHO's reform agenda, both globally and regionally. The European Region is planning for 2016–2017 in full alignment with the global process and in direct response to the expressed priorities and health needs of the Member States of the Region. During the biennium, the Regional Office will continue to strengthen its monitoring and accountability mechanisms in order to provide greater clarity to Member States in terms of both programmatic and financial performance, with a view to enhancing the ability of regional governing bodies to give strategic direction and advice to the Secretariat. Corporate resource allocation in the Regional Office will build on the experience of 2014–2015 (the first biennium under the financing dialogue approach) with the objective of a "fully funded budget" in which the priorities established by Member States globally and regionally will be funded to the maximum extent possible.

159. The Regional Office will conduct resource mobilization and cooperation with donors in line with the principles and objectives of the global coordinated resource mobilization policy. Procedures are in place to help Regional Office staff in the development of high-quality proposals and well-planned projects and agreements. Methods will be set up to facilitate information sharing, compliance with timelines and reporting requirements.

160. The finance, compliance and procurement unit of the Regional Office will continue to ensure the integrity of accounting throughout the Region and timely recording of income, in keeping with International Public Sector Accounting Standards.

6.4 Management and administration

161. This programme area covers the bulk of the Regional Office's administrative functions at regional and country levels that enable the technical work in the Region. The overall priority for this programme area in 2016–2017 will continue to be delivery of administrative services, as efficiently and effectively as possible, in accordance with WHO rules and regulations.

162. The Regional Office will implement new global human resources policies for recruitment and sourcing, rotation and mobility, reassignment and the achievement of gender balance. Human resources planning for 2016–2017 will be based on the objectives set in the global PB 2016–2017 as applicable to the European Region. Human resources priorities for 2016–2017 include continued efforts to streamline timely recruitment; workforce planning to ensure the availability of qualified, motivated staff that meet the needs of the Organization at regional and country levels; and implementation of mechanisms for more effective staff performance management and accountability.

163. In the area of information technology, the Regional Office will continue to modernize, harmonize and increase staff productivity. The focus will be on enabling functions, in particular in the area of information management and support of WHO reform, and ensuring essential informatics services aligned with agreed organizational standards.

164. Much of this programme area is concerned with delivering the full range of administrative and logistical services to the staff of all WHO offices in the Region. The nature of this work will not change radically in 2016–2017; the focus will be on streamlining and strengthening service delivery to optimize the use of resources. This includes providing services to the Regional Office, country offices and other out-posted offices for conferences, infrastructure, security and printing.

6.5 Strategic communication

165. In 2016–2017, communications will continue to illustrate the work of the Regional Office and ensure that important information and messages are accessible to all relevant audiences through a variety of media. In alignment with the global communications strategy, stronger emphasis will be placed on web and social media and on training regional and country office staff to communicate better and to use various communications channels.

166. In the next biennium, the Regional Office plans to strengthen its support to Member States by enriching country websites with information about BCAs and their implementation in national languages. The work of the governing bodies will be facilitated by a searchable online database of resolutions and other documents.

Table 8. Proposed PB 2016–2017 for category 6 (Corporate services/enabling functions) by programme area (compared with PB 2014–2015), US$ million

	2014–2015 allocated budget			2016–2017 proposed budget			% increase / decrease 14–15 to 16–17
	Countries	Region	Regional Office for Europe Total	Countries	Region	Regional Office for Europe total	
6.1 Leadership and governance	12.7	16.3	29.0	18.3	11.9	30.2	4%
6.2 Transparency, accountability and risk management	0.0	2.2	2.2	0.5	1.9	2.4	10%
6.3 Strategic planning, resource coordination and reporting	0.1	3.4	3.5	1.1	3.0	4.1	16%
6.4 Management and administration	5.0	9.9	14.9	6.9	9.0	15.9	7%
6.5 Strategic communications	0.1	4.3	4.4	1.0	3.4	4.4	–1%
Total category 6	17.9	36.1	54.0	27.8	29.2	57.0	6%

Annex. Proposed PB 2016–2017 for the WHO European Region by programme area as compared with PB 2014–2015

Category and programme area	2014–2015 allocated budget			2016–2017 proposed budget			% increase / decrease 14–15 to 16–17
	Countries	Region	Regional Office for Europe total	Countries	Region	Regional Office for Europe total	
1. Communicable diseases							
1.1 HIV/AIDS	1.9	3.8	5.6	1.4	3.2	4.6	−17%
1.2 Tuberculosis	7.1	3.9	11.0	8.3	2.7	11.0	0%
1.3 Malaria	0.2	1.1	1.3	0.2	1.1	1.3	−5%
1.4 Neglected tropical diseases	0.0	0.7	0.7	0.0	0.6	0.6	−13%
1.5 Vaccine-preventable diseases	2.6	9.4	12.0	3.6	8.5	12.1	1%
Subtotal	11.7	18.9	30.6	13.5	16.1	29.6	−3%
2. Noncommunicable diseases							
2.1 Noncommunicable diseases	4.1	10.6	14.7	11.1	9.7	20.8	41%
2.2 Mental health and substance abuse	1.8	3.8	5.6	2.9	2.2	5.1	−9%
2.3 Violence and injuries	2.9	6.2	9.2	2.2	5.5	7.7	−16%
2.4 Disability and rehabilitation	0.7	0.1	0.7	0.4	0.1	0.5	−30%
2.5 Nutrition	0.2	2.4	2.6	0.3	1.8	2.1	−21%
Subtotal	9.7	23.1	32.8	16.9	19.2	36.1	10%
3. Promoting health through the life course							
3.1 Reproductive, maternal, newborn, child and adolescent health	3.6	3.4	7.0	3.5	3.5	7.0	0%
3.2 Aging and Health	0.1	1.4	1.5	0.4	1.0	1.4	−8%
3.3 Gender, equity and human rights mainstreaming	0.2	1.2	1.4	0.1	1.1	1.2	−17%
3.4 Social determinants of health	1.0	6.5	7.5	1.8	5.1	6.9	−8%
3.5 Health and the environment	2.4	20.3	22.7	4.5	17.0	21.5	−5%
Subtotal	7.3	32.8	40.1	10.3	27.7	38.0	−5%
4. Health systems							
4.1 National health policies, strategies and plans	4.1	12.2	16.3	4.4	8.1	12.5	−23%
4.2 Integrated people-centred health services	6.4	7.6	14.0	5.3	7.1	12.4	−11%
4.3 Access to medicines and health technologies and strengthening regulatory capacity	0.6	4.4	5.0	1.2	4.1	5.3	5%
4.4 Heath systems Information and evidence	1.1	8.3	9.4	2.6	7.2	9.8	4%
Subtotal	12.3	32.5	44.8	13.5	26.5	40.0	−11%

Category and programme area	2014–2015 allocated budget			2016–2017 proposed budget			% increase / decrease 14–15 to 16–17
5. Preparedness, surveillance and response							
5.1 Alert and response capacities	1.0	4.3	5.3	2.1	3.2	5.3	–1%
5.2 Epidemic- and pandemic-prone diseases	0.9	5.0	5.9	1.4	2.7	4.1	–30%
5.3 Emergency risk and crisis management	1.1	2.5	3.6	3.0	3.5	6.5	81%
5.4 Food safety	0.3	0.6	0.9	0.3	0.8	1.1	23%
Subtotal	3.3	12.4	15.7	6.8	10.2	17.0	9%
6. Corporate services / enabling functions							
6.1 Leadership and governance	12.7	16.3	29.0	18.3	11.9	30.2	4%
6.2 Transparency, accountability and risk management	0.0	2.2	2.2	0.5	1.9	2.4	10%
6.3 Strategic planning, resource coordination and reporting	0.1	3.4	3.5	1.1	3.0	4.1	16%
6.4 Management and administration	5.0	9.9	14.9	6.9	9.0	15.9	7%
6.5 Strategic Communications	0.1	4.3	4.4	1.0	3.4	4.4	–1%
Subtotal	17.9	36.1	54.0	27.8	29.2	57.0	6%
Total	**62.3**	**155.7**	**218.0**	**88.8**	**129.2**	**218.0**	**0%**
Emergencies							
5.5 Polio eradication	1.1	5.8	6.9	1.4	6.0	7.4	7%
5.6 Outbreak and crisis response	2.4	0.6	3.0	0.7	2.3	3.0	0%
Subtotal	3.6	6.4	9.9	2.1	8.3	10.4	5%
Total	**65.9**	**162.0**	**227.9**	**90.9**	**137.5**	**228.4**	**0%**

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