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Le budget programme 2014-2015 – la perspective du Bureau régional de l'OMS pour l'Europe

Le présent document évoque la perspective du Bureau régional de l'OMS pour l'Europe en ce qui concerne l'avant-projet de budget programme 2014-2015. Il a été préparé, et doit donc être lu, en conjonction avec cet avant-projet.

Le document présente le contexte et la justification des choix programmatiques proposés par le secrétariat du Bureau régional de l'Europe pour la période biennale à venir dans le cadre de la réforme en cours à l'OMS. Il est à noter que plusieurs modifications ont été apportées au cours de cette dernière période biennale, lorsque la directrice régionale a pris ses fonctions en février 2010. Ces changements transparaissent dans la planification opérationnelle pour 2012-2013. Certains d'entre eux sont toutefois en suspens en attendant l'issue des discussions sur la réforme de l'OMS. Les efforts visant à appliquer ces changements vont désormais reprendre et, le cas échéant, seront alignés sur le processus de réforme de l'OMS au sens plus large.

Plusieurs nouveaux domaines de travail (réalisations et produits) seront introduits dans un souci de priorisation. En raison du scénario prévoyant des ressources et un budget constants, d'autres domaines ne peuvent plus être retenus. Le modèle institutionnel du Bureau régional de l'OMS pour l'Europe sera davantage affiné afin de fournir le niveau le plus élevé possible d'assistance technique aux États membres, en tenant compte des compétences disponibles dans chaque pays membre ainsi que dans les institutions européennes. En ce qui concerne l'allocation budgétaire et le financement, ce document sur la perspective européenne dépasse le cadre du budget programme pour 2014-2015 en chiffrant les conséquences de la définition des priorités et le financement en vue d'enrichir les débats du Comité régional.

Le Comité régional est invité à examiner et à commenter les propositions présentées dans ce document, et à y apporter des suggestions, dans le contexte du processus de réforme de l'OMS, du douzième programme général de travail et du budget programme 2014-2015, y compris la proposition de scénario d'enveloppe constante pour le budget mondial.

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1. Introduction

1. Le présent document a été préparé conformément au concept d'une seule OMS et d'un seul budget programme. Par conséquent, il doit être consulté en conjonction avec le douzième programme général de travail et le budget programme 2014-2015. Il est prévu un processus en deux étapes : tout d'abord, lors de la soixante-deuxième session du Comité régional de l'OMS pour l'Europe (CR62), ce document étayera le débat engagé par le Comité régional sur le budget programme mondial pour la période 2014-2015 à la lumière des priorités et objectifs spécifiques du Bureau régional de l'OMS pour l'Europe ; ensuite, au CR63 (suite à l'adoption du budget programme mondial par l'Assemblée mondiale de la santé), un engagement se dégagera envers les réalisations et produits spécifiques pour la Région européenne de l'OMS, qui fera office de « contrat » entre le Comité régional et le secrétariat, sous la supervision du Comité permanent du Comité régional (CPCR). Ce « contrat » permettra de promouvoir l'efficacité, la transparence et la responsabilisation eu égard aux résultats et aux ressources, et sera conforme aux précédentes demandes formulées par les organes directeurs de la Région européenne (Comité régional et CPCR).

2. Le travail sur l'utilisation du budget programme comme outil stratégique de responsabilisation (EUR/RC61/Inf.Doc./10) a commencé lors de la période biennale précédente avec un plan visant à expérimenter, entre autres, les concepts, les outils et les responsabilités dans le cadre d'un essai pilote en 2012-2013. Cependant, certains aspects spécifiques de cet essai pilote ont été mis en veilleuse en attendant que se dégage une vision plus claire des discussions relatives à la réforme à l'échelle de l'Organisation. Celles-ci ont désormais tellement progressé que l'essai pilote peut continuer au Bureau régional de l'Europe. Le processus de réforme de l'OMS a notamment permis l'adoption d'une chaîne de résultats utilisée dans le document EUR/RC61/Inf.Doc./10, dont les notions de responsabilité mutuelle pour les réalisations et la responsabilisation spécifique du secrétariat concernant les produits. Le premier rapport sur l'essai pilote de ce cadre de responsabilisation sera présenté au CPCR en novembre 2012. Les autres essais effectués pendant le restant de la période 2012-2013 permettront d'éclairer la planification opérationnelle pour 2014-2015, à compter du début de 2013.

2. Cadre directeur

3. Le douzième programme général de travail et le budget programme 2014-2015 constituent des instruments essentiels pour la mise en œuvre de la réforme de l'OMS. Dans les deux documents, il est prévu que l'OMS ne doit pas tout faire, mais se concentre sur les besoins les plus pressants, là où l'OMS possède des atouts propres. Cela pourrait se traduire par une plus petite OMS, non pas parce que l'Organisation fait moins dans tous les champs d'activités, mais plutôt parce qu'elle est sélective dans ses travaux. Le Bureau régional de l'OMS pour l'Europe et sa directrice régionale soutiennent pleinement les efforts de réforme, le douzième programme général de travail et le budget programme 2014-2015. Ce document relatif à la perspective du Bureau régional de l'Europe constitue une première étape dans la phase de concrétisation des idées, concepts et plans dans la Région européenne.

2.1 Valeurs

4. Le douzième programme général de travail prend comme point de départ la phrase d'introduction du préambule de la Constitution de l'Organisation mondiale de la santé : « La

santé est un état de complet bien-être physique, mental et social, et ne consiste pas seulement en une absence de maladie ou d'infirmité. »

5. Les valeurs clés sous-tendant le nouveau cadre politique européen pour la santé et le bien-être, Santé 2020, ainsi que la perspective du Bureau régional concernant le budget programme 2014-2015 sont en fait le droit au niveau de santé le plus élevé qu'il est possible d'atteindre, tel qu'exprimé dans la Constitution, ainsi que la réduction des inégalités de santé. Ces approches s'inspirent des débats engagés lors de la Soixante-cinquième Assemblée mondiale de la santé sur l'intégration des déterminants sociaux de la santé, et de la résolution WHA62.14 priant l'OMS « de faire des déterminants sociaux de la santé un principe régissant l'application de mesures, notamment d'indicateurs objectifs qui permettent de surveiller les déterminants sociaux de la santé, dans tous les domaines d'activité concernés, et de promouvoir, comme objectif de tous les domaines d'activité de l'Organisation et en particulier des programmes prioritaires de santé publique, l'action sur les déterminants sociaux de la santé en vue de réduire les inégalités en matière de santé. »

2.2 Définition des priorités

6. Le douzième programme général de travail classe les programmes de l'OMS en six catégories pour la définition des priorités : 1) maladies transmissibles ; 2) maladies non transmissibles ; 3) promouvoir la santé à toutes les étapes de la vie ; 4) systèmes de santé ; 5) préparation, surveillance et intervention ; et 6) services institutionnels/fonctions d'appui.[1] En outre, le douzième programme général de travail, à la suite d'une consultation avec les États membres en février 2012 (ce fut d'ailleurs confirmé plus tard par l'Assemblée mondiale de la santé), fixe cinq critères mondiaux pour la définition des priorités entre les catégories et au sein de celles-ci. Un bref résumé de la façon dont ces derniers s'appliquent dans la Région européenne est présenté ci-dessous.

La situation sanitaire actuelle

7. Le Rapport sur la santé en Europe 2012 portera sur le niveau et la répartition de la santé. Plusieurs éléments seront d'ailleurs mis en lumière.

- **Tendances démographiques.** Étant donné la baisse des taux de fécondité dans la Région, la croissance démographique va donc bientôt prendre fin, et la population vieillit déjà rapidement. La migration influence également les transitions démographiques ainsi que les profils de santé des pays. En 2045, il est prévu que 80 % de la population vivra dans les zones urbaines (en augmentation par rapport au pourcentage relevé en 2010, soit 70 %), et l'on estime que la population de la Région comprendra 4 % de migrants en situation régulière et 4 % en situation irrégulière.
- **Mortalité.** Si les indicateurs européens en termes de mortalité infantile sont les plus bas au monde, il existe cependant des différences marquantes entre les pays. Les taux de mortalité maternelle ont été réduits de 50 % depuis 1990, et les tendances de mortalité chez les personnes âgées de 65 ans et plus, toutes causes confondues, ont également diminué. Dans les deux cas, cependant, il existe des différences importantes entre les pays et dans chacun d'eux.
- **Cause de décès.** Les maladies non transmissibles concouraient à 80 % de tous les décès en 2009, les maladies cardiovasculaires représentant près de 50 % de la mortalité, suivies par le cancer (20 %) et les traumatismes et les intoxications (9 %). Les cas de maladies

[1] La perspective spécifique du Bureau régional de l'OMS pour l'Europe concernant chacune de ces six catégories figure à l'annexe A (en anglais).

transmissibles sont moins fréquents que dans le reste du monde. Cependant, depuis 1990, on observe une lente augmentation des maladies infectieuses et parasitaires. Les principaux problèmes sont la tuberculose, notamment la tuberculose multirésistante, le VIH/sida (progression la plus rapide de l'épidémie signalée en Europe orientale et en Asie centrale), d'autres maladies sexuellement transmissibles et les hépatites virales.

- **Charge de morbidité.** La perte évitable d'années de vie corrigées du facteur invalidité (AVCI) oscille entre 10 et 28 % chez les populations des pays à revenus faible et intermédiaire. Cette perte d'AVCI accuse un rythme deux fois supérieur à celui des pays à revenu élevé. Les principaux facteurs de risque à l'origine de la perte d'AVCI sont la nutrition, la sédentarité et la consommation de substances engendrant la dépendance, dont le tabac et l'alcool.

8. Les inégalités de santé continuent de croître dans la Région. Afin de poursuivre l'analyse de l'ampleur et des raisons de ces inégalités, ainsi que de leurs répercussions politiques, le Bureau régional a mis en œuvre l'étude européenne sur les déterminants sociaux de la santé et la fracture sanitaire.[2] En outre, une série de rapports publiés par l'Organisation de coopération et de développement économiques (OCDE) en 2011 laissent entendre que la principale force motrice derrière la hausse des inégalités est l'accroissement des écarts de revenus dans de nombreux pays.[3] La récession économique touchant plusieurs États membres de la Région européenne, accompagnée de mesures d'austérité, va encore aggraver les inégalités à moins que des mesures préventives ne soient prises.

Les besoins des différents pays

9. Les besoins des pays qui ont signé des accords de collaboration biennaux (ACB) avec l'OMS sont bien connus à la lumière des résultats des évaluations menées à ce sujet dans les États en question, et des consultations tenues avant la conclusion des ACB. Pour les pays ne disposant pas d'ACB, cependant, une étude initiale aura lieu au cours des prochains mois afin de s'assurer que leurs besoins et leurs priorités sont bien pris en compte dans les activités menées par le secrétariat. L'objectif est de s'assurer que les besoins de l'ensemble des 53 États membres de la Région européenne sont pris en considération. Il faut également que les possibilités de collaboration pendant la période 2014-2015 soient définies avant que la planification opérationnelle pour 2014-2015 ne commence au début de 2013. Au final, tous les États membres auront formulé des stratégies de coopération nationale avec l'OMS (voir également la section 4.2).

Instruments ayant fait l'objet d'un accord international

10. Un examen des documents et des résolutions des organes directeurs ainsi que des déclarations politiques effectuées lors des conférences ministérielles organisées dans la Région européenne entre 1990 et 2010 a révélé la prise de plus de 1000 engagements au cours de ces vingt dernières années. Certains de ceux-ci, cependant, portent sur des thématiques identiques ou similaires. En outre, plusieurs accords internationaux conclus au niveau de l'Assemblée mondiale de la santé, d'autres entités du système des Nations Unies et instances internationales ont une incidence directe sur la santé. Santé 2020, tel que présenté au RC62, peut être considéré comme un document permettant la consolidation et l'intégration de ces instruments, en se concentrant sur les besoins prioritaires les plus urgents et le comblement des lacunes si nécessaire (voir également la section 3).

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[2] Un résumé de l'étude sur les déterminants sociaux de la santé en Europe et de la fracture sanitaire fait l'objet d'un document de référence pour le comité régional.
[3] www.oecd.org/els/social/inequality (consulté le 21 août 2012)

Interventions rentables et fondées sur des bases factuelles et potentiel d'exploitation des connaissances, des sciences et des technologies

11. C'est la base de l'ensemble du travail accompli dans la Région. Lors de la phase d'élaboration de Santé 2020 au cours de ces deux dernières années, tous les éléments de preuve disponibles ont été systématiquement analysés afin de recenser les interventions les plus rentables pour satisfaire les besoins de la Région en matière de santé. L'examen a notamment porté sur les déterminants sociaux de la santé, la gouvernance et l'adoption d'une approche intersectorielle, la macro-économie, la santé publique, l'économie de la prévention/promotion de la santé, l'impact de la crise financière et les systèmes de santé. En vue d'améliorer et de poursuivre ce travail, le Comité consultatif européen de la recherche en santé a été redynamisé.

Les atouts propres au Bureau régional de l'OMS pour l'Europe

12. Les atouts propres au Bureau régional englobent de nombreux éléments. L'OMS est une organisation d'États membres, de portée mondiale, caractérisée par une adhésion universelle et dotée d'un mécanisme de prise de décisions démocratique. L'OMS a un rôle normatif et un pouvoir fédérateur solides, et collabore en même temps avec les gouvernements pour traduire les connaissances générées grâce à ce travail normatif en politiques, programmes et actions au niveau national. L'OMS fait office de « gardien de la santé publique », et sa principale et seule mission est de protéger les intérêts de la santé publique de la population du monde. Cela s'applique à l'ensemble de l'organisation, et à tous les niveaux. Dans la Région européenne, comme dans toutes les autres Régions, l'OMS est investi d'un mandat clair par ses États membres, d'ailleurs défini par le Comité régional pour l'Europe, qui approuve l'ensemble des politiques, stratégies, plans d'action et autres initiatives stratégiques essentielles pour la Région européenne. L'OMS est politiquement impartiale, et ne sert que les intérêts de la santé publique. Le Bureau régional de l'Europe peut convoquer les États membres de la Région sur toute question de santé publique. Il est le relais de nombreux réseaux techniques de collaboration entre institutions et experts européens. La présence du Bureau régional dans les pays est conforme aux capacités des États en question : elle est particulièrement forte dans plusieurs pays qui en ont le plus besoin. De par sa nature décentralisée, le Bureau régional peut intervenir plus rapidement face aux besoins spécifiques de chaque pays. Il fait office d'intermédiaire et de fédérateur honnête, accessible sur le long terme, et dispose d'une masse critique de compétences dans toute une série de domaines techniques, avec notamment la possibilité de faire appel aux spécialistes de l'ensemble de l'Organisation et de puiser dans l'expertise des institutions de premier plan.

13. Tous ces atouts, combinés à la profondeur de son expérience, mettent le Bureau régional de l'OMS pour l'Europe dans une position unique pour contribuer à la concrétisation du savoir – aider les responsables politiques à mobiliser, trier et appliquer les connaissances – et favoriser l'adoption d'une approche transversale et homogène dans le traitement des thématiques, ce que la plupart des autres organisations sont incapables de faire.

14. Un travail intensif et systématique a été réalisé dans la Région au cours de ces deux dernières années sur la base de critères de priorisation très similaires à ceux convenus par les États membres au niveau mondial. Ce fut le cas lors du processus d'élaboration de Santé 2020, ainsi que dans la planification opérationnelle pour 2012-2013. Ce travail a été réalisé dans le contexte de la vision de la directrice régionale, telle qu'approuvée par le CR60 à Moscou, et en vue d'assurer une plus grande responsabilité à l'égard des organes directeurs. Des liens transversaux entre l'avant-projet de budget programme 2014-2015 et le portefeuille de résultats/produits actuel pour 2012-2013 du Bureau régional figurent dans les annexes B et C.

3. Les principales priorités de la Région européenne

15. La Région européenne a toujours disposé d'une politique de la santé et, par conséquent, le CR60 a prié la directrice régionale de l'OMS pour Europe de mettre à jour la politique européenne de la santé. Santé 2020,[4] un cadre politique global, intégré et axé sur l'action en vue d'améliorer la santé et le bien-être et de réduire le manque d'équité en santé, a donc été soumis au CR62 pour examen. Il attire l'attention des ministres de la Santé et d'autres ministres et responsables sur les déterminants sociaux, économiques et environnementaux de la santé. L'ensemble des politiques, stratégies et programmes de la Région seront élaborés sur la base de ce cadre politique qui, d'ailleurs, orientera également les activités menées par le Bureau régional avec les pays. Le soutien à l'élaboration des politiques nationales de la santé et au renforcement des systèmes de santé constituera la principale approche intégrée, et les déterminants de la santé et de l'équité sont incorporés à tous les domaines techniques et programmes, par le biais de cette politique.

16. Santé 2020 poursuit deux objectifs stratégiques, à savoir : tout d'abord, l'amélioration de la santé pour tous et la réduction de la fracture sanitaire et, ensuite, l'amélioration du leadership et de la gouvernance participative pour la santé. Il recense également quatre grands domaines prioritaires : domaine prioritaire n° 1. « Investir dans la santé en adoptant une perspective qui porte sur toute la durée de la vie et responsabiliser les populations », qui correspond à la catégorie III du douzième programme général de travail ; domaine prioritaire n° 2 : « Relever les principaux défis sanitaires de la Région en matière de lutte contre les maladies non transmissibles et transmissibles », qui correspond aux catégories I, II et V ; domaine prioritaire n° 3 : « Renforcer les systèmes de santé centrés sur la personne, les capacités de santé publique ainsi que la préparation en cas de crise », qui est divisé entre les catégories IV et V du programme général de travail ; et domaine prioritaire n° 4 : « Créer des communautés résilientes et instaurer des environnements de soutien », réparti entre les catégories III et V.

17. Santé 2020 propose six grands buts. Alors que les indicateurs et les buts ne sont pas une fin en soi, ils promeuvent la santé et le bien-être en constituant un outil de priorisation et de motivation de la performance et la responsabilisation. Ces buts sont régionaux dans la mesure où ils sont convenus et seront suivis au niveau régional. Selon les circonstances, tous les États membres contribueront à la réalisation de ces buts et suivront les progrès réalisés en conséquence. De même, le secrétariat concentrera ses ressources et ses efforts afin d'aider les États membres à atteindre les buts d'ici 2020. Certains de ceux-ci peuvent être liés à une seule catégorie du douzième programme général de travail, tandis que d'autres ne peuvent être atteints que grâce aux efforts concertés de nombreux acteurs et programmes (tableau 1).

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[4] *Santé 2020 – Un cadre politique européen à l'appui des actions pangouvernementales et pansociétales en faveur de la santé et du bien-être* (EUR/RC62/9).

Tableau 1. Buts régionaux proposés pour 2020 (toujours un processus en cours qui doit être achevé en 2013)[5]

Grands domaines cibles de Santé 2020	**Grands buts ou cibles générales**	**Principales cibles clés** *(les États membres n'ont pas encore convenu de leur quantification)*	**Catégories**				
			I	**II**	**III**	**IV**	**V**
1. Charge de morbidité et facteurs de risque	1. Réduire la mortalité prématurée dans la Région européenne d'ici à 2020	1. % de réduction annuelle, en valeur relative, de la mortalité globale par maladie cardiovasculaire, cancer, diabète et maladie respiratoire chronique d'ici à 2020		*			
		2. Réaliser et maintenir l'élimination de certaines maladies à prévention vaccinale (poliomyélite, rougeole, rubéole, prévention du syndrome de rubéole congénitale)	*				*
		3. % de réduction des accidents de la route d'ici à 2020		*			
2. Personnes en bonne santé, bien-être et déterminants	2. Augmenter l'espérance de vie en Europe	Augmentation continue de l'espérance de vie au rythme actuel			*		*
	3. Limiter le manque d'équité en matière de santé en Europe (objectif des déterminants sociaux)	Sur le plan de la santé, réduire le fossé entre les groupes touchés par l'exclusion sociale et la pauvreté, et le reste de la population et 1) % ou 2) % à % de réduction de la différence entre les populations européennes en termes d'espérance de vie d'ici à 2020	*	*	*	*	*
	4. Améliorer le bien-être des populations de la Région européenne	En 2012, le Bureau régional de l'Europe a lancé une initiative pour la mesure du bien-être et la définition de buts à cet égard grâce à une alliance internationale à laquelle participent la Commission européenne et l'OCDE. Un groupe d'experts internationaux s'est réuni deux fois et a fourni un cadre et une définition pour le bien-être, cette dernière étant d'ailleurs prise en considération dans le glossaire de Santé 2020. Les prochaines étapes de cette initiative comprennent la définition des indicateurs et des buts.			*		*
3. Processus, gouvernance et systèmes de santé	5. Couverture universelle et « droit à la santé »	Les systèmes de financement des soins de santé garantissent la couverture universelle, la solidarité et et la durabilité d'ici à 2020				*	*
	6. Les États membres fixent des cibles ou buts nationaux	Les processus nationaux de définition des buts sont mis en place, et les buts sont ainsi formulés				*	*

[5] Pour de plus amples informations sur le cadre politique et la stratégie Santé 2020, veuillez consulter le document EUR/RC62/8, paragraphes 126-129 et Encadré n° 5.

4. Les résultats escomptés du secrétariat

18. Le projet de douzième programme général de travail et le projet de budget programme 2014-2015 définissent une nouvelle chaîne de résultats, c'est à dire des ressources, des activités/processus, des produits, des réalisations et un impact. La responsabilité pour les produits incombe exclusivement au secrétariat de l'OMS, alors que celle relative aux réalisations est répartie entre chaque État membre et le secrétariat. L'impulsion en faveur d'une plus grande responsabilisation (notamment la définition plus précise des résultats escomptés par le secrétariat) constitue l'un des principes essentiels de la réforme de l'OMS qui, d'ailleurs, sous-tend à la fois le programme général de travail et le budget programme.

4.1 Le portefeuille de résultats pour la Région

19. Pour la planification opérationnelle 2012-2013, le Bureau régional de l'Europe a utilisé une chaîne de valeurs similaire à celle reprise désormais dans le douzième programme général de travail et dans le budget programme programme 2014-2015. Une plus grande priorité et une plus grande précision ont été cependant accordées aux résultats au niveau régional, ce qui permet de mieux détailler et spécifier les réalisations escomptées. Par ailleurs, la chaîne de valeurs du Bureau régional met l'accent sur les valeurs ajoutées au processus, par exemple par le secrétariat, plutôt que simplement sur les résultats.

20. Le portefeuille de résultats du Bureau régional pour 2012-2013 (cf. l'annexe C) constitue le point de départ de la planification régionale pour 2014-2015. Les modifications apportées au portefeuille actuel ne devrait pas dépasser 20 %. Le portefeuille de 2012-2013 a été élaboré sur la base de la même logique en matière de résultats, à l'aide de critères de priorisation similaires à ceux utilisés pour le programme général de travail et le budget programme 2014-2015. On reconnaît que la réalisation souhaitée des résultats et des impacts de santé publique exige, dans la plupart des cas, des efforts concertés et soutenus sur plusieurs années. Le portefeuille de 2014-2015 représentera une évolution plutôt qu'une révolution. Celui de 2012-2013 comprend 27 résultats prioritaires clés et 57 autres résultats prioritaires. Un examen rigoureux des priorités est actuellement en cours pour déterminer les résultats régionaux qui seront maintenus, ceux qui seront abandonnés progressivement ainsi que les nouveaux à ajouter au portefeuille pour la période 2014-2015.

4.2 Le modèle institutionnel

21. Le Bureau régional situé à Copenhague (Danemark) s'érige en centre des activités de l'OMS en Europe. Outre quatre bureaux géographiquement dispersés (GDO) (à Barcelone, à Bonn, à Venise et à Athènes) et l'Observatoire européen des systèmes et des politiques de santé, on compte 29 bureaux de pays, un bureau de l'OMS à Bruxelles chargé de coordonner les relations avec l'Union européenne, et un sous-bureau du bureau de pays en Serbie situé à Pristina, chargé de la situation humanitaire au Kosovo.

22. Le modèle institutionnel du Bureau régional de l'OMS pour l'Europe dérive des atouts qui lui sont propres (section 2.2), et est principalement motivé par le niveau élevé de compétences et de capacités techniques existant au sein des institutions et services publics européens. Le modèle institutionnel possède deux caractéristiques principales.

- Chaque fois que c'est possible, un modèle interpays prévaudra si les capacités techniques sont disponibles dans les pays afin de répondre à leurs besoins communs par l'adoption d'approches à l'échelle régionale. On s'attend à ce qu'un volume croissant d'activités du

Bureau régional soient réalisées de cette façon. Quand un produit au sein d'un résultat est pertinent pour un nombre limité de pays seulement, un modèle multipays peut être utilisé, en visant une utilisation optimale des ressources au sein du groupe de pays concernés. Des produits sont, et continueront d'être, hautement spécifiques aux besoins et au contexte de chaque pays. Dans ce cas, un mode d'opération axé sur le pays restera le modèle de prédilection.

- La mise en œuvre d'activités systématiques et intensifiées avec les 284[6] centres collaborateurs de l'OMS dans la Région européenne se traduira par la réalisation d'une plus grande proportion de produits conjointement avec ces centres. Parmi les nouvelles pratiques appliquées, il convient de mentionner l'analyse des capacités des centres collaborateurs de l'OMS avant de recruter des consultants externes et du nouveau personnel. Les produits réalisés avec ces centres sont recensés dans les plans de travail au niveau du Système de gestion mondiale (GSM).

23. Le modèle institutionnel susmentionné nécessite une masse critique de compétences techniques hautement qualifiées dans les principaux domaines d'activité prioritaires à des fins d'organisation et de coordination. Ces compétences se situeront principalement au niveau interpays. Du personnel technique sera affecté au niveau des pays uniquement si les circonstances l'exigent et pour une période limitée. Les activités menées dans les pays sont planifiées avec l'État membre concerné, dans le cadre d'un accord de collaboration biennal (ACB), dans lequel sont précisés l'impact à atteindre, ainsi que les réalisations et les produits spécifiques pour chaque cas. Au cours de la période 2012-2013, des stratégies de collaboration avec les pays seront formulées pour couvrir, à terme, tous les États membres, à commencer par ceux qui n'ont pas actuellement conclu d'accord officiel avec le Bureau régional.[7]

5. Budget

24. L'avant-projet de budget programme, présenté au Comité régional pour examen et commentaires, ne comprend pas de chiffres budgétaires pour la période 2014-2015, mais seulement des concordances entre, d'une part, le Plan stratégique à moyen terme pour 2008-2013 et, d'autre part, la structure des dépenses réelles du douzième programme général de travail en 2010-2011 et le budget approuvé pour 2012-2013. Cette section du document relatif à la perspective européenne fournit quelques considérations stratégiques initiales sur les enveloppes budgétaires potentielles et leur ventilation, ainsi qu'une analyse du budget pour 2012-2013. Une description plus détaillée des coûts sera réalisée en préparation pour le Conseil exécutif.

5.1 Deux scénarios budgétaires

25. Deux scénarios sont présentés à l'intérieur du concept d'un budget global constant pour l'OMS dans le cadre du douzième programme général de travail. Le scénario 1 suppose une enveloppe similaire pour le budget des programmes de base du Bureau régional en 2012-2013, tandis que les budgets pour les Programmes spéciaux et dispositifs de collaboration et les Interventions en cas d'épidémies ou de crises ont été ajustés aux dépenses arrondies pour

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[6] Parmi ceux-ci, 111 sont mis en œuvre par le Bureau régional de l'OMS pour l'Europe, le reste principalement par le Siège.
[7] Voir également *Une stratégie de pays pour le Bureau régional de l'OMS pour l'Europe* (document EUR/RC61/17).

2010-2011, afin de mieux refléter les niveaux réels de fonctionnement. Le budget total de ce scénario s'élève donc à 221 millions d'USD (tableau 2).

26. Dans le scénario 2, les budgets pour les Programmes spéciaux et dispositifs de collaboration et les Interventions en cas d'épidémies ou de crises restent les mêmes que dans le premier scénario, alors que le budget pour les programmes de base est porté à 212 millions d'USD. L'hypothèse est qu'au sein de l'enveloppe budgétaire globale et constante de l'OMS, certaines fonctions sont déconcentrées du Siège dans le cadre des efforts de réforme de l'OMS visant à harmoniser et à clarifier la répartition des tâches entre les niveaux de l'Organisation. Il convient de noter que, dans ce scénario, le budget global de l'OMS ne connaîtra aucune modification, seule changera sa répartition entre les différents niveaux.

27. Le tableau 3 présente une concordance concernant les dépenses réelles en 2010-2011 et le budget programme approuvé par l'Assemblée mondiale de la santé pour 2012-2013, entre la structure du Plan stratégique à moyen terme 2008-2013 et la nouvelle structure du douzième programme général de travail pour les programmes de base. En ce qui concerne la période 2014-2015, les deux scénarios présentés dans le tableau précédent sont ventilés par catégorie.

28. Dans le scénario 1, le budget de la catégorie VI a été augmenté de 5 % afin de compenser des hausses de coût anticipées par rapport à 2010-2011. Il convient de noter qu'entre 2010-2011 et 2012-2013, aucune augmentation n'a été portée aux budgets des OS 12/13 (catégorie VI), en dépit d'une hausse considérable des coûts, conduisant ainsi à une réduction marquée des effectifs travaillant dans cette catégorie.

29. Dans les catégories techniques, les catégories II et IV se sont vu allouer des budgets nettement supérieurs à leurs dépenses pour 2010-2011, ce qui confirme l'importance accrue accordée aux maladies non transmissibles et au renforcement des systèmes de santé, d'ailleurs déjà mise en évidence au cours de la période biennale 2012-2013, et présentant en même temps un défi en termes de mobilisation des ressources nécessaires. La catégorie III s'est vu affecter un budget du même niveau que celui de la période 2012-2013, soit environ 15 % au-dessus des dépenses de 2010-2011. Cependant, il convient ici de noter que la majeure partie des activités menées pour Santé 2020, y compris les études connexes, ont été réalisées dans le cadre de l'OS 7, en concordance avec la catégorie III. Les activités de suivi visant à soutenir les politiques de santé nationale seront principalement réalisées dans le cadre de la catégorie IV (Systèmes de santé) et intégrées au travail de l'ensemble des catégories. Le budget affecté à la catégorie V est d'environ 1 million d'USD au-dessus du montant alloué pour la période 2012-2013, mais il est inférieur aux dépenses de 2010-2011. C'est en fait le résultat de la priorisation interne permettant, dans un scénario de ressources constantes, une augmentation continue au niveau des catégories III et IV. Il convient en outre de noter que tous les produits des Interventions en cas d'épidémies ou de crises relèvent de cette catégorie, et que les budgets alloués à ce poste seront ajustés en fonction des besoins d'urgence à mesure qu'ils se présentent.

30. De même, le budget alloué à la catégorie I a été revu à la baisse par rapport à celui de 2012-2013 et aux dépenses réelles en 2010-2011. C'est en fait le résultat de la priorisation réalisée dans le cadre de l'enveloppe budgétaire régionale, qui repose principalement sur les critères liés à la situation de la santé et la disponibilité d'interventions rentables et menées avec succès.

31. Le scénario 2 illustre une situation où certaines fonctions, notamment l'apport d'une assistance technique aux pays, seront décentralisées du Siège. Si les catégories I, III et V offrent le plus grand potentiel à cet égard, toutes les catégories sont en fait concernées. Comme cela se produirait dans le cadre d'une enveloppe budgétaire globale constante, cette décentralisation impliquerait un transfert du budget et des ressources du Siège aux Régions.

Tableau 2 : Deux scénarios budgétaires pour 2014-2015 par segment budgétaire et comparés aux périodes biennales précédentes

Enveloppes budgétaires indicatives pour 2014-2015 – par segment de budget	**Dépenses réelles 2010-2011**		**Budget 2012-2013** Approuvé par l'Ass. mondiale de la santé		**2014-2015**					
					Scénario 1			**Scénario 2**		
	Millions USD	% du total	Millions USD	% du total	Millions USD	% du total	% p. rap. à 2010-2011	Millions USD	% du total	% p. rap à 2010-2011
Programmes de base[note 1]	171,8	86 %	192,9	90 %	193,0	87 %	112 %	212,0	88 %	123 %
Programmes spéciaux et dispositifs de collaboration	23,3	12 %	10,1	5 %	23,0	10 %	99 %	23,0	10 %	99 %
Intervention en cas d'épidémie ou de crise	5,4	3 %	11,1	5 %	5,0	2 %	92 %	5,0	2 %	92 %
Total	**200,5**	**100 %**	**214,1**	**100 %**	**221,0**	**100 %**	**110 %**	**240,0**	**100 %**	**120%**

Note 1 : pour 2012-2013, il est tenu compte d'un transfert de 1,1 million d'USD du Siège à EURO comparé au budget programme approuvé par l'Assemblée mondiale de la santé en raison de la transition managériale du bureau de l'OMS/EU du Siège à EURO

Tableau 3 : Deux scénarios budgétaires pour les programmes de base par catégorie et comparés aux périodes biennales précédentes

Scénarios d'enveloppes budgétaires pour 2014-2015 – programmes de base	**Dépenses réelles 2010-2011**		**Budget 2012-2013** Approuvé par l'Ass. mondiale de la santé		**2014-2015**					
					Scénario 1			**Scénario 2**		
	Millions USD	% du total	Millions USD	% du total	Millions USD	% du total	% p. rap. à 2010-2011	Millions USD	% du total	% p. rap. à 2010-2011
Catégorie I : Maladies transmissibles	24,3	16 %	26,9	14 %	21,1	11 %	87 %	27,6	13 %	113 %
Catégorie II : Maladies non transmissibles	17,8	9 %	29,6	15 %	31,0	16 %	175 %	32,0	15 %	180 %
Catégorie III : Toutes les étapes de la vie	32,7	16 %	37,1	19 %	37,5	19 %	115 %	42,5	20 %	130 %
Catégorie IV : Système de santé	24,8	17 %	34,6	18 %	35,0	18 %	141 %	37,0	17 %	149 %
Catégorie V : Prép., surv. et interv.	16,8	14 %	9,7	5 %	10,5	5 %	62 %	15,0	7 %	89 %
Catégorie VI : Serv. institutionnels[note 1]	55,3	28 %	55,1	29 %	57,9	30 %	105 %	57,9	27 %	105 %
Total	**171,8**	**100 %**	**192,9**	**100 %**	**193,0**	**100 %**	**112 %**	**212,0**	**100 %**	**123 %**

Note 1 : pour 2012-2013, il est tenu compte d'un transfert de 1,1 million d'USD du Siège à EURO comparé au budget programme approuvé par l'Assemblée mondiale de la

5.2 Analyse du budget pour 2012-2013

32. Une analyse des coûts prévus pour la période 2012-2013 figure au tableau 4 et s'inspire du modèle potentiel de présentation du budget pour la période 2014-2015. Le tableau indique la répartition planifiée des coûts entre les activités et le personnel, ainsi que les coûts prévus pour tous les produits techniques, activités uniquement, résumés au niveau des fonctions essentielles de l'OMS. Un certain nombre de questions sont soulevées, en particulier en ce qui concerne la répartition des coûts entre les fonctions de base, notamment le caractère approprié des priorités. Ces questions seront abordées dans l'analyse détaillée des coûts réalisée au cours de ces prochains mois, en vue de préparer la version du budget programme pour 2014-2015 qui sera soumise au Conseil exécutif.

Reflet fidèle du coût des efforts du personnel

33. Dans le modèle institutionnel du Bureau régional de l'OMS pour l'Europe (voir section 4.2), l'assistance technique apportée aux pays est en grande partie assurée par le Bureau régional, y compris les GDO. En vertu des règlements financiers de l'OMS, les coûts du personnel associés sont donc comptabilisés au niveau régional plutôt qu'au niveau national à qui reviennent les avantages. Il en résulte une image déformée des efforts, des coûts des produits et des investissements dans le programme de pays du Bureau régional. Afin d'obtenir une image plus fidèle de la réalité, les membres du personnel feront rapport sur l'endroit et la nature des efforts qu'ils ont en fait déployés. Le résultat de l'analyse pour les six premiers mois de 2012 sera présenté au CPCR, et contribuera à la description plus détaillée des coûts pour la période 2014-2015 d'ailleurs réalisée après le CR62.

5.3 Financement du budget

34. Les ressources disponibles pour le financement des activités du Bureau régional lors de la dernière période biennale se ventilent à peu près comme suit : contributions fixées = 26 %, recettes issues des dépenses d'appui aux programmes = 7 %, compte des contributions volontaires de base = 6 %, et contributions volontaires à des fins spécifiées = 61 %. Dans ce dernier cas, les deux tiers environ ont été mobilisés par le Bureau régional, le reste provenant des efforts de mobilisation de ressources déployés à l'échelle de l'Organisation. La forte proportion de contributions volontaires à des fins spécifiées complique la planification à long terme des résultats et en particulier des capacités des ressources humaines. En outre, ces contributions altèrent souvent la définition des priorités pour certains programmes et activités qui tendent à être surfinancés, tandis que d'autres connaissent des carences à cet égard. Le dialogue prévu dans le processus de réforme de l'OMS à ce sujet pourrait conduire à un financement initial du budget programme. Cela générerait de très nombreux effets positifs sur l'obtention des résultats, et permettrait d'accroître à la fois la pertinence et l'efficacité. En outre, en abandonnant le modèle d'affectation des fonds des contributions fixées en 13 sections, comme c'est actuellement le cas, pour se limiter à une ou peut-être deux sections, on pourra renforcer davantage la capacité du Bureau régional à gérer efficacement les ressources. Il s'agit en effet de s'assurer qu'aucun domaine prioritaire n'est surfinancé en raison de l'affectation des contributions volontaires des donateurs à des fins spécifiques, tandis que d'autres domaines prioritaires sont sous-financés.

Tableau 4 : Analyse préliminaire des coûts prévus en 2012-2013 (tous les segments) par activité, personnel et fonction essentielle de l'OMS

En fonction de l'analyse des produits (données du 10 mai 2012) – tous les segments budgétaires	**Catégories** *(en concordance avec la structure du Plan stratégique à moyen terme)*						
	I : Maladies transm.	**II : Maladies non transm.**	**III : Toutes les étapes de la vie**	**IV : Syst. de santé**	**V : Prép., surv. et interv.**	**VI : Serv. instit..**	**Total**
Budget (millions USD)							
Activités	11,9	16,6	13,5	13,6	8,2	12,6	76,2
Salaires	20,1	13,1	23,6	26,0	12,6	42,5	137,9
Total	**32,0**	**29,6**	**37,1**	**39,6**	**20,8**	**55,1**	**214,1**
Produits (activités) relatifs aux fonctions essentielles							
FE1-Leadership et partenariats	3,1 %,	18,3 %,	20,0 %,	11,3 %,	8,7 %,	38,8 %,	18,1 %,
FE2-Recherche et connaissance	4,5 %,	7,5 %,	11,7 %,	35,2 %,	-	-	10,2 %,
FE3-Normes et critères	27,4 %,	12,2 %,	6,3 %,	8,2 %,	27,1 %,	-	11,9 %,
FE4-Politiques éthiques et fondées sur des b. fact.	0,6 %,	6,3 %,	0,7 %,	9,0 %,	-	-	3,1 %,
FE5-Soutien/Renf. des capacités[note2]	64,2 %,	44,5 %,	60,4 %,	29,8 %,	62,6 %,	11,6 %,	43,4 %,
FE6-Suivi de la santé	0,2 %,	11,3 %,	0,9 %,	6,5 %,	1,6 %,	-	4,0 %,
Soutien institutionnel	-	-	-	-	-	49,6 %,	9,3 %,
Total	**100,0 %**	**100,0 %**	**100,0 %**	**100,0 %**	**100,0 %**	**100,0 %**	**100,0 %**

Note 2: tous les coûts de la catégorie 6 planifiés dans les pays relevant de la fonction essentielle 5

Annex A. Specific perspectives on the six categories

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

Category I – Communicable Diseases

Box 1.

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

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

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

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

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

Key priorities and changes to the portfolio

Current health situation

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

Individual country needs

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

Internationally agreed instruments

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

Evidence-based, cost-effective interventions

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

Comparative advantage of WHO

Since it was founded, WHO has provided stewardship in communicable disease prevention, and is the only international partner to establish processes and set strategies to achieve and certify

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

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

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

Country focus

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

Category II – Noncommunicable Diseases (NCDs)

Box 2

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

1. **Reduce premature mortality in Europe by 2020** – 1. % relative annual reduction in overall mortality from cardiovascular disease, cancer, diabetes, and chronic respiratory disease until 2020; and 3. % reduction in road traffic accidents by 2020

3. **Reduce inequities in health in Europe (social determinants target)** – Reduce the gap in health status between population groups experiencing social exclusion and poverty and the rest of the population and 1) % or 2) %– % reduction in the difference in life expectancy between European populations by 2020.

Some of the highest burden NCDs, which account for the majority of preventable morbidity and death in the WHO European Region, share common risk factors (tobacco use, harmful use of

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

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

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

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

Key priorities and changes to the portfolio

Current health situation

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

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

Needs of individual countries

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

Internationally agreed instruments

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

Evidence-based and cost-effective interventions

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

Comparative advantage of WHO

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

Country focus

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

Category III – Promoting health throughout the life course

Box 3

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

2. **Increase life expectancy in Europe** – Continued Increase in life expectancy at current rate

3. **Reduce inequities in health in Europe (social determinants target)** – Reduce the gap in health status between population groups experiencing social exclusion and poverty and the rest of the population and 1) % or 2) %–% reduction in the difference in life expectancy between European populations by 2020

4. **Enhance well-being of the European population** – (*to be elaborated further during 2012/2013*)

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

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

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

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

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

Key priorities and changes to the portfolio

Current health situation

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

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

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

Needs of individual countries

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

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

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

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

Internationally agreed instruments

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

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

Evidence-based, cost-effective interventions

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

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

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

Comparative advantage of WHO

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

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

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

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

With the presentation of the Strategy and Action Plan for healthy ageing in Europe (EUR/RC62/8) WHO Regional Office for Europe will be ready to support Member States in their efforts to improve quality of life in the older population. Health in all approaches is part of the Regional strategy for prevention of maltreatment and other adverse experiences in childhood planned for RC63 for implementation in 2014–15.

Country focus

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

Category IV – Health systems

Box 4

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

3. **Reduce inequities in health in Europe (social determinants target)** – Reduce the gap in health status between population groups experiencing social exclusion and poverty and the rest of the population and 1) % or 2) %–% reduction in the difference in life expectancy between European populations by 2020.

5. **Universal coverage and "right to health"** – Funding systems for health care guarantee universal coverage, solidarity and sustainability by 2020.

6. **Member States set national targets or goals** – National target setting processes established and targets formulated.

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

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

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

Key priorities and changes to the portfolio

Current health situation

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

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

Needs of individual countries

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

Internationally agreed instruments

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

Evidence-based, cost-effective interventions

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

Comparative advantage of WHO

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

[3] EUR/RC62/10.Add.1 and EUR/RC62/9

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

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

Country focus

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

Category V – Preparedness, surveillance and response

Box 5

Direct contribution to Health 2020:

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

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

Priority Area 4: Creating supportive environments and resilient communities

1. **Reduce premature mortality in Europe by 2020** – 2. Achieve and sustain elimination of selected vaccine preventable diseases (polio, measles, rubella, prevention of Congenital Rubella Syndrome).

2. **Increase life expectancy in Europe** – Continued Increase in life expectancy at current rate.

3. **Reduce inequities in health in Europe (social determinants target)** – Reduce the gap in health status between population groups experiencing social exclusion and poverty and the rest of the population and 1) % or 2) %– % reduction in the difference in life expectancy between European populations by 2020.

4. **Enhance well-being of the European population** (*to be further elaborated during 2012/2013*)

5. **Universal coverage and "right to health"** – Funding systems for health care guarantee universal coverage, solidarity and sustainability by 2020.

6. **Member States set national targets or goals** – National target setting processes established and targets formulated.

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

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

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

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

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

Key priorities and changes to the portfolio

Current health situation

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

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

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

Needs of individual countries

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

Internationally agreed instruments

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

Evidence-based, cost-effective interventions

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

Comparative advantage of WHO

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

Country focus

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

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

Category VI – Corporate services/Enabling functions

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

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

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

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

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

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

Thematic Area 1 – Leadership in health and Strategic Management

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

Thematic Area 2 – Country Focus

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

[4] EUR/RC62/13

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

Thematic Area 3 – Governance and convening

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

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

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

Thematic Area 5 – Strategic communication

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

Thematic Area 6 – Knowledge management

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

Thematic Area 7 – Accountability and Risk Management

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

Thematic Area 8 – Management and administration

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

Annexe B. Proposition de résultats pour 2014-2015 au niveau mondial

Catégorie I : Maladies transmissibles

	Résultats pour 2014-2015 au niveau mondial	**Résultats pour 2012-2013 au niveau européen (annexe B)**
1	Nombre de personnes vivant avec le VIH et qui bénéficient d'un traitement antirétroviral *(VIH/sida)*	**4, 34, 35**
2	Pourcentage de patients tuberculeux dont le cas a été notifié et qui ont bénéficié d'un dépistage du VIH dans les endroits où la prévalence du VIH est élevée *(tuberculose)*	**36**
3	Pourcentage de la population risquant de contracter le paludisme et qui, dans le cadre de la lutte antivectorielle, possède une moustiquaire de lit imprégnée d'insecticide ou est protégée grâce à la pulvérisation d'insecticide à effet rémanent à l'intérieur des habitations *(paludisme)*	**6, 39**
4	Mise en place d'interventions visant à prévenir et à combattre durablement la dengue dans les pays d'endémie prioritaires *(maladies tropicales négligées)*	**S/O**
5	Couverture par la chimioprévention pour lutter contre la filariose lymphatique, l'onchocercose, la schistosomiase, les géohelminthiases et le trachome *(maladies tropicales négligées)*	**33**
6	Nombre de patients tuberculeux bénéficiant d'un traitement contre la tuberculose MR chaque année *(tuberculose)*	**5, 37, 38**
7	Couverture moyenne, à l'échelle mondiale, par trois doses de vaccin antidiphtérique-antitétanique-anticoquelucheux *(maladies à prévention vaccinale)*	**1, 28**

Catégorie II : Maladies non transmissibles

	Résultats pour 2014-2015 au niveau mondial	**Résultats pour 2012-2013 au niveau européen (annexe B)**
1	25 % de baisse relative de l'hypertension artérielle mesurée en fonction de la prévalence standardisée sur l'âge de l'hypertension artérielle chez les sujets âgés de 18 ans et plus *(maladies non transmissibles)*	**9, 44, 45**
2	10 % de baisse relative de l'usage nocif de l'alcool mesurée en fonction de la consommation par habitant du nombre de litres d'alcool pur, dans la population adulte *(maladies non transmissibles)*	**13, 60**
3	30 % de baisse relative de la consommation de tabac à fumer mesurée en fonction de la prévalence standardisée sur l'âge de la consommation de tabac à fumer chez les personnes âgées de 15 ans et plus *(maladies non transmissibles)*	**15, 58, 59**
4	30 % de baisse relative de l'apport alimentaire en sel mesurée en fonction de la consommation moyenne quotidienne de sel, standardisée sur l'âge, dans la population adulte (âgée de 18 ans et plus) *(maladies non transmissibles)*	**9, 14, 19, 57**
5	10 % de baisse relative de la sédentarité mesurée en fonction de la prévalence standardisée sur l'âge d'une activité physique insuffisante chez les adultes âgés de 18 ans et plus *(maladies non transmissibles)*	**9, 57, 61**
6	Absence d'augmentation de l'obésité chez l'adulte mesurée en fonction de la prévalence standardisée sur l'âge de l'obésité chez l'adulte de 18 ans ou plus *(maladies non transmissibles)*	**14, 19**
7	Absence d'augmentation de l'obésité chez l'enfant mesurée en fonction de la prévalence standardisée sur l'âge de l'obésité chez l'enfant de moins de cinq ans *(maladies non transmissibles)*	**14, 19, 57**

8	>80 % de couverture par une polychimiothérapie parmi les personnes âgées de 30 ans et plus qui présentent un risque à l'âge de 10 ans d'infarctus du myocarde ou d'accident vasculaire cérébral ≥30 %, ou qui sont déjà atteintes d'une maladie cardiovasculaire *(maladies non transmissibles)*	**44,45**
9	40 % de réduction relative des retards de croissance mesurée en fonction de la prévalence d'une petite taille pour l'âge (<-2 écarts-types) chez les enfants de moins de cinq ans *(nutrition)*	**19, 57, 72**
10	Taux de traitement chirurgical de la cataracte mesuré en fonction du nombre d'interventions chirurgicales pratiquées par an pour un million d'habitants *(handicaps)*	**S/O**
11	Proportion de pays disposant d'une législation complète concernant les cinq principaux facteurs de risque d'accident de la circulation *(violence et traumatismes)*	**8, 42, 43**
12	Nombre de pays dont la proportion du budget de la santé consacrée à la santé mentale a augmenté *(santé mentale)*	**7, 40, 41, 55, 56**
13	Extension de la prévention et de la détection précoce du cancer pour parvenir aux objectifs suivants : a) dépistage du cancer du col de l'utérus au moins une fois chez 70 % des femmes âgées de 30 à 49 ans ; b) augmentation de 25 % de la proportion de cancers du sein diagnostiqués à un stade précoce ; c) <1 % de prévalence de l'état de porteur du HBsAg *(maladies non transmissibles)*	**44, 46**

Catégorie III : Promouvoir la santé à toutes les étapes de la vie

	Résultats pour 2014-2015 au niveau mondial	**Résultats pour 2012-2013 au niveau européen (annexe B)**
1	Baisse du nombre de grossesses chez les adolescentes *(santé sexuelle et génésique)*	**47**
2	>80 % des enfants chez qui on soupçonne une pneumonie reçoivent des antibiotiques *(santé de l'enfant)*	**48**
3	>50 % des nourrissons sont allaités exclusivement au sein jusqu'à l'âge de six mois *(santé de la mère et du nouveau-né)*	**11**
4	>50 % des mères et des nourrissons bénéficient de soins postnatals dans les deux jours suivant l'accouchement *(santé de la mère et du nouveau-né)*	**11**
5	>de 80 % des femmes enceintes bénéficient de soins prénatals, dispensés par un prestataire qualifié, au moins quatre fois au cours de la grossesse *(santé de la mère et du nouveau-né)*	**11**
6	>de 80 % des femmes enceintes accouchent avec l'aide d'un accoucheur qualifié *(santé de la mère et du nouveau-né)*	**11**
7	Notification d'une baisse des besoins non satisfaits en matière de contraception *(santé sexuelle et génésique)*	**49, 50, 53**
8	Nombre d'États membres qui mettent en œuvre des politiques sectorielles destinées à prévenir et/ou à atténuer les risques environnementaux et professionnels *(santé et environnement)*	**18, 61, 66, 67, 68, 69, 70, 71**
9	À déterminer – indicateur de la couverture par les services de santé concernant le vieillissement *(vieillissement et qualité de vie)*	**10**
10	À déterminer – indicateur de l'équité entre les catégories socio-économiques (*déterminants sociaux)*	**16, 61, 62, 63, 65**
11	À déterminer – indicateur de l'équité entre les sexes *(équité entre les sexes)*	**64, 65**

Catégorie IV : Systèmes de santé

	Résultats pour 2014-2015 au niveau mondial	Résultats pour 2012-2013 au niveau européen (annexe B)
1	Nombre/proportion d'États membres qui : i) disposent d'une stratégie nationale pour le secteur de la santé assortie de buts et de cibles ; ii) procèdent à un examen annuel auquel participent plusieurs parties prenantes ; et iii) établissent un rapport sur l'évaluation de la performance du secteur de la santé dans le cadre des examens annuels *(politiques, stratégies et plans nationaux de santé)*	**17, 21, 23, 24, 26, 73, 80, 81, 82**
2	Nombre/proportion d'États membres où la couverture de l'enregistrement des naissances et de décès – avec indication fiable de la cause de décès – s'améliore parmi ceux où elle est inférieure à 90 % *(politiques, stratégies et plans nationaux de santé)*	**23, 24, 80**
3	Nombre/proportion d'États membres où le pourcentage de ménages confrontés à des dépenses directes catastrophiques : i) est inférieur à XX % ; et ii) n'est pas supérieur dans le quintile le plus pauvre que dans le quintile le plus riche *(politiques, stratégies et plans nationaux de santé)*	**25, 75, 76**
4	Nombre/proportion d'États membres où le pourcentage de ménages appauvris à cause des dépenses directes de santé est inférieur à XX % *(politiques, stratégies et plans nationaux de santé)*	**25**
5	Nombre/proportion d'États membres où l'indice national de couverture par les services essentiels s'améliore *(services de santé intégrés et centrés sur la personne)*	**22, 24, 74, 79**
6	Nombre d'États membres où le paiement des prestataires de soins de santé est réglementé *(services de santé intégrés et centrés sur la personne)*	**S/O**
7	Nombre d'États membres prévoyant une homologation appropriée des prestataires de services *(services de santé intégrés et centrés sur la personne)*	**S/O**
8	À déterminer – indicateur relatif aux personnels de santé *(services de santé intégrés et centrés sur la personne)*	**77, 78**
9	Nombre d'États membres qui mettent en œuvre un contrôle réglementaire approprié des produits médicaux *(accès aux produits médicaux)*	**86**
10	Nombre d'États membres disposant de systèmes de suivi des prix et de la disponibilité des médicaments et des produits médicaux *(accès aux produits médicaux)*	**27**
11	Nombre de pays utilisant une liste de médicaments essentiels, actualisée au cours des cinq dernières années, pour les achats publics et les remboursements *(accès aux produits médicaux)*	**87**

Catégorie V : Préparation, surveillance et intervention

	Résultats pour 2014-2015 au niveau mondial	Résultats pour 2012-2013 au niveau européen (annexe B)
1	Nombre d'États membres qui effectuent ou actualisent une évaluation des risques pour la santé liés à plusieurs dangers en situation d'urgence au moins tous les deux ans *(gestion des crises et des risques associés aux urgences)*	**12**
2	Pourcentage d'États membres qui effectuent, au moins une fois tous les deux ans, un exercice d'entraînement aux interventions en situation d'urgence sanitaire *(gestion des crises et des risques associés aux urgences)*	**52**
3	Pourcentage d'États membres qui offrent un ensemble de services de santé de base aux populations touchées dans les 10 jours suivant la survenue d'une situation d'urgence importante *(gestion des crises et des risques associés aux urgences)*	**32, 51**

4	35. Nombre d'États membres qui possèdent et maintiennent les principales capacités requises par le Règlement sanitaire international (2005) *(capacités d'alerte et d'intervention)*	**3**
5	Pourcentage d'États membres disposant de plans nationaux de gestion des risques en situation d'urgence couvrant les épidémies et les pandémies *(maladies à potentiel pandémique et épidémique)*	**12, 30, 31**
6	Pourcentage d'États membres qui disposent d'un programme de sécurité des hôpitaux *(gestion des crises et des risques associés aux urgences)*	**S/O**
7	Nombre d'États membres qui disposent d'un programme de sécurité sanitaire des aliments doté d'un cadre juridique et d'une structure pour son application *(sécurité sanitaire des aliments)*	**2 (à déterminer), 20, 71**
8	Tous les États membres parviennent aux niveaux de couverture vaccinale requis pour arrêter la transmission du poliovirus (*éradication de la poliomyélite)*	**29**

Annex C. The Regional Office for Europe's Outcome and Output Portfolio - 2012–2013

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

List of abbreviations

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

EC	European Commission
ECDC	European Centre for Disease Prevention and Control
EEA	European economic area
EFSA	European Food Safety Authority
EHEC	Enterohaemorrhagic E. coli is a bacterium that can cause severe food-borne disease.
EMRO	WHO Regional Office for the Eastern Mediterranean
EOC	Emergency operations centre
EURO	WHO Regional Office for Europe
EVIPNet	Evidence-informed policy-making network
FAO	Food and Agriculture Organization of the United Nations
FCTC	WHO Framework Convention for Tobacco Control
Flu Surv	Influenza surveillance
GAVI	The GAVI Alliance (formerly the “Global Alliance for Vaccines and Immunization”) is a public-private global health partnership committed to saving children’s lives and protecting people’s health by increasing access to immunization in poor countries.
GDO	Geographically dispersed office
GF	The Global fund to Fight AIDS, Tuberculosis and Malaria
GPW12	WHO General Programme of Work for the period 2014–2019
GSM	Global Management System
Health 2020	New European framework strategy for health and well-being
HEN	European Health Evidence Network
HFA	Health for All
HFA DBs	Health for All Databases
HiTs	Health Systems in Transition
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
HRBA	Human rights-based approach
HRH	Human resources for health
HRP	United Nations Development Programme/ United Nations Population Fund/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction
HSFP	Health Systems Funding Platform (of the GAVI Alliance)

HSS	Health systems and services
ICD	International Classification of Diseases
ICP	Intercountry programme. This is a means of delivering technical assistance to countries
IHP	International Health Partnership
IHR	International Health Regulations
ILI	Influenza-like illness
IMCI	Integrated management of childhood illnesses
JANS	Joint Assessment of National Health Strategies and Plans
KPO	Key Priority Outcome. These are outcomes in the Regional Office's outcome portfolio, which are given particular attention in terms of monitoring, management, and resourcing
LRTAP	Convention on Long-range Transboundary Air Pollution
M/XDR-TB	Multi and extensively drug-resistance tuberculosis
MAL	Malaria
MC	Multicountry - a mode of delivering technical assistance to countries
MDGs	Millennium Development Goals (Eight United Nations development targets to be achieved by 2015)
MDG1	Eradicate extreme poverty and hunger
MDG2	Achieve universal primary education
MDG3	Promote gender equality and empower women
MDG4	Reduce child mortality
MDG5	Improve maternal health
MDG 6	Combat HIV/AIDS, malaria and other diseases
MDG7	Ensure environmental sustainability
MDG8	Develop a global partnership for development
MDR TB	Multi-drug resistant tuberculosis
MEA	Multilateral environmental agreements
mhGAP	Mental Health Gap Action Programme
MNH	Mental health
MPOWER	Measures, set out in the WHO FCTC, to assist in country-level implementation of effective interventions to reduce the demand for tobacco

MS	Member State of WHO
MTSP	Medium-term Strategic Plan 2008–20013
NCD	Noncommunicable disease
NCD AP	Action Plan for the Global Strategy on the Prevention and Control of Noncommunicable Diseases
NGO	Nongovernmental organization
NHP	National health policy
NIS	Newly independent States
NTDs	Neglected tropical diseases
Nut	Nutrition
OCR	Outbreak and crisis response. These activities are governed by acute external events. The resource requirements are normally significant and difficult to predict and budgeting is therefore an uncertain process.
OECD	Organization for Economic Co-operation and Development
OIE	World Organization for Animal Health
OPO	Other Priority Outcome
OWER	Organization-wide Expected Results. These are part of the MTSP2008-2013 results chain
PA	Physical activity
PB	WHO biennial Programme Budget
PHC	Primary health care
PHEM	Public health and emergency management
PHS	Public health services
RC	WHO Regional Committee for Europe
SARI surv	Severe Acute Respiratory Infections surveillance
SCRC	Standing Committee of the WHO Regional Committee for Europe
SDH	Social Determinants of Health
SO	Strategic objectives, as set out in MTSP208-2009:
SO1	Communicable diseases
SO2	HIV/AIDS, Tuberculosis and Malaria
SO3	Chronic non communicable conditions

SO4	Child, adolescent, maternal, sexual and reproductive health, and ageing
SO5	Emergencies and disasters
SO7	Risk factors for health
SO8	Healthier environment
SO9	Nutrition and food safety
SO10	Health systems and services
SO11	Medical products and technologies
SO12	WHO leadership, governance and partnerships
SO13	Enabling and support functions
SO13bis	The part of SO13 that is financed through the post-occupancy charge, which is included as a programme direct cost within all strategic objectives and appears in work plans as an integral component of the standard staff cost. These costs are separated out and explicitly shown in Annex 1 of the PB2012-2013. This is done in order to avoid double accounting.
SPA	Special programmes and collaborative arrangements. These are activities that are fully within WHO's results hierarchy and over which WHO has executive authority. The activities in this budget segment, however, are undertaken in collaboration with partners and thus the magnitude of associated operations is determined by the special nature of the activity and the joint strategic decisions of the collaboration.
SWAPs	Sector-wide approaches
TB	Tuberculosis
TEACH-VIP	A comprehensive injury prevention and control curriculum
THE PEP	The Pan-European Programme on Transport and Health
UN	United Nations
UN City	Shared facilities for all UN organizations in Copenhagen. WHO will move into these new premises early 2013.
UNECE	United Nations Economic Commission for Europe
UNEP	United Nations Environment Programme
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
VCS	Specified Voluntary Contributions. Earmarked voluntary funding contributions with strict restrictions on use imposed by the donor.
VG	Vulnerable group
VIP	Violence and injury prevention

WB	World Bank
WHA	World Health Assembly
WHO	World Health Organization
WHO CC	WHO Collaborating Centre
WMO	World Meteorological Organization
WPV	Wild poliovirus