Всемирная организация здравоохранения

Европейское региональное бюро

Европейский региональный комитет
Шестьдесят вторая сессия

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ОРИГИНАЛ: АНГЛИЙСКИЙ

Программный бюджет на 2014–2011 гг. – взгляд с позиций Европейского регионального бюро ВОЗ

Настоящий документ отражает позиции Европейского регионального бюро ВОЗ в отношении предлагаемого проекта программного бюджета на 2014–2015 гг. (ПБ 2014–2015), на основе которого он был составлен. Поэтому оба документа следует рассматривать совместно.

Документ содержит отправные сведения и обоснование программных решений, предлагаемых Секретариатом Европейского регионального бюро на предстоящий двухлетний период в контексте проводимой в настоящее время реформы ВОЗ. Следует отметить, что в течение предшествующего двухлетнего периода, после того как Региональный директор в феврале 2010 г. приступила к своим обязанностям, был осуществлен ряд изменений, нашедших отражение в процессе оперативного планирования на 2012–2013 гг. При этом внедрение отдельных изменений было задержано до получения результатов дискуссий по реформе ВОЗ. Работа по практическому осуществлению данных изменений теперь будет возобновлена и, по мере необходимости, приведена в соответствие с процессом реформы ВОЗ в более общем плане.

В ходе приоритизации будет установлен ряд новых областей работы (намечены промежуточные и итоговые результаты). В условиях постоянного бюджета и объема ресурсов это будет означать невозможность сохранения некоторых других областей. Будет осуществляться дальнейшее совершенствование бизнес-модели Европейского регионального бюро ВОЗ в целях обеспечения на высоком уровне наилучшей возможной технической помощи государствам-членам, с учетом имеющейся экспертизы в отдельных государствах-членах и европейских учреждениях. Что касается бюджетных ассигнований и финансирования, содержание документа выходит за рамки ПБ 2014–2015 и включает цифры, характеризующие результаты распределения приоритетов и вопросы финансирования, для придания дополнительной актуальности дискуссиям на сессии Регионального комитета.

Региональному комитету предлагается рассмотреть и обсудить документ и дать замечания и рекомендации по содержащимся в нем предложениям, с учетом процесса реформы ВОЗ, Двенадцатой общей программы работы и ПБ 2014–2015, включая предлагаемый сценарий сохраняющегося на постоянном уровне глобального бюджетного пакета.

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ • ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО
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Содержание

1. Введение

1. Настоящий документ подготовлен в соответствии с концепцией Единая ВОЗ – Единый программный бюджет. Поэтому его следует рассматривать совместно с Двенадцатой общей программой работы (ОПР-12) и Программным бюджетом на 2014–2015 гг. (ПБ 2014–2015). Предусматривается двухступенчатый процесс: вначале, на шестьдесят второй сессии Европейского регионального комитета ВОЗ (РК-62) данный документ ляжет в основу обсуждений глобального программного бюджета на 2014–2015 гг., касающихся специфических приоритетов и планируемых результатов деятельности Европейского регионального бюро ВОЗ; затем, на РК-63 (после принятия Всемирной ассамблеей здравоохранения глобального Программного бюджета) будут приняты обязательства в отношении конкретных промежуточных и итоговых результатов для Европейского региона ВОЗ. Эти обязательства лягут в основу "контракта" между Региональным комитетом и Секретариатом, надзор за выполнением которого будет осуществлять Постоянный комитет Регионального комитета (ПКРК). Такой контракт будет способствовать эффективности, прозрачности и подотчетности в отношении как результатов, так и ресурсов, и будет учитывать запросы, поступившие ранее от европейских руководящих органов (РК и ПКРК).

2. Работа по использованию Программного бюджета как стратегического инструмента подотчетности (см. EUR/RC61/Inf.Doc./10) была начата в прошлом двухлетии, когда, в частности, было принято решение провести в период 2012–2013 гг. пилотное тестирование концепций, инструментов и порядка распределения ответственности. Однако осуществление конкретных аспектов этой апробации было отложено до получения четких результатов проводимых в масштабах всей Организации обсуждений реформы ВОЗ. Эти обсуждения сейчас настолько продвинулись вперед, что данный пилотный проект Европейского регионального бюро может быть продолжен. Следует особо отметить, что в рамках процесса реформирования ВОЗ была принята цепочка результатов, использованная в EUR/RC61/Inf.Doc./10, включая концепции взаимной подотчетности за итоговые результаты и подотчетности Секретариата за промежуточные результаты. Первый доклад о практической апробации данной схемы подотчетности будет представлен на рассмотрение на совещании ПКРК в ноябре 2012 г. Результаты дальнейшей апробации, которая будет проходить в течение оставшейся части двухлетия 2012–2013 гг., будут учтены при оперативном планировании на 2014–2015 гг. (начнется в начале 2013 г.).

2. Руководящие принципы

3. ОПР-12 и ПБ 2014–2015 являются важнейшими инструментами для осуществления реформы ВОЗ. Основной принцип, заложенный в этих документах, заключается в том, что ВОЗ не будет стремиться к всеобъемлющей деятельности, но сосредоточит свои усилия на тех областях, где имеются самые значительные потребности и где у ВОЗ есть сравнительные преимущества. Это означает, что определенное сокращение объемов деятельности ВОЗ станет результатом не ослабления усилий по всем направлениям, а более четкого и избирательного определения приоритетных областей работы. Европейское региональное бюро ВОЗ и Региональный директор полностью поддерживают работу по реформированию ВОЗ, ОПР-12 и ПБ 2014–2015. Настоящий документ, в котором изложена позиция Европейского регионального бюро, – первый шаг по претворению идей, концепций и планов в практические действия на уровне Европейского региона.

2.1 Ценности

4. Отправной точкой ОПР-12 служат вступительные слова преамбулы Устава Всемирной организации здравоохранения: “Здоровье является состоянием полного физического, душевного и социального благополучия, а не только отсутствием болезней и физических дефектов”.

5. Ключевыми ценностями, на которых строятся основы новой Европейской политики в поддержку здоровья и благополучия Здоровье-2020, а также позиция Регионального бюро по ПБ 2014–2015, являются закрепленное в Уставе право на наивысший достижимый уровень здоровья и сокращение социальных неравенств по показателям здоровья. В основе данного подхода лежат проходившие в рамках Шестьдесят пятой сессии Всемирной ассамблеи здравоохранения обсуждения о важнейшем значении социальных детерминант здоровья, а также резолюция WHA62.14, в которой ВОЗ предлагается: “принять социальные детерминанты здоровья в качестве одного из руководящих принципов для реализации мер, включая объективные показатели мониторинга социальных детерминант здоровья во всех соответствующих областях работы, и содействовать воздействию на социальные детерминанты здоровья для уменьшения несправедливости в отношении здоровья в качестве цели всех областей работы Организации, особенно приоритетных программ общественного здравоохранения”.

2.2 Установление приоритетов

6. В ОПР-12 программы ВОЗ в целях установления приоритетов распределены по шести следующим категориям: (I) инфекционные болезни; (II) неинфекционные заболевания; (III) укрепление здоровья на протяжении всей жизни; (IV) системы здравоохранения; (V) обеспечение готовности, эпиднадзор и ответные действия; (VI) корпоративные услуги/вспомогательные функции[1]. Помимо этого в ОПР-12 на основе выводов консультации с государствами-членами (февраль 2012 г.), в дальнейшем подтвержденных Всемирной ассамблеей здравоохранения, сформулированы пять глобальных критериев для установления приоритетов между категориями и внутри отдельных категорий. Ниже приведено краткое описание этих критериев в применении к Европейскому региону.

Текущая ситуация в области здравоохранения

7. Общий уровень здоровья населения и распределение его показателей будут описаны в Докладе о состоянии здравоохранения в Европе, 2012 г. Наиболее яркие черты текущей ситуации следующие:

- **Демографические тенденции.** По мере повсеместного сокращения уровней фертильности рост численности населения скоро прекратится, при этом отмечается его стремительное старение. На демографические процессы и характеристики показателей здоровья стран также влияет миграция. Прогнозируется, что к 2045 г. 80% населения Региона будет проживать в городских зонах (в 2010 г. этот показатель составлял 70%); население Региона, по оценкам, будет включать 4% официально зарегистрированных и 4% незарегистрированных мигрантов.

[1] Частные перспективы Европейского регионального бюро ВОЗ по каждой из шести категорий приведены в Приложении А.

- **Смертность.** Показатели детской смертности в Европе самые низкие в мире. Однако имеются резкие различия между странами. За период с 1990 г. уровни материнской смертности снизились на 50%, также отмечаются тенденции снижения смертности от всех причин среди лиц в возрасте 65 лет и старше. По обоим последним показателям, однако, имеются существенные различия между странами и внутри стран.
- **Причины смерти.** В 2009 г. 80% всей смертности приходилось на НИЗ, причем почти 50% всей смертности обусловили сердечно-сосудистые заболевания, за которыми следовали злокачественные новообразования (20%) и травмы и отравления (9%). Инфекционные болезни встречаются реже, чем в остальной части мира. Однако в период с 1990 г. наблюдается медленный рост инфекционной и паразитарной заболеваемости. Основную озабоченность вызывают туберкулез, включая туберкулез с множественной лекарственной устойчивостью (МЛУ-ТБ), ВИЧ/СПИД, распространение которого наиболее быстро происходит в странах Восточной Европы и Центральной Азии, другие болезни, передаваемые половым путем, а также вирусные гепатиты.
- **Бремя болезней.** Устранимое сокращение числа лет жизни с поправкой на ограничения жизнедеятельности (показатель DALY) составляет, по различным странам, от 10% до 28%, причем в странах с низким и средним уровнем дохода масштабы потерь DALY вдвое выше, чем в странах с высоким уровнем дохода. Эти потери связаны, главным образом, с воздействием таких факторов риска, как нездоровое питание, недостаток физической активности и использование веществ, вызывающих привыкание, включая табак и алкоголь.

8. В Регионе продолжается обострение социальных несправедливостей в отношении здоровья. В целях углубленного анализа масштабов, причин и стратегического значения этих неравенств, по поручению Европейского регионального бюро проведено исследование – Европейский обзор социальных детерминант здоровья и разрыва по показателям здоровья[2]. В ряде докладов Организации экономического сотрудничества и развития (ОЭСР), опубликованных в 2011 г., содержатся выводы о том, что основная движущая сила в росте несправедливостей – это наблюдаемый во многих странах углубляющийся разрыв по уровням дохода населения[3]. Экономический спад в ряде государств-членов Европейского региона, который сопровождается мерами жесткой бюджетной экономии, еще в большей степени углубит социальные неравенства, если не принять меры, направленные на их преодоление.

Потребности отдельных стран

9. Потребности стран, подписавших двухгодичные соглашения о сотрудничестве (ДСС) с ВОЗ, хорошо известны благодаря проведенным оценкам страновых медико-санитарных потребностей и консультациям, на основе которых составлялись ДСС. Для стран, где нет ДСС, в течение предстоящих месяцев будет осуществлен первоначальный обзор, чтобы обеспечить адекватный учет их потребностей и приоритетов при планировании деятельности Секретариата. Цель заключается в том, чтобы еще до старта (в начале 2013 г.) процесса оперативного планирования на 2014–2015 гг. определить потребности всех 53 государств-членов и наметить спектр сотрудничества на

[2] Рабочее резюме Европейского обзора социальных детерминант и разрыва по показателям здоровья представлено Региональному комитету в качестве справочного документа.
[3] www.oecd.org/els/social/inequality (по состоянию на 21 августа 2012 г.).

2014-2015 гг. Предусмотрено, что в перспективе во всех государствах-членах будут составлены стратегии странового сотрудничества с ВОЗ (см. также раздел 4.2).

Согласованные международные инструменты

10. Проведенный обзор документов, резолюций руководящих органов и политических заявлений министерских конференций, состоявшихся в Европейском регионе за период с 1990 по 2010 гг., выявил свыше 1000 обязательств, которые были приняты в течение этого двадцатилетнего периода. Некоторые из них отражают идентичную или сходную тематику. Кроме того, имеется ряд международных соглашений на уровне Всемирной ассамблеи здравоохранения, других структур ООН и международных форумов, имеющих непосредственное отношение к вопросам здоровья. Политику Здоровье-2020, основы которой представлены на РК-62, можно рассматривать в качестве консолидирующего и интегрирующего механизма для этих обязательств с особым вниманием к наиболее актуальным приоритетным потребностям и к заполнению выявляемых пробелов (см. также раздел 3).

Научно обоснованные, эффективные с точки зрения затрат мероприятия и потенциал для использования знаний, науки и технологии

11. Вышеуказанные факторы определяют всю деятельность в Регионе. В ходе проводимой в течение последних двух лет разработки политики Здоровье-2020 все имеющиеся фактические данные были систематическим образом проанализированы в целях выявления наиболее затратно-эффективных вмешательств для удовлетворения медико-санитарных потребностей Региона. В частности, предприняты обзоры по таким темам, как социальные детерминанты здоровья, стратегическое руководство и межсекторальное сотрудничество, макроэкономика и общественное здравоохранение, экономические аспекты профилактики и укрепления здоровья, последствия финансового кризиса и системы здравоохранения. Для дальнейшего развития и продолжения этой работы активизирована деятельность Европейского консультативного комитета по научным исследованиям в области здравоохранения (EACHR).

Сравнительные преимущества Европейского регионального бюро ВОЗ

12. Сравнительные преимущества Регионального бюро включают множество элементов. ВОЗ – это организация государств, которая имеет глобальный характер и характеризуется всеобщим членством и демократическим механизмом принятия решений. ВОЗ обладает важной нормативной функцией и способностью объединять усилия различных заинтересованных сторон, и в то же время работает с правительствами стран, для того чтобы претворить знания, накопленные путем ее нормативной деятельности, в национальную политику, программы и действия. ВОЗ – “гарант общественного здравоохранения”, и основной и единственный интерес Организации на всех ее уровнях – это защита здоровья людей во всем мире. В Европейском регионе, как и во всех остальных регионах, ВОЗ имеет четкий мандат от своих государств-членов, полученный через Европейский региональный комитет, поскольку все стратегии, политика, планы действий и другие ключевые стратегические вмешательства должны получить его одобрение. ВОЗ – это политически нейтральная организация, которая преследует только интересы общественного здоровья. Европейское региональное бюро может созывать вместе государства-члены для обсуждения любого вопроса общественного здравоохранения; это центр многочисленных технических и сотрудничающих сетей, организаций и учреждений и отдельных экспертов со всей Европы. Региональное бюро поддерживает свое присутствие в странах в соответствии с их потенциалом – более мощное в отдельных странах, где имеются максимальные потребности. Децентрализованная природа Бюро означает, что оно может реагировать и

удовлетворять конкретные потребности индивидуальных стран более оперативным образом. Региональное бюро – это честный посредник и долгосрочная мобилизующая сила; оно имеет критическую массу экспертизы по широкому кругу индивидуальных технических областей, включая возможность привлекать специалистов из различных звеньев Организации и использовать экспертные знания ведущих учреждений.

13. Все эти сильные стороны, в сочетании с богатством практического опыта, ставят Европейское региональное бюро ВОЗ в уникальное положение для оказания поддержки в реальном претворении знаний – помогая руководителям, отвечающим за проведение политики, распределять и применять знания, а также для активного применения междисциплинарного подхода к оптимальному решению различных вопросов, что выходит за рамки возможностей большинства других организаций.

14. В Регионе в течение последних двух лет проводится интенсивная систематическая работа с использованием критериев приоритизации, весьма аналогичных тем, которые были согласованы государствами-членами на глобальном уровне. Это стало характерной чертой процесса разработки политики Здоровье-2020, а также оперативного планирования на 2012–2013 гг. Данная работа проводилась с учетом концептуального видения Регионального директора, которое было утверждено на РК-60 в Москве, и в целях обеспечения большей подотчетности на уровне руководящих органов. Взаимосвязи между предлагаемым проектом программного бюджета на 2014–2015 гг. и имеющимся портфелем итоговых и промежуточных результатов работы Регионального бюро (2012–2013 гг.) приведены в Приложениях B и C.

3. Основные приоритеты Европейского региона

15. Традицией Европейского региона ВОЗ является наличие сформулированной политики в области здравоохранения, и поэтому РК-60 предложил Региональному директору подвергнуть эту политику очередному обновлению. Всеобъемлющие, комплексные и ориентированные на практические действия основы политики, получившей название “Здоровье-2020”[4] и направленной на улучшение здоровья, повышение уровня благополучия и сокращение неравенств по показателям здоровья, представлены на рассмотрение РК-62. Основы политики Здоровье-2020 ставят перед министрами здравоохранения, а также министрами и другими руководителями, определяющими политику остальных секторов, задачи по воздействию на социальные, экономические и экологические детерминанты здоровья. Все направления политики, стратегии и программы в Регионе будут разрабатываться в рамках этих основ политики, в соответствии с ними Региональное бюро будет вести работу со странами. Основным объединяющим приоритетом станет поддержка в разработке национальных стратегий и укреплении систем здравоохранения, а детерминанты здоровья и вопросы социальной справедливости выведены благодаря этой политике на первый план во всех технических областях и программах.

16. Политика Здоровье-2020 призвана решить две стратегические задачи: первая – улучшение здоровья для всех и сокращение разрыва по показателям здоровья; вторая – совершенствование лидерства и коллективного руководства в интересах здоровья. Далее в основах определены четыре широких приоритетных области: Приоритетная область 1: “Инвестирование в здоровье на всех этапах жизни человека и расширение прав и возможностей граждан”, что соотносится с категорией III ОПР-12; Приоритетная

[4] *Здоровье-2020: Основы Европейской политики в поддержку действий всего государства и общества в интересах здоровья и благополучия* (EUR/RC62/9).

область 2: “Решение наиболее актуальных проблем Региона в отношении инфекционных и неинфекционных заболеваний”, что соотносится с категориями I, II и V; Приоритетная область 3: “Укрепление ориентированных на человека систем здравоохранения, потенциала охраны общественного здоровья, а также готовности к чрезвычайным ситуациям”, разделена между категориями IV и V ОПР; Приоритетная область 4: “Создание благоприятных условий окружающей среды и обеспечение “прочности” местных сообществ”, разделена между категориями III и V.

17. В основах политики Здоровье-2020 предложены также шесть главных целевых ориентиров. Хотя использование индикаторов и целевых ориентиров и не является самоцелью, они содействуют улучшению показателей здоровья и благополучия, являясь инструментом приоритизации и обеспечения эффективности и подотчетности. Эти целевые ориентиры являются региональными в том смысле, что они согласованы и будут отслеживаться на региональном уровне. В зависимости от своих обстоятельств все государства-члены будут вносить вклад в достижение этих целевых ориентиров и, соответственно, осуществлять мониторинг достигнутого прогресса. Со своей стороны, Секретариат сосредоточит ресурсы и усилия на оказании поддержки государствам-членам в достижении этих целевых ориентиров к 2020 г. Некоторые из целевых ориентиров можно привязать к отдельным категориям ОПР-12, тогда как другие могут быть достигнуты только благодаря коллективным усилиям многих сторон и в рамках множества программ (табл. 1).

Таблица 1. Предлагаемые региональные целевые ориентиры для достижения к 2020 г. (работа по их составлению продолжается, ее завершение ожидается в 2013 г.)[5]

Широкие целевые области политики Здоровье-2020	**"Всеобъемлющие", или главные целевые ориентиры**	**Ключевые целевые области** *(Количественные параметры подлежат согласованию с государствами-членами)*	**Категории**				
			I	**II**	**III**	**IV**	**V**
1. Бремя болезней и факторы риска	1. К 2020 г. сократить преждевременную смертность среди населения Европы	1. % относительного ежегодного (в период до 2020 г.) снижения общей смертности от сердечно-сосудистых заболеваний, рака, диабета и хронических болезней органов дыхания		*			
		2. Добиться устойчивой элиминации отдельных болезней, предупреждаемых с помощью вакцин (полиомиелит, корь, краснуха, профилактика синдрома врожденной краснухи)	*				*
		3. % сокращения к 2020 г. частоты дорожно-транспортных несчастных случаев		*			
2. Здоровые люди, благополучие и детерминанты	2. Повысить среднюю продолжительность жизни в Европе	Непрерывный рост средней продолжительности жизни с сохранением имеющихся на сегодня темпов			*		*
	3. Сократить масштабы несправедливостей в отношении здоровья в Европе (ориентир в сфере социальных детерминант)	Сократить разрыв по показателям здоровья между группами, подверженными социальному отчуждению и бедности, и остальной частью населения с сокращением на 1) % или 2) %–% различий в средней продолжительности жизни между группами европейского населения	*	*	*	*	*
	4. Повысить уровень благополучия населения Европы	В 2012 г. Европейское региональное бюро, в рамках международного альянса с участием Европейской комиссии и ОЭСР, приступило к реализации инициативы по разработке измеримых показателей и установлению целевых ориентиров для повышения уровня благополучия. Международная группа экспертов провела два совещания и составила концептуальные рамки и определение понятия "благополучие"; это определение приведено в глоссарии основ политики Здоровье-2020. Следующие шаги в рамках этой инициативы включают разработку индикаторов и целевых ориентиров.			*		*
3. Процессы, стратегическое руководство и системы здравоохранения	5. Всеобщий охват и "право на здоровье"	К 2020 г. системы финансирования медико-санитарной помощи будут гарантировать всеобщий охват, солидарность и устойчивость в предоставлении услуг				*	*
	6. Государства-члены определяют национальные целевые ориентиры или цели	Процессы национального целевого планирования созданы, и целевые ориентиры сформулированы				*	*

[5] Более детальное описание основ политики и стратегии Здоровье-2020 – см. документ EUR/RC62/8, пункты 126–129 и вставку 5.

4. Какие практические задачи предстоит решить Секретариату

18. В проектах ОПР-12 и Программного бюджета на 2014–2014 гг. предлагается новая цепочка результатов, а именно: вводимые ресурсы (input) – мероприятия и процессы (activities/processes) – промежуточные результаты (outputs) – итоговые результаты (outcomes) – конечный полезный эффект (impact). Достижение промежуточных результатов относится исключительно к сфере ответственности Секретариата ВОЗ, тогда как ответственность за итоговые результаты разделена между отдельными государствами-членами и Секретариатом. Одним из основных принципов реформы ВОЗ, лежащих в основе как ОПР, так и ПБ, является стремление к большей подотчетности, включая более четкое определение конкретных практических задач, за решение которых отвечает Секретариат ВОЗ.

4.1 Региональный портфель итоговых результатов

19. В процессе оперативного планирования на 2012–2013 гг. Европейское региональное бюро использовало такую же цепочку ценностей, какая в настоящее время включена в ОПР-12 и ПБ 2014–2015, однако с большим упором и с большей детализацией в отношении итоговых результатов на региональном уровне, таким образом обеспечивая более подробное изложение и специфичность поставленных задач. В цепочке ценностей Регионального бюро, кроме того, учитываются и дополнительные полезные эффекты, например привнесенные Секретариатом, а не просто результаты деятельности.

20. Портфель итоговых результатов Регионального бюро на 2012–2013 гг. (см. Приложение C) – это отправная точка для регионального планирования на 2014–2015 гг. Масштаб изменений настоящего портфеля, по прогнозам, не превысит 20%. Портфель на 2012–2013 гг. был разработан с использованием той же логики получения результатов и критериев приоритизации, как и в ОПР, и в ПБ 2014–2015, и с учетом того, что достижение желаемых итоговых результатов и конечного полезного эффекта для общественного здоровья в большинстве случаев требуют согласованных и устойчивых усилий в течение ряда лет. Таким образом, портфель на 2014–2015 гг. отражает скорее “эволюционные”, чем “революционные” процессы. Портфель итоговых результатов на 2012–2013 гг. включает 27 “ключевых приоритетных итоговых результатов” (Key Priority Outcomes, KPO) и 57 “других приоритетных итоговых результатов” (Other Priority Outcomes, OPO). В настоящее время проводится тщательный анализ приоритизации, для того чтобы решить, какие региональные итоговые результаты следует сохранить, какие упразднить и какие новые результаты добавить к портфелю на 2014–2015 гг.

4.2 Бизнес-модель

21. Центр сосредоточения работы ВОЗ в Европе – это Региональное бюро, базирующееся в Копенгагене (Дания). Кроме этого, функционируют четыре географически удаленных офиса (ГУО) в Барселоне, Бонне, Венеции и Афинах, Европейская обсерватория по системам и политике здравоохранения, офис в Брюсселе, который отвечает за координацию взаимоотношений с Европейским союзом, а также 29 страновых офисов и филиал офиса ВОЗ в Сербии, находящийся в Приштине и занимающийся вопросами гуманитарной ситуации в Косове.

22. Бизнес-модель Европейского регионального бюро ВОЗ базируется на его сравнительных преимуществах (раздел 2.2), и ее основной движущей силой является высокий уровень профессиональных навыков и технического потенциала, который существует в европейских учреждениях и государственных службах. Модель характеризуется двумя следующими принципиальными чертами.

- Везде, где возможно, будет превалировать межстрановой формат деятельности – когда страны используют имеющиеся у них технические возможности для решения общих проблем на основе общерегиональных подходов. Ожидается, что представленность данного формата в суммарном объеме работы Регионального бюро будет возрастать. Там, где непосредственные промежуточные результаты в рамках получения итоговых результатов актуальны лишь для ограниченного числа стран, может быть использован многострановой подход, который позволит обеспечить оптимальное использование ресурсов, имеющихся в пределах данной группы стран. Однако имеются и будут сохраняться в последующем промежуточные результаты, которые носят сугубо специальный характер в приложении к потребностям и условиям отдельных стран. В подобных случаях методом выбора будет оставаться страновой формат деятельности.
- Систематическая и активизированная работа с 284[6] сотрудничающими центрами (СЦ) ВОЗ в пределах Европейского региона будет означать, что все большая доля непосредственных результатов будет достигаться в кооперации с этими центрами. Вновь вводимая практика включает положение о том, что прежде чем осуществлять найм на работу новых сотрудников и привлекать внешних консультантов, будут изучаться возможности соответствующих сотрудничающих центров. Промежуточные результаты, полученные в сотрудничестве с СЦ ВОЗ, учитываются в рабочих планах Глобальной системы управления.

23. Для практического осуществления вышеописанной бизнес-модели необходимы консолидация, синергизм и координация критической массы высокоспециализированной технической экспертизы по основным приоритетным областям работы. Эта экспертиза будет сосредоточена, главным образом, на межстрановом уровне. Лишь при явной необходимости, продиктованной конкретными обстоятельствами, технические сотрудники будут командированы на страновой уровень и лишь на ограниченный период времени. Страновая работа планируется с каждым по отдельности государством-членом и охватывается ДСС, где указывается конечный полезный эффект и планируются промежуточные и итоговые результаты по каждому направлению. В течение 2012–2013 гг. будет наращиваться процесс составления стратегий странового сотрудничества (ССС), который охватит в конечном итоге все государства-члены, начиная с тех, где в настоящее время нет формального соглашения с Региональным бюро[7].

5. Бюджет

24. Предлагаемый проект программного бюджета, представленный для обсуждений и замечаний Региональному комитету, не включает фактические цифры на 2014–2015 гг., показывая только различия между ССП 2008–2013 гг., с одной стороны, и реальными

[6] Из них 111 созданы под эгидой Европейского регионального бюро ВОЗ, остальные – главным образом штаб-квартиры.
[7] См. также *Страновая стратегия Европейского регионального бюро ВОЗ* (документ EUR/RC61/17).

расходами в 2010–2011 гг., представленными в соответствии со структурой ОПР-12, и утвержденным бюджетом на 2012–2013 гг., с другой. Данный раздел содержит предварительные стратегические соображения о возможных бюджетных пакетах и их разбивке, а также анализ бюджета на 2012–2013 гг. Более детальное распределение планируемых затрат будет осуществлено в рамках подготовки к соответствующей сессии Исполнительного комитета.

5.1 Два бюджетных сценария

25. В соответствии с концепцией сохранения общего постоянного бюджета ВОЗ на период ОПР-12 представлены два возможных сценария. Сценарий 1 предполагает наличие такого же бюджетного пакета базовых программ для ЕРБ ВОЗ, как и на 2012–2013 гг., однако при этом бюджеты Специальных программ и механизмов сотрудничества (SPA) и Реагирования на вспышки и кризисы (OCR) приведены в соответствие с округленными расходами на 2010–2011 гг. в целях более четкого отражения фактического уровня деятельности. Таким образом, общий бюджет по этому сценарию составляет 221 млн долл. США (табл. 2).

26. По сценарию 2 бюджеты SPA и OCR остаются такими же, как и в сценарии 1, тогда как бюджет базовых программ увеличивается до 212 млн долл. США. При этом предполагается, что при сохранении постоянного общего бюджетного пакета ВОЗ ряд функций будут переданы от штаб-квартиры на нижестоящие уровни в рамках реформы ВОЗ, направленной на оптимизацию разделения труда по всем звеньям Организации. Следует подчеркнуть, что по этому сценарию суммарный бюджет ВОЗ останется прежним, изменится лишь его распределение между уровнями.

27. В табл. 3 показаны позиции бюджета на 2014–2015 гг. в сравнении с фактическими расходами в 2010–2011 гг. и одобренным Всемирной ассамблеей здравоохранения программным бюджетом на 2012–2013 гг., что характеризует переход от структуры ССП 2008–2013 к структуре новой ОПР-12 в применении к базовым программам. В отношении 2014–2015 гг. два сценария, представленные в предыдущей таблице, разбиты по категориям.

28. В соответствии со сценарием 1 бюджет категории VI увеличен на 5% с учетом прогнозируемого роста стоимости по сравнению с 2010–2011 гг. Следует отметить, что в период между 2010–2011 и 2012–2013 гг. бюджеты СЦ-12/13 (категория VI) не увеличивались, несмотря на существенный рост стоимости, что таким образом привело к выраженному сокращению численности персонала, работающего в программах этой категории.

29. Из числа технических категорий, категории II и IV получили бюджеты значительно выше по сравнению с расходами в 2010–2011 гг., что подтверждает повышенное внимание, уделяемое проблеме неинфекционных заболеваний и укреплению систем здравоохранения, уже проявленное в течение двухлетнего периода 2012–2013 гг. и в то же время влекущее за собой трудности в плане изыскания необходимых ресурсов. Для категории III бюджет остается на таком же уровне, как и в 2012–2013 гг., что приблизительно на 15% выше расходов в 2010–2011 гг. Следует, однако, отметить, что подавляющая часть работы по теме Здоровье-2020, включая связанные с этим процессом научные исследования, была осуществлена в рамках СЦ-7 и перешла в категорию III. Последующая работа в поддержку национальных стратегий здравоохранения в основном будет осуществляться в рамках категории IV (Системы здравоохранения) и будет поставлена на первый план в работе по всем категориям. Бюджетные отчисления для категории V примерно на 1 млн долл. США превышают ассигнования на 2012–2013 гг., однако остаются ниже суммы расходов в 2010–2011 гг. Это является результатом

внутренней приоритизации, позволяющей при сценарии постоянных ресурсов обеспечить систематический рост по категориям III и IV. Следует также отметить, что все итоговые результаты по сегменту OCR также входят в эту категорию, и бюджет OCR будет скорректирован в зависимости от чрезвычайных потребностей в случае их возникновения.

30. Аналогичным образом, бюджетные ассигнования на категорию I снижены по сравнению как с ассигнованиями на 2012–2013 гг., так и фактическими расходами в 2010–2011 гг. Это явилось результатом перераспределения приоритетов в рамках регионального бюджетного пакета, главным образом на основе критериев, относящихся к медико-санитарной ситуации и к наличию проверенных экономически эффективных вмешательств.

31. Сценарий 2 отражает ситуацию, где определенные функции, в частности для предоставления технической помощи странам, будут переданы с уровня штаб-квартиры в нижестоящие звенья. По прогнозам, хотя имеется определенный потенциал во всех категориях, он максимально проявится в категориях I, III и V. Поскольку это может происходить на фоне общего постоянного бюджетного пакета, то такая децентрализация будет означать, что и бюджет, и ресурсы будут перемещены с уровня штаб-квартиры на региональный уровень.

Таблица 2. Два бюджетных сценария на 2014–2015 гг. в разбивке по сегментам бюджета в сравнении с предыдущими двухлетними периодами

Предварительные бюджетные пакеты на 2014–2015 гг. – в соответствии с сегментами бюджета	Фактические расходы в 2010–2011 гг.		Бюджет на 2012–2013 гг. Утверждено ВАЗ		2014–2015 гг. Сценарий 1			2014–2015 гг. Сценарий 2		
	млн долл. США	% от суммарного объема	млн долл. США	% от суммарного объема	млн долл. США	% от суммарного объема	% изменений от 2010–2011	млн долл. США	% от суммарного объема	% изменений от 2010–2011
Базовые программы (BASE)[прим.1]	171,8	86%	192,9	90%	193,0	87%	112%	212,0	88%	123%
Специальные программы и механизмы сотрудничества (SPA)	23,3	12%	10,1	5%	23,0	10%	99%	23,0	10%	99%
Реагирование на вспышки и кризисы (OCR)	5,4	3%	11,1	5%	5,0	2%	92%	5,0	2%	92%
Итого:	200,5	100%	214,1	100%	221,0	100%	110%	240,0	100%	120%

Примечание 1: на период 2012–2013 гг. этот сегмент включает сумму 1,1 млн долл. США, перешедшую от штаб-квартиры в ЕРБ ВОЗ в связи с соответствующим переподчинением офиса ВОЗ при ЕС.

Таблица 3. Два бюджетных сценария для базовых программ в разбивке по категориям и в сравнении с предыдущими двухлетними периодами

Сценарии формирования бюджетных пакетов на 2014–2015 гг. – Базовые программы	Фактические расходы		Бюджет на 2012–2013 Утверждено ВАЗ		2014–2015 гг. Сценарий 1			2014–2015 гг. Сценарий 2		
	млн долл. США	% от суммарного объема	млн долл. США	% от суммарного объема	млн долл. США	% от суммарного объема	% изменений от 2010–2011	млн долл. США	% от суммарного объема	% изменений от 2010–2011
Категория I: Инфекционные болезни	24,3	16%	26,9	14%	21,1	11%	87%	27,6	13%	113%
Категория II: Неинфекционные заболевания	17,8	9%	29,6	15%	31,0	16%	175%	32,0	15%	180%
Категория III: Этапы жизни	32,7	16%	37,1	19%	37,5	19%	115%	42,5	20%	130%
Категория IV Системы здравоохранения	24,8	17%	34,6	18%	35,0	18%	141%	37,0	17%	149%
Категория V: Готовн., надзор и реаг.	16,8	14%	9,7	5%	10,5	5%	62%	15,0	7%	89%
Категория VI: Корпоративные услуги[прим. 1]	55,3	28%	55,1	29%	57,9	30%	105%	57,9	27%	105%
Итого:	**171,7**	**100%**	**192,9**	**100%**	**193,0**	100%	112%	212,0	100%	123%

Примечание 1: на период 2012–2013 гг. этот сегмент включает сумму 1,1 млн долл. США, перешедшую от штаб-квартиры в ЕРБ ВОЗ в связи с соответствующим переподчинением офиса ВОЗ при ЕС.

5.2 Анализ бюджета на 2012–2013 гг.

32. В табл. 4 представлен анализ планируемых затрат на 2012–2013 гг. в соответствии с предполагаемым окончательным вариантом бюджета на 2014–2015 гг. Таблица показывает планируемое распределение затрат между мероприятиями и кадровым обеспечением, так же как и планируемые расходы на все технические промежуточные результаты и мероприятия, суммированные до уровня основных функций ВОЗ. Возникает ряд вопросов, в частности в отношении распределения расходов по основным функциям, например правильно ли расставлены акценты. Эти вопросы будут в деталях обсуждаться в течение предстоящих месяцев в ходе подготовки версии программного бюджета на 2014–2015 гг. для представления Исполнительному комитету.

Достоверное отражение стоимости рабочей нагрузки на персонал

33. В бизнес-модели ЕРБ ВОЗ (см. раздел 4.2) техническая помощь странам главным образом предоставляется с уровня Регионального бюро, включая его географически удаленные офисы (ГУО). Таким образом, в соответствии с финансовыми правилами ВОЗ, расходы на кадровое обеспечение учитываются на региональном уровне, а не на страновом, где фактически генерируется конечный полезный эффект. В результате возникает искаженная картина рабочей нагрузки на персонал, стоимости получения промежуточных результатов и инвестиций ЕРБ ВОЗ в страновую программу. В целях обеспечения более приближенной к реальности картины сотрудники будут отчитываться по тому, где и в какой связи ими были предприняты фактические рабочие усилия. Результат анализа за первые шесть месяцев 2012 г. будет представлен на рассмотрение ПКРК и составит часть основы для более детального расчета планируемых затрат на 2014–2015 гг., который будет произведен после сессии Регионального комитета.

5.3 Финансирование бюджета

34. Имеющиеся ресурсы для финансирования деятельности ЕРБ ВОЗ в прошедшем двухлетнем периоде были распределены приблизительно следующим образом: обязательные взносы (AC) = 26%, поступающие отчисления на поддержку программ (AS) = 7%, счет основных добровольных взносов (CVCA) = 6% и целевые добровольные взносы (VCS) = 61%. Из суммы последних около двух третей были мобилизованы Региональным бюро, а остальные фонды поступили в результате усилий по мобилизации ресурсов в масштабах всей Организации. Высокая доля VCS делает долгосрочное планирование результатов и особенно масштабов кадрового обеспечения весьма затрудненным. Кроме того, VCS часто искажают картину распределения приоритетов, так что одни программы и мероприятия имеют тенденцию к избыточному финансированию, в то время как другие испытывают дефицит. Финансовый диалог, предусмотренный реформой ВОЗ, мог бы вести к “авансовому” финансированию программного бюджета. Это имело бы огромный позитивный эффект на достижение результатов и повысило бы и актуальность, и эффективность. Далее, сокращение числа бюджетных позиций при распределении фондов обязательных взносов с 13 разделов, как это имеет место в настоящее время, до одного или двух также позволит Региональному бюро более эффективно управлять ресурсами в целях обеспечения того, чтобы ни одна приоритетная область не была избыточно финансирована вследствие целевых указаний доноров добровольных взносов, в то время как другие приоритетные области будут недофинансированы.

Таблица 4. Предварительный анализ планируемых затрат на 2012–2013 гг. (все сегменты) в разбивке по мероприятиям, расходам на кадровое обеспечение и основным функциям ВОЗ

На основе анализа итоговых результатов (по сост. на 10 мая 2012 г.) – Все сегменты бюджета	Категории (*переход от структуры ССП*) I: Инф. бол.	II: Неинф. бол.	III: Этапы жизни	IV: Системы здр.	V: Готовн., надзор и реаг.	VI: Корп.	Итого:
Бюджет (млн долл. США)							
Мероприятия	11,9	16,6	13,5	13,6	8,2	12,6	76,2
Заработная плата	20,1	13,1	23,6	26,0	12,6	42,5	137,9
Итого:	**32,0**	**29,6**	**37,1**	**39,6**	**20,8**	**55,1**	**214,2**
Итоговые результаты (мероприятия) в соотношении с основными функциями (ОФ)							
ОФ-1 – Лидерство и партнерства	3,1%,	18,3%,	20,0%,	11,3%,	8,7%,	38,8%,	18,1%,
ОФ-2 – Исследования и знания	4,5%,	7,5%,	11,7%,	35,2%,	-	-	10,2%,
ОФ-3 – Нормы и стандарты	27,4%,	12,2%,	6,3%,	8,2%,	27,1%,	-	11,9%,
ОФ-4 – Научно обосн. политика с соблюдением этических норм	0,6%,	6,3%,	0,7%,	9,0%,	-	-	3,1%,
ОФ-5 – Поддержка/Наращивание потенциала[прим.1]	64,2%,	44,5%,	60,4%,	29,8%,	62,6%,	11,6%,	43,4%,
ОФ-6 – Мониторинг здоровья	0,2%,	11,3%,	0,9%,	6,5%,	1,6%,	-	4,0%,
Корпоративная поддержка	-	-	-	-	-	49,6%,	9,3%,
Итого:	**100,0%**	**100,1%**	**100,0%**	**100,0%**	**100,0%**	**100,0%**	**100,0%**

Примечание 1: Все планируемые затраты на уровне стран по категории 6 отнесены к основной функции 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[8] 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.

[8] 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[9] 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

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

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

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

Internationally agreed instruments

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

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

Evidence-based, cost-effective interventions

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

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

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

Comparative advantage of WHO

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

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

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

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

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

Country focus

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

Category IV – Health systems

Box 4

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

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

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

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

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

Key priorities and changes to the portfolio

Current health situation

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

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

Needs of individual countries

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

Internationally agreed instruments

With regard to international instruments, in 2008 the 53 Member States in the WHO European Region endorsed the Tallinn Charter on Health Systems, Health and Wealth (EUR/RC58/R4). Soon afterwards the financial crisis broke out, putting the commitments by the Member States to the test and leading to the Regional Committee's resolution on health in times of global economic crisis (EUR/RC59/R3). In 2011, the Regional Committee provided the mandate to strengthen Public Health in the WHO European Region with the Resolution EUR/RC61/R2, calling for the development of a WHO European Action Plan on Strengthening Public Health Capacities and Services to be presented at RC62 as an implementation pillar of Health 2020.[10] 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.

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

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

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

Country focus

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

Category V – Preparedness, surveillance and response

Box 5

Direct contribution to Health 2020:

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

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

Priority Area 4: Creating supportive environments and resilient communities

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

Public health emergencies in the WHO European Region are common and cover natural and manmade (technological) disasters, including increased occurrence of severe extreme weather events, civil unrest or military conflicts and communicable diseases outbreaks. Lessons learnt

emphasize the importance of rigorous engagement in health emergency preparedness and risk management processes. Regional efforts include improving influenza surveillance and pandemic preparedness, the full implementation of the International Health Regulations, particularly the national capacity for surveillance and response, and preparedness of the health sector for mass gathering events and humanitarian crises. Laboratory capacity, addressed through programmes in Categories I and V, will be critical in providing support for the rapid detection and response to outbreaks.

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

The sixty-first World Health Assembly adopted a resolution to treat the completion of polio eradication as a programmatic emergency. While the European Region has no countries with ongoing transmission of polio virus, the large outbreak in 2010 in central Asia shows the vulnerability of the Region. Until poliovirus is eradicated worldwide, all polio-free regions, including the European Region, remain at risk of importation. It is therefore essential that the region maintains its efforts to keep its polio-free status.

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

Key priorities and changes to the portfolio

Current health situation

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

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

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

Needs of individual countries

Overall demand from Member States in all the technical areas of Category V is with parts of it delivered through intercountry work and others in response to unexpected emergencies is often

not reflected in BCAs. Several Member States have asked for extensions on compliance with the International Health Regulations (2005) core capacity deadlines and strengthening of laboratory and detection and response capacity. Given the interconnectivity of the countries in the Region, strengthening health sector's capacities for the preparedness, prevention, surveillance and response capacity, incl. environmental emergencies, is of real importance to all 53 Member States in the European Region.

Internationally agreed instruments

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

Evidence-based, cost-effective interventions

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

Comparative advantage of WHO

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

Country focus

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

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

Category VI – Corporate services/Enabling functions

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

- 53 Member States, the *largest number of any region*;
- Four official languages affecting translation/publication costs, the *highest of any region*;
- A strengthened oversight function with frequent meetings and an increased membership of the Standing Committee of the Regional Committee (SCRC);
- Copenhagen is an expensive duty station;
- WHO Regional Office for Europe has a strong country presence, with 29 country offices, the *second highest among regions*;
- WHO Regional Office for Europe maintains effective partnerships with all major players in region;
- More focus on communication and dissemination of information than previously.

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

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

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

Thematic Area 1 – Leadership in health and Strategic Management

The WHO Regional Office for Europe will fully align itself to the global initiative, while building on past achievements to maintain and further strengthen its leadership role in public

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

Thematic Area 2 – Country Focus

The interim country strategy for the next two years[11] 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 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.

[11] EUR/RC62/13

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.

Приложение B. Предлагаемые глобальные итоговые результаты на 2014–2015 гг.

Категория I: Инфекционные болезни

	Глобальные итоговые результаты, 2014–2015 гг.	Итоговые результаты для ЕРБ ВОЗ, 2012–2013 гг. (Приложение C)
1	Число людей, живущих с ВИЧ, проходящих антиретровирусную терапию *(ВИЧ/СПИД)*	**4, 34, 35**
2	Процент протестированных на ВИЧ больных туберкулезом в местах высокой распространенности ВИЧ *(туберкулез)*	**36**
3	Процент населения, подвергающегося риску малярии, в отношении которого применяются меры борьбы с переносчиками с помощью пропитанных инсектицидом надкроватных сеток или распыления инсектицидов остаточного действия внутри помещений *(малярия)*	**6, 39**
4	Устойчивые мероприятия по профилактике лихорадки денге и борьбе с ней в приоритетных странах, эндемичных по этой болезни (*забытые тропические болезни*)	**–**
5	Охват превентивной химиотерапией для борьбы с лимфатическим филяриатозом, онхоцеркозом, шистосомозом, передающимся через почву гельминтозом и трахомой (*забытые тропические болезни*)	**33**
6	Число больных туберкулезом, принимающих участие ежегодно в программе лечения МЛУ-ТБ *(туберкулез)*	**5, 37, 38**
7	Глобальный средний охват тремя дозами АКДС *(болезни, предупреждаемые с помощью вакцин)*	**1, 28**

Категория II: Неинфекционные заболевания

	Глобальные итоговые результаты, 2014–2015 гг.	Итоговые результаты для ЕРБ ВОЗ, 2012–2013 гг. (Приложение C)
1	Относительное сокращение на 25% кровяного давления/гипертензии, измеряемой с помощью стандартизованной по возрасту распространенности повышенного уровня кровяного давления среди людей в возрасте 18 лет и старше *(неинфекционные заболевания)*	**9, 44, 45**
2	Относительное сокращение на 10% вредного употребления алкоголя, измеряемого с помощью потребления на душу населения чистого алкоголя в литрах *(неинфекционные заболевания)*	**13, 60**
3	Относительное сокращение на 30% курения табака, измеряемого с помощью стандартизованной по возрасту распространенности курения табака в настоящее время среди людей в возрасте 15 лет и старше *(неинфекционные заболевания)*	**15, 58, 59**
4	Относительное сокращение на 30% потребления соли с пищей, измеряемого с помощью стандартизованного по возрасту среднего потребления в день взрослыми (18 лет и старше) *(неинфекционные заболевания)*	**9, 14, 19, 57**
5	Относительное сокращение на 10% недостатка физической активности, измеряемого с помощью стандартизованной по возрасту недостаточной физической активности среди взрослых в возрасте 18 лет и старше *(неинфекционные заболевания)*	**9, 57, 61**
6	Отсутствие увеличения распространенности ожирения среди взрослых, измеряемого с помощью стандартизованной по возрасту распространенности ожирения среди взрослых в возрасте 18 лет и старше *(неинфекционные заболевания)*	**14, 19**

7	Отсутствие увеличения распространенности ожирения среди детей, измеряемого с помощью стандартизованной по возрасту распространенности ожирения среди детей в возрасте до 5 лет *(неинфекционные заболевания)*	**14, 19, 57**
8	>80% охвата многолекарственной терапией для людей старше 30 лет с 10-летним риском инфаркта или инсульта ≥ 30%, или с существующей сердечно-сосудистой болезнью *(неинфекционные заболевания)*	**44, 45**
9	Относительное сокращение на 40% задержки роста, измеряемой по распространенности низкого роста для данного возраста (< -2 SD) среди детей в возрасте до 5 лет *(питание)*	**19, 57, 72**
10	Коэффициент хирургического лечения катаракты, измеряемый с помощью числа хирургических операций, выполняемых в год на миллион человек населения *(инвалидности)*	**–**
11	Доля стран, имеющих всеобъемлющие законы, направленные на пять ключевых факторов риска для безопасности дорожного движения (*насилие и травмы*)	**8, 42, 43**
12	Число стран с увеличенными бюджетами на охрану психического здоровья по отношению ко всему бюджету здравоохранения *(психическое здоровье)*	**7, 40, 41, 55, 56**
13	Расширение профилактики и раннего выявления онкологических заболеваний для достижения следующих показателей: a) 70% женщин в возрасте 30–49 лет, прошедших по крайней мере один раз скрининг на цервикальный рак; b) увеличение на 25% доли случаев диагностирования рака молочной железы на ранних стадиях; c) распространенность носителей HBsAg < 1% *(неинфекционные заболевания)*	**44, 46**

Категория III: Укрепление здоровья на протяжении всей жизни

	Глобальные итоговые результаты, 2014–2015 гг.	**Итоговые результаты для ЕРБ ВОЗ, 2012–2013 гг. (Приложение C)**
1	Сокращение числа подростковых беременностей (*сексуальное и репродуктивное здоровье*)	**47**
2	>80% детей с подозреваемой пневмонией получают антибиотики *(здоровье детей)*	**48**
3	>50% младенцев получают исключительно грудное вскармливание в течение шести месяцев (*здоровье матерей и новорожденных*)	**11**
4	>50% матерей и новорожденных получают послеродовую помощь в течение двух дней после родов (*здоровье матерей и новорожденных*)	**11**
5	>80% женщин во время беременности получают квалифицированную дородовую помощь не менее четырех раз (*здоровье матерей и новорожденных*)	**11**
6	>80% беременных женщин получают квалифицированное родовспоможение (*здоровье матерей и новорожденных*)	**11**
7	Зарегистрировано сокращение неудовлетворенных потребностей в контрацепции (*сексуальное и репродуктивное здоровье*)	**49, 50, 53**
8	Число государств-членов, осуществляющих политику, которая предотвращает и/или уменьшает экологические и профессиональные риски (*здоровье и окружающая среда*)	**18, 61, 66, 67, 68, 69, 70, 71**
9	Будет определено позднее – показатель охвата услугами здравоохранения для старения *(здоровое старение)*	**10**
10	Будет определено позднее – показатель справедливости в различных социально-экономических группах *(социальные детерминанты)*	**16, 61, 62, 63, 65**
11	Будет определено позднее – показатель справедливости для гендерных вопросов *(равенство полов)*	**64, 65**

Категория IV: Системы здравоохранения

	Глобальные итоговые результаты, 2014–2015 гг.	Итоговые результаты для ЕРБ ВОЗ, 2012–2013 гг. (Приложение С)
1	Количество/доля государств-членов, которые: (i) имеют национальную стратегию сектора здравоохранения с целями и задачами; (ii) проводят ежегодный обзор многочисленных участников; и (iii) составляют доклады об эффективности сектора здравоохранения для информирования ежегодных обзоров (*политика, стратегии и планы здравоохранения*)	**17, 21, 23, 24, 26, 73, 80, 81, 82**
2	Количество/доля государств-членов, в которых охват регистрацией случаев рождения и смерти с указанием достоверных причин смерти улучшается среди государств-членов с охватом менее 90% (*политика, стратегии и планы здравоохранения*)	**23, 24, 80**
3	Количество/доля государств-членов, в которых доля домашних хозяйств с катастрофическими расходами наличными: (i) составляет менее XX%; и (ii) составляет не более самой бедной квинтили домашних хозяйств, чем в самой богатой квинтили (*политика, стратегии и планы здравоохранения*)	**25, 75, 76**
4	Количество/доля государств-членов, в которых процент домашних хозяйств, повергнутых в нищету в результате оплаты услуг здравоохранения наличными, составляет менее XX% (*политика, стратегии и планы здравоохранения*)	**25**
5	Количество/доля государств-членов, в которых показатель национального охвата основными услугами улучшается *(комплексное предоставление социально-ориентированных услуг)*	**22, 24, 74, 79**
6	Количество государств-членов, в которых регулируется оплата услуг провайдеров помощи (*комплексное предоставление социально-ориентированных услуг*)	**–**
7	Количество государств-членов, имеющих надлежащую аккредитацию услуг (*комплексное предоставление социально-ориентированных услуг*)	**–**
8	Будет определено позднее: показатель для трудовых ресурсов здравоохранения (*комплексное предоставление социально-ориентированных услуг*)	**77, 78**
9	Количество государств-членов, осуществляющих надлежащий регулирующий контроль медицинских продуктов (*доступ к медицинской продукции*)	**86**
10	Количество государств-членов с системами мониторинга цен и наличия лекарственных средств и медицинских продуктов (*доступ к медицинской продукции*)	**27**
11	Количество стран, использующих перечень основных лекарственных средств, обновленный в течение последних пяти лет для государственных закупок и возмещения (*доступ к медицинской продукции*)	**87**

Категория V: Готовность, эпиднадзор и ответные меры

	Глобальные итоговые результаты, 2014–2015 гг.	**Итоговые результаты для ЕРБ ВОЗ, 2012–2013 гг. (Приложение С)**
1	Количество государств-членов, проводящих или обновляющих оценки множественных рисков для здоровья в чрезвычайных ситуациях по крайней мере один раз в два года (*управление рисками в кризисных и чрезвычайных ситуациях*)	**12**
2	Процент государств-членов, проводящих общенациональные учения по ответным мерам в случае чрезвычайной ситуации в области здравоохранения по крайней мере один раз в два года (*управление рисками в кризисных и чрезвычайных ситуациях*)	**52**
3	Процент государств-членов, предоставляющих базисный пакет мер неотложной медицинской помощи пострадавшему населению в течение 10 дней при масштабной чрезвычайной ситуации (*управление рисками в кризисных и чрезвычайных ситуациях*)	**32, 51**
4	Количество государств-членов, выполняющих и поддерживающих требования Международных медико-санитарных правил (2005 г.) об основных возможностях (*возможности для предупреждения и ответных мер*)	**3**
5	Процент государств-членов, имеющих национальные планы преодоления риска чрезвычайных ситуаций, которые включают эпидемические и пандемические болезни *(болезни, способные вызывать эпидемии и пандемии)*	**12, 30, 31**
6	Количество государств-членов, имеющих активную “Программу по безопасным больницам” (*управление рисками в кризисных и чрезвычайных ситуациях*)	**–**
7	Количество государств-членов с программой по безопасности пищевых продуктов, имеющей юридическую базу и структуру применения *(безопасность пищевых продуктов)*	**2 (будет уточнено), 20, 71**
8	Все государства-члены добились уровней охвата вакцинами, необходимых для того, чтобы остановить передачу полиовируса *(ликвидация полиомиелита)*	**29**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

List of abbreviations

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

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

HRH	Human resources for health
HRP	United Nations Development Programme/ United Nations Population Fund/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction
HSFP	Health Systems Funding Platform (of the GAVI Alliance)
HSS	Health systems and services
ICD	International Classification of Diseases
ICP	Intercountry programme. This is a means of delivering technical assistance to countries
IHP	International Health Partnership
IHR	International Health Regulations
ILI	Influenza-like illness
IMCI	Integrated management of childhood illnesses
JANS	Joint Assessment of National Health Strategies and Plans
KPO	Key Priority Outcome. These are outcomes in the Regional Office's outcome portfolio, which are given particular attention in terms of monitoring, management, and resourcing
LRTAP	Convention on Long-range Transboundary Air Pollution
M/XDR-TB	Multi and extensively drug-resistance tuberculosis
MAL	Malaria
MC	Multicountry - a mode of delivering technical assistance to countries
MDGs	Millennium Development Goals (Eight United Nations development targets to be achieved by 2015)
MDG1	Eradicate extreme poverty and hunger
MDG2	Achieve universal primary education
MDG3	Promote gender equality and empower women
MDG4	Reduce child mortality
MDG5	Improve maternal health
MDG 6	Combat HIV/AIDS, malaria and other diseases
MDG7	Ensure environmental sustainability
MDG8	Develop a global partnership for development

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

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

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