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## TWELFTH WHO GENERAL PROGRAMME OF WORK 2014–2019 AND PROGRAMME BUDGET 2014–2015

### Introduction

1. The World Health Organization, in line with the Programmatic Reforms, completed the Twelfth General Programme of Work (GPW) 2014-2019 and the Programme Budget (PB) 2014-2015. The Sixty-sixth World Health Assembly (WHA) in May 2013, approved both documents.
2. The Twelfth General Programme of Work 2014-2019 provides a high level strategic vision for the work of WHO in the next six years and is one of the main elements of the WHO programmatic reform. The document approved by the WHA is a product of many reviews and interactions with Member States and the Secretariat through mechanisms established by WHO.
3. The Programme Budget 2014-2015 presents the organization's expected deliverables and budget requirements for the 2014-2015 biennium. The PB is organized by Categories and Programme Areas, and develops the results chain from outcomes to outputs with the respective indicators, baselines and targets. In addition, the document provides a summary of deliverables by WHO levels (Country offices, Regional offices and Headquarters).
4. The Region of the Americas contributed significantly to the global process (both Member States and the Pan American Sanitary Bureau (PASB) via the various consultations and mechanisms established by WHO.
5. The 12th GPW and the PB 2014-2015 have greatly influenced the development of the new PAHO Strategic Plan 2014-2019 and its first Program and Budget which corresponds to the period 2014-2015 and have provided further opportunities for harmonization and alignment. **A good degree of alignment has been achieved thus far.**

PAHO has used the approved GPW and PB to inform the documents that will be presented to PAHO's Executive Committee and Directing Council.

6. For the first time, the WHA didn't approve the appropriations of Assessed Contributions (AC), giving full flexibility to the Director General to determine appropriations of the AC at a later date. This could have implications for the Americas Regional Office which has received a constant amount of AC in the last three biennia.

**Action by the Executive Committee**

7. The Committee is requested to take note of the approved documents and potential implications for the Region and make any recommendations it considers necessary.

**Annexes**

A: [Twelfth WHO General Programme of Work 2014-2019](#) (hyperlink)

B: [Programme Budget 2014-2015](#) (hyperlink)



**World Health  
Organization**

**Annex A**

**SIXTY-SIXTH WORLD HEALTH ASSEMBLY  
Provisional agenda item 12.2**

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## **Draft twelfth general programme of work**

## OVERVIEW

1. The purpose of the general programme of work is to provide a high-level strategic vision for the work of WHO.<sup>1</sup> This, the twelfth in the series, establishes priorities and provides an overall direction for the six-year period beginning in January 2014 and is the product of an extended interaction between the Secretariat and Member States. It has been prepared as part of an extensive programme of reform in WHO, which began in 2010. It reflects the three main components of WHO reform: programmes and priorities, governance and management. In this context, the general programme of work sets out leadership priorities that will both define the key areas in which WHO seeks to exert its influence in the world of global health and drive the way work is carried out across and between the different levels of the Secretariat. Secondly, the general programme of work sets the direction for more effective governance by Member States as well as a stronger directing and coordinating role for WHO in global health governance. Lastly, through a clear results chain, it explains how WHO's work will be organized over the next six years; how the work of the Organization contributes to the achievement of a clearly defined set of outcomes and impacts; and the means by which WHO can be held accountable for the way resources are used to achieve specified results. The three programme budgets in the period set out the detail of what will be achieved during each biennium.

2. The current draft general programme of work reflects detailed comments made on successive drafts. The process started with discussions at the Member State meeting on programmes and priority setting in February 2012 and an outline presented at the Sixty-fifth World Health Assembly, and proceeded through the following governance forums: the six regional committees in 2012; the Programme Budget and Administration Committee at its seventeenth meeting in January 2013; the Executive Board at its 132nd session; and a subsequent web-based consultation.

3. The draft twelfth general programme of work builds on lessons learnt from the Eleventh General Programme of Work and, as requested by Member States it incorporates key elements of the former Medium-term strategic plan 2008–2013. In this regard, the Eleventh General Programme of Work focused more on a health agenda for the world than for WHO itself, with WHO's role being the focus of the Medium-term strategic plan 2008–2013. The draft twelfth general programme of work seeks to redress that balance in a single document. It does so by combining the high-level strategic vision of its predecessor with a focus on how WHO's focus and priorities are shaped by the environment in which the Organization works. Secondly, reducing the duration of the general programme of work from 10 years to 6 ensures close alignment with the planning and budgeting cycle. Thirdly, the present draft general programme of work identifies a selected number of high-level results at outcome and impact level and sets out the means by which their achievement can be monitored and evaluated. Lastly, the draft general programme of work signals changes in the way that financial resources will be deployed in order to achieve these results.

4. The draft twelfth general programme of work is organized as follows.

**Chapter 1** provides an analysis of the changing political, economic and institutional context in which WHO is working. Following a review of current epidemiological and demographic trends, it outlines the impact that these changes have on people's health, countries' health systems and, in the final section, on health governance and the changing demands made on international organizations.

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<sup>1</sup> As required under Article 28 of the WHO Constitution.

**Chapter 2** then examines the implications of this analysis for WHO – in terms of functions and values, highlighting the need for both continuity and change. This chapter spells out the links between the changing context and the programmatic, governance and management elements of WHO reform. In particular, it provides more detail on the relationship between core functions and the roles and responsibilities of each level of the Organization.

**Chapter 3** focuses on the six leadership priorities that provide programmatic direction for the next six years, and that reflect the programmatic and priority-setting aspect of reform. The early part of the chapter sets out how these priorities were derived. It then goes on to examine each priority in turn indicating how it responds to the analysis of context in Chapter 1, setting out the main elements of WHO's work in each case.

**Chapter 4** focuses on two further priorities that reflect the governance and managerial aspects of reform. Governance is addressed from two perspectives: WHO's role in global health governance, including the way in which Member States govern the Organization; and WHO's involvement in governance processes in other sectors and forums that potentially impact on health. The second part of the chapter focuses on the reform of management policies, systems and practices.

**Chapter 5** describes how WHO's work will be organized, namely: in five technical categories and one managerial category. It then outlines the structure and elements of the results chain, explaining the relationship between outputs for which the Secretariat is responsible and how they contribute to the achievement both of outcomes and of eight impact level goals, for which Member States, other partners and the Secretariat share responsibility. The final part of the chapter sets out a new framework for monitoring and evaluation.

**Chapter 6** outlines a new financing model and signals the direction in which financial resources will shift between categories of work over the six-year period.

## CHAPTER 1

### SETTING THE SCENE

#### **New political, economic, social and environmental realities**

5. The draft twelfth general programme of work has been formulated in light of the lessons learnt during the period of the Eleventh General Programme of Work, which was prepared in 2005, during a period of sustained global economic growth. Despite a prevailing sense of optimism, the Eleventh General Programme of Work characterized the challenges for global health in terms of gaps in social justice, responsibility, implementation and knowledge.

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

7. As the decade progressed, the world witnessed the most severe financial and economic crisis since the 1930s. The full consequences of this disaster have yet to play out. Nevertheless, it is already apparent that the crisis has accelerated the advent of a new order in which growth is a feature of several emerging and developing economies, and in which many developed countries struggle to maintain a fragile recovery.

8. At the start of the second decade of this century, around three quarters of the world's absolute poor live in middle-income countries. Many of these countries are becoming less dependent on (and no longer eligible for) concessionary finance. As a result, an approach to poverty reduction based on externally-financed development is becoming rapidly outdated. In its place is a need for new ways of working that support the exchange of knowledge and best practice, backed by strong normative instruments, and that facilitate dialogue between different States and between the State, the private sector and civil society.

9. At the same time, many of the world's poorest people will remain dependent on external financial and technical support. It is therefore likely that the greatest need – as well as the focus of much traditional development finance – will become increasingly concentrated in the world's most unstable and fragile countries. This in turn raises important questions about how the work of the United Nations in other, less poor, countries will be financed.

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

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

12. The world faces both challenges and opportunities, many of which have direct implications for global health:

- A continuing economic downturn in some developed countries with consequent decreases in public spending puts the social contract between people and their governments under ever-increasing pressure. Reductions in public spending risk creating a vicious cycle with a negative impact on basic services, low health and educational attainment, and high youth unemployment. At the opposite end of the age spectrum, those retiring from work may face the spectre of impoverishment and ill health in old age.
- By 2050, 70% of the world's population will live in cities. Rapid unplanned urbanization is a reality, particularly in low- and middle-income countries. Urbanization brings opportunities for health, not least from well-resourced city administrations, but equally it brings risks of exclusion and inequity. Migration between countries can offer benefits to both the countries from which migrants leave and those to which they migrate; however, this is by no means guaranteed and many migrants are exposed to increased health risks in their search for economic opportunity.
- The demographic dividend that accrues from a larger, young working population has boosted economic growth in many parts of the world. For many countries this presents a vital opportunity, but one that will be lost in the absence of efforts to increase youth employment. Chronic unemployment combined with a lack of economic and political rights and any form of social protection can give lead to outrage and uprising.
- The global environment is equally under pressure. Key planetary thresholds, such as loss of biodiversity, have been crossed; and others soon will be. In many parts of the world, climate change will jeopardize the fundamental requirements for health, including clean urban air, safe and sufficient drinking-water, a secure and nutritious food supply, protection from extreme weather events and adequate shelter. Most people and governments accept the scientific case for sustainable development. They also recognize that health contributes to its achievement, benefits from robust environmental policies and offers one of the most effective ways of measuring progress. Nevertheless, at global and national levels, progress in the creation of institutions and policies that are better able to ensure a more coherent approach to social, environmental and economic policy has been disappointingly slow.
- In the face of these challenges, countries with different national interests seek solutions to shared problems. Global groupings (such as the G20) with more limited or like-minded membership offer a means of making more rapid progress on specific issues, but lack the legitimacy conferred by fully multilateral processes. Similarly in health, issue-based alliances, coalitions and partnerships have been influential in making more rapid progress in tackling challenges such as child and maternal mortality, and HIV/AIDS, tuberculosis and malaria. But the most complex problems still require well-managed multilateral negotiations in an organization with universal membership in order to reach a fair and equitable deal for all.

## The evolving agenda for global health

### Current health and demographic trends

13. More than a decade after world leaders adopted the Millennium Development Goals and their targets, substantial progress has been made in poverty reduction, reducing child and maternal mortality, improving nutrition, and reducing morbidity and mortality due to HIV infection, tuberculosis and malaria. Progress in many countries that have the highest rates of mortality has accelerated in recent years, although large gaps persist among and within countries.

14. Malnutrition remains the underlying cause of death in an estimated 35% of all deaths among children under five years of age. The proportion of malnourished children in developing countries declined from 28% to 17% between 1990 and 2011. This rate of progress is close to that required to meet the relevant Millennium Development Goal target.

15. Between 1990 and 2011, under-five mortality dropped by 41%. Although the global rate of decline in child deaths has accelerated in the past decade, from 1.8% per annum between 1990 and 2000 to 3.2% per annum between 2000 and 2011, even this remains insufficient to reach the Millennium Development Goal target.

16. The number of maternal deaths has fallen from 543 000 in 1990 to an estimated 287 000 in 2010. However, the rate of decline in mortality will need to double in order to achieve the Millennium Development Goal target. Of particular concern is the fact that babies born to adolescent mothers account for roughly 11% of all births worldwide. In low- and middle-income countries, complications from pregnancy and childbirth are the leading cause of death among adolescent girls, and perinatal deaths are 50% higher among babies born to mothers under 20 years of age.

17. Neonatal mortality rates declined by over 30% between 2009 and 2011 – a slower decline than for child mortality overall – and the proportion of deaths in children aged under five years that occur in the neonatal period increased from 36% in 1990 to 43% in 2011.

18. About half the world's population is at risk of contracting malaria, and an estimated 216 million cases of malaria led to 655 000 deaths in 2010, 86% of them being children under the age of five years. The estimated incidence of malaria fell by 17% globally between 2000 and 2010. Coverage with interventions such as the distribution of insecticide-treated bednets and indoor residual spraying has greatly increased but must be sustained in order to prevent the resurgence of disease and deaths.

19. The number of new cases of tuberculosis each year has been slowly dropping since 2006. In 2011, there were an estimated 8.7 million new cases, of which about 13% involved people living with HIV. Mortality due to tuberculosis has fallen by 41% since 1990 and globally a 50% reduction will be achieved by 2015.

20. In 2011, 2.5 million people were newly infected with HIV, 24% fewer than in 2001. At the same time, access to antiretrovirals (with currently over 8 million people in low- and middle-income countries on treatment) means an overall increase in the number of people living with HIV as fewer people are now dying from AIDS-related causes.

21. Neglected tropical diseases thrive in the poorest, most marginalized communities, causing severe pain, permanent disability and death to millions of people. Through a coordinated and integrated approach adopted since 2007, control, elimination and even eradication of these diseases has been shown to be feasible.



22. The Millennium Development Goal target of halving the proportion of the population without sustainable access to safe drinking-water has been met, although disparities persist within and between countries. With regard to basic sanitation, however, 2500 million people lack access to improved sanitation facilities.

23. Many people continue to face a scarcity of medicines in the public sector, forcing them to the private sector where prices can be substantially higher. Surveys undertaken from 2007 to 2011 indicated that, in the public sector, of the medicines available in low- and middle-income countries, the average availability of selected generic medicines was only 51.8%. Moreover, the cost of even the lowest priced generics in the private sector averaged five times the international reference prices; in some countries, they were up to 14 times more expensive. The cost of even the lowest priced generics can put common treatments beyond the reach of low-income households. Patients with chronic diseases requiring long-term treatment are particularly vulnerable to such difficulties.

24. In almost every country, the proportion of people aged over 60 years is growing faster than any other age group, as a result of both longer life expectancy and declining fertility rates. At the same time, there will be more young people in the adolescent age group than ever before. Within the period of the Twelfth General Programme of Work there will be more people aged over 60 than children under five. By 2050, 80% of the world's older people will be living in what are currently low- and middle-income countries. Although population ageing can be seen as a success story for public health policies and for socioeconomic development, it also challenges society to adapt, in order to maximize the health and functional capacity of older people as well as their social participation and security. Moreover, these changes in demography emphasize the importance of maintaining a focus on health not for particular age groups in isolation, but across the whole life-course.

### **More complex health challenges**

25. Beyond their epidemiological and demographic aspects, the new political, economic, social and environmental realities are reflected in a more complex agenda for global health, in terms of the impact they have on the institutions responsible for delivering better health. In 2010, total health spending reached US\$ 6.45 trillion – more than double the US\$ 2.93 trillion that was being spent in 2000. The health sector, as one of the world's largest employers, has had a key role in helping to stabilize economies in the face of recent financial shocks. The role of health in development has also had a higher profile. Spending on development assistance for health rose from US\$ 10.52 billion in 2000 to US\$ 26.8 billion 10 years later.

26. In some countries health spending remains below what is required to provide even the most basic services. By contrast, in many developed economies, health care costs continue to rise faster than gross domestic product due to the growing burden of noncommunicable diseases in ageing populations, combined with rising public expectations, and increasing costs of technology. For countries facing a continuing economic downturn, the net effect will be to threaten the financial sustainability of health systems. Smart solutions – those that focus on prevention, early detection of disease and the promotion of healthy lifestyles – will be needed to sustain the universality of health coverage where it has been achieved and to make further progress where it has not. Without such changes, pressures on public funding are likely to increase exclusion among those without the financial means to access care.

27. The growing epidemiological importance of noncommunicable diseases as a cause of mortality is not new. Nor is the fact that these diseases are a growing cause of mortality and morbidity in all countries. Chronic diseases, such as heart disease, stroke, cancer, chronic respiratory diseases and

diabetes, are by far the leading cause of mortality in the world, representing 63% of all deaths. Of the 36 million people who died from chronic disease in 2008, nine million were under 60 and 90% of these premature deaths occurred in low- and middle-income countries. What has changed is the growing recognition – not just among health professionals but also among finance ministers, heads of state and a wider public – of the enormity of the social and economic consequences of a failure to act on this knowledge. Nevertheless, one of the biggest challenges in the coming decade is to bridge the gap between rhetoric and reality when it comes to concrete action and the allocation of resources, not just in the health sector, but across governments and societies.

28. Meeting the challenge of noncommunicable diseases and in particular dealing with their social, environmental and economic determinants through multisectoral responses, at different points throughout the life-course, requires a change in the role of health ministries. Although the aspect of providing and financing health services continues, they need also to function more effectively as a broker and interlocutor with other parts of government, becoming part of an overall system to create wellness and well-being, not just one that prevents and treats disease. Ministries thus need the capacity to steer, regulate and negotiate with a wide range of partners in an increasingly complex environment.

29. With growing complexity comes the need for a greater focus of the *means* by which better health outcomes can be secured, namely: health as a human right; health equity; stronger and more resilient health systems; health as an outcome of policies in a wide range of other sectors; and innovation and efficiency in the face of financial constraints. There is growing inequity, within and between countries, both in access to health services and medical products and in health outcomes. Not only is this of concern in its own right, it can also act as a constraint to other aspects of economic and social development.

30. The new health agenda needs to acknowledge the close links between health and sustainable development. Health policy contributes to sustainable development and poverty reduction if people are protected from catastrophic expenditure when they fall ill. Equally, health is a beneficiary of policies that improve the environment. Addressing the relationship between health, climate change and other major environmental factors such as air pollution will be of growing importance in coming years. Lastly, measuring the impact on health can generate public and political interest in sustainability policies that have a more diffuse or deferred outcome.

### **More effective health security and humanitarian action**

31. The last decade has shown the need to be prepared for the unexpected. Shocks must be anticipated, even if their provenance, location and severity cannot be predicted, and no matter whether they result from new and re-emerging diseases, from conflicts, or from natural disasters.

32. Until recently humanitarian systems have operated separately from those dealing with public health emergencies. Increasingly, it is recognized that a more holistic response is required to emergency risk management; one that integrates prevention, emergency risk reduction, preparedness, surveillance, response and recovery.

33. Furthermore, the distinction between relief and development is artificial. The transition from humanitarian action to development is rarely linear, and the separation of related programmes can be counterproductive. Countries affected have higher rates of poverty and a few have yet to achieve a single Millennium Development Goal. Building greater resilience and stability requires investment in political and institutional capacity building, a focus on preparedness through emergency risk management, and the recognition that humanitarian relief and development are deeply interdependent.

## New challenges in health governance

34. The assets the world has at its disposal to improve peoples' health could be deployed more effectively and more fairly. Better governance of health can result in instruments that help to reduce transnational threats to health (for example, the International Health Regulations (2005), and the Pandemic Influenza Preparedness Framework); through common approaches and strategies to address shared global, regional or subregional problems (for example, the WHO Global Code of Practice on the International Recruitment of Health Personnel); and through the solidarity and momentum that comes from shared goals (for example, the health-related Millennium Development Goals, and the voluntary goals and targets proposed in relation to noncommunicable diseases).

35. Several factors have been instrumental in broadening the health governance agenda:

**(a) Multiple voices.** Health governance is no longer the exclusive preserve of nation states. Civil society networks, individual nongovernmental organizations at international and community levels, professional groups, philanthropic foundations, trade associations, the media, national and transnational corporations, and individuals and informal diffuse communities that have found a new voice and influence thanks to information technology and social media – all of these actors have an influence on decision making that affects health.

**(b) New actors.** The institutional landscape of global health is increasingly complex, and incentives that favour the creation of new organizations, financing channels, and monitoring systems over the reform of those that already exist, risk making the situation worse. The impact of some of these changes is seen in the evolution of development thinking from the Paris Declaration on Aid Effectiveness to the Busan Partnership for Effective Development Cooperation, with its greater focus on partnership and South–South cooperation as well as other forms of cooperation.<sup>1</sup>

**(c) Wider concerns.** The dynamic in many governance discussions revolves around how to protect human health while at the same minimizing disruption to travel, trade and economic development. Although getting this balance right remains a critical concern, there are added dimensions to the debate, some of which are introduced through the greater use of human rights instruments, which increase the focus on fairness and equity.

**(d) Health governance and governance for health.** Implicit in the social determinants approach to health, as articulated in the Rio Political Declaration on Social Determinants of Health (2011), are two distinct concepts: *governance of health*, which addresses many of the issues referred to above and which essentially involves a coordinating, directing and internal coherence function. The second concept, *governance for health*, relates to an advocacy and public policy function that seeks to influence governance in other sectors in ways that have a positive impact on human health.

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

## **Growing pressures on multilateral organizations**

36. Just as overall growth in gross official development assistance has slowed, so have annual growth rates in the provision of such assistance by multilateral donor organizations, which have declined in recent years from 9% in 2008 to only 1% in 2011. Within this total, earmarked funding is growing faster than other core contributions.

37. Most multilateral financing goes to five main clusters of organizations. Over 80% of the US\$ 54 billion total in 2010 went to European institutions (the European Development Fund plus the European Union budget); the International Development Association (World Bank); United Nations funds and programmes; the African and Asian Development Bank; and the Global Fund to Fight Aids, Tuberculosis and Malaria. The remainder is shared between over 200 multilaterals, of which WHO is one.

38. The combination of austerity measures in donor countries and fragmentation within the multilateral system results in a series of sometimes conflicting pressures on international organizations. First, while the demand is for work that is relevant to all Member States, the demand from donors is often for a more exclusive focus on the needs of the poorest countries. Second, while the comparative advantage of many multilaterals is in the development of negotiated agreements, norms, standards and other public goods, performance evaluation conducted by bilateral agencies, singly and collectively, has focused more on traditional development outcomes. Third, although systems of governance and accountability remain agency-specific for many United Nations organizations, the demand for more effective integration at country level has increased the transaction costs of coordination.

39. These pressures demand in response that multilaterals define their respective comparative advantage, clearly articulate priorities, ensure financial accountability, have systems in place to effectively manage risk and, above all, ensure that they are able to convincingly demonstrate results. In many organizations, including WHO, these concerns underpin recent reforms.

## CHAPTER 2

### WHO: UNIQUE VALUES, FUNCTIONS AND COMPARATIVE ADVANTAGE

40. WHO has been at the forefront of improving health around the world since its founding in 1948. As Chapter 1 has shown, the challenges confronting public health have changed in profound ways and, in some cases, with exceptional speed. The overall purpose of the WHO programme of reform is to ensure that WHO evolves to keep pace with these changes. This chapter examines the implications of this changing context for WHO in terms of the need for continuity and change.

#### **Continuity: enduring principles and values**

41. WHO remains firmly committed to the principles set out in the preamble to the Constitution (as set out in Box 1).

#### **Box 1. Constitution of the World Health Organization: principles**

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

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

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

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

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

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

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

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

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

42. In a context of growing inequity, competition for scarce natural resources, and a financial crisis that threatens basic entitlements to health care, it would be hard to find a better expression of health as a fundamental right, as a prerequisite for peace and security, and the key role of equity, social justice, popular participation and global solidarity in the Organization's work.

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

- The combination of WHO's intergovernmental foundation and its regionalized structure confers a unique legitimacy in engaging and supporting countries. In particular, the review of health governance issues in Chapter 1 highlights to the need for negotiated solutions to shared international health problems, particularly in instances of interaction between health and other sectoral interests (such as trade, migration, security and intellectual property). In addition, the capacity to convene and facilitate the negotiation of binding and non-binding international instruments distinguishes WHO from other health actors. A commitment to multilateralism remains a core element of WHO's work.
- Represented in some 150 countries, territories and areas by a WHO Office, the Organization is uniquely positioned to remain as a provider of technical support to individual Member States, facilitating increasing links within and between countries in the interests of South-South and triangular cooperation. WHO will continue to provide humanitarian assistance, ensuring that care for peoples' health is central to disaster relief efforts.
- In line with the principle of equity and social justice, WHO will continue to give emphasis where needs are greatest. Although WHO's work will continue to be relevant to all Member States, the Organization sees health as being central to poverty reduction. The analysis in Chapter 1 points to the fact that the greatest absolute number of poor people are now citizens of middle-income and emerging economies. The focus is therefore not only on countries, but on poor populations within countries.
- WHO is committed to the mainstreaming of gender, equity and human rights and will establish an accountability mechanism to monitor the effectiveness of the mainstreaming process. WHO is committed to operationalizing the United Nations System-wide Action Plan (UN SWAP) to further the goals of gender equality and women's empowerment within the policies and programmes of the United Nations system.
- In its normative and standard setting work, which benefits Member States collectively, WHO is and will remain a science and evidence-based Organization with a focus on public health. The environment in which WHO operates is becoming ever more complex and politicized; however WHO's legitimacy and technical authority lies in its rigorous adherence to the systematic use of evidence as the basis for all policies. This also underpins the Organization's core function of monitoring health trends and determinants at global, regional and country level. As a public health agency, WHO continues to be concerned not only with the purely medical aspects of illness, but with the determinants of ill-health and the promotion of health as a positive outcome of policies in other sectors.

## Core functions and division of labour

44. The six core functions that were articulated in the Eleventh General Programme of Work remain a sound basis for describing the nature of WHO's work. They are:

1. Providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
2. Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
3. Setting norms and standards, and promoting and monitoring their implementation;
4. Articulating ethical and evidence-based policy options;
5. Providing technical support, catalysing change, and building sustainable institutional capacity;
6. Monitoring the health situation and assessing health trends.

45. However, effective management requires a clear differentiation of roles and responsibilities between the different levels of the Organization, in terms of how they work together, and what they actually deliver. To be of greater operational significance, the six core functions thus need to be seen in relation to the roles and responsibilities of the three levels.

46. An analysis of this relationship is being developed in the form of a matrix that links the six core functions on one axis and with the three levels of the Organization on the other. Defining relationships in this way facilitates the identification of overarching roles and functions. For example, in terms of core function 5, (providing technical support, catalysing change, and building sustainable institutional capacity) the matrix would show how the country office takes the lead (within the Secretariat) in developing and negotiating a country cooperation strategy; managing technical cooperation; implementation and monitoring of international commitments, conventions and legal instruments; and in emergency and crisis response. The role of the Regional Office is to provide and coordinate support as needed for these processes. The role of headquarters is to coordinate the development of corporate guidance for the development of the country cooperation strategy and to promote best practice in the provision of technical collaboration. By contrast, headquarters takes the lead on the formulation of technical norms and standards, while the role of the country and regional offices is to support adaptation where necessary and to provide some of the evidence on which norms, standards and methodologies are based.

47. The same analytical approach will also be used to define roles and functions at a programmatic level. This is a particularly significant development as it will have the effect of formalizing the so-called category networks.<sup>1</sup> These informal networks have been used as a way of ensuring the engagement of all levels of WHO in the preparation of the proposed programme budget for 2014–2015.

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<sup>1</sup> The six categories are those agreed by Member States in 2012. Their programmatic content is discussed in more detail in Chapter 5.

48. Lastly, at an even greater level of detail, the matrix approach will be used as a template for defining the precise contribution to be made by each level of WHO in relation to the delivery of each specific output included in the programme budget.

### **WHO reform: a strategic response to a changing environment**

49. The twenty-first century has witnessed a series of commitments, opportunities, innovations, successes, setbacks and surprises that are unprecedented in the history of public health. Equally unprecedented has been the growing vulnerability of health to new threats arising from the radically increased interdependence of nations and policy spheres. The forces driving these changes are powerful, virtually universal and almost certain to shape health for years to come. They reinforce the pressures on international organizations that were outlined at the end of Chapter 1.

### **Finance aligned with priorities**

50. WHO continues to play a critical role as the world's leading technical authority on health. At the same time, the Organization has found itself overcommitted, overextended and in need of reform. Priority setting, in particular, has been neither sufficiently selective nor strategically focused. Moreover, most analysts now suggest that the financial crisis will have long-term consequences, and not only in the OECD countries that provide a large proportion of WHO's voluntary funding. It is therefore evident that WHO needs to respond strategically to a new, longer-term constrained financial reality rather than reacting managerially to a short-term crisis. Sustainable and predictable financing that is aligned to a carefully defined set of priorities, and agreed by Member States, is therefore central to the vision of a reformed WHO. The process of priority setting through which the set of high-level strategic priorities have been identified is discussed in more detail in the next chapter.

### **Effective health governance**

51. The analysis in Chapter 1 also points to the need for WHO to enhance its effectiveness in health governance. As a practical expression of the Constitutional function to act as "the directing and coordinating authority on international health work", health governance has several components. It includes WHO's multilateral convening role in bringing countries together to negotiate conventions, regulations, resolutions, and technical strategies and supporting their implementation in countries. In response to the recent proliferation of agencies, funding channels and reporting systems, it also includes WHO's role in bringing greater coherence and coordination to the global health system. Lastly, it refers to the role of WHO's Member States as governors and shareholders of the Organization.

52. In the overall vision for a reformed WHO, health governance is a critical global function involving all levels of WHO: at headquarters through the work of the governing bodies and interactions with other global players; at the regional level, in interactions with regional economic and political bodies and in addressing regional, subregional and other local cross-border issues; and at country level, in helping governments as they seek to reform and strengthen their health system and align domestic and international finance around national health priorities. The general programme of work returns to the issue of health governance in Chapter 4.



### **Pursuit of organizational excellence**

53. The managerial elements of WHO's reform respond to the need for a more flexible and agile organization that can address rapidly changing global health needs. The vision that guides reform has been to replace outdated managerial and organizational structures and to build an organization that is more effective, efficient, responsive, objective, transparent and accountable.

54. In structural terms, the objective is to improve support to countries, through strengthened, accountable and more appropriately resourced country offices in those countries where a physical presence is needed. Where it is not, support will continue to be provided by headquarters, regional, and subregional offices. Secondly, reform has sought to delineate clear roles and responsibilities for the three main levels of WHO, seeking synergy and alignment around common Organization-wide policy and strategic issues, at the same time as striving for a clear division of labour with accountability for resources and results.

55. By the time the new general programme of work begins, many of the reforms to WHO's management systems will be in place. These include reforms related to human resources, results-based planning and budgeting, financial controls, risk management, evaluation and communications. Nevertheless, the implementation of these reforms throughout the Organization in pursuit of continuous improvements in performance will continue to be a priority for the period of the programme of work, as discussed in the second part of Chapter 4.

## CHAPTER 3

### PRIORITY SETTING

56. In early 2012, a meeting of Member States agreed the following criteria to be used in setting priorities in WHO for the period 2014–2019 to be covered by the twelfth general programme of work:

- The current health situation including: demographic and epidemiological trends and changes, urgent, emerging and neglected health issues; taking into account the burden of disease at the global, regional and/or country levels.
- Needs of individual countries for WHO support as articulated, where available, through the country cooperation strategy, as well as national health and development plans.
- Internationally agreed instruments that involve or impact health such as declarations and agreements, as well as resolutions, decisions and other documents adopted by WHO's governing bodies at the global and regional levels.
- The existence of evidence-based, cost-effective interventions and the potential for using knowledge, science and technology for improving health
- The comparative advantage of WHO, including:
  - (a) capacity to develop evidence in response to current and emerging health issues;
  - (b) ability to contribute to capacity building;
  - (c) capacity to respond to changing needs based on an on-going assessment of performance;
  - (d) potential to work with other sectors, organizations, and stakeholders to have a significant impact on health.

#### Leadership priorities

57. The criteria agreed in early 2012 were the starting point for at the six leadership priorities proposed below. The first step in the process was to review the context in which WHO is working, as set out in Chapter 1, in the light of these criteria, focusing particularly on WHO's comparative advantage.

58. Leadership priorities give focus and direction to WHO's work. They link to the Organization's role in health governance, highlighting areas in which WHO's advocacy and technical leadership in the global health arena are most needed. These are the areas in which WHO will seek to shape the global debate, to secure country involvement and to drive the way the Organization works – integrating efforts across and between levels of WHO.

59. These priorities do not mirror the more formal structure of the results chain, because they have been selected as areas in which WHO's leadership is the prime concern. Like the priorities set out by a new national government, they are identifying issues and topics that stand out from the totality of WHO's work.

60. The results chain will be the primary tool for the monitoring and evaluation of WHO's performance. WHO's effectiveness in implementing the leadership priorities will also be assessed. Chapter 5 examines WHO's framework for monitoring and evaluation, and its links with both the results chain and the organizing framework for WHO's work in the programme budget. Choices about individual leadership priorities are discussed in subsequent sections below.

## Box 2

### Leadership priorities 2014–2019

**Advancing universal health coverage:** enabling countries to sustain or expand access to essential health services and financial protection and promoting universal health coverage as a unifying concept in global health.

**Health-related Millennium Development Goals** – addressing unfinished and future challenges: accelerating the achievement of the current health-related Goals up to and beyond 2015. This priority includes completing the eradication of polio and selected neglected tropical diseases.

**Addressing the challenge of noncommunicable diseases** and mental health, violence and injuries and disabilities.

Implementing the provisions of the **International Health Regulations:** ensuring that all countries can meet the capacity requirements specified in the International Health Regulations (2005).

Increasing access to essential, high-quality and affordable **medical products** (medicines, vaccines, diagnostics and other health technologies).

Addressing the **social, economic and environmental determinants** of health as a means of reducing health inequities within and between countries.

61. The remainder of this chapter reviews each of the six leadership priorities in turn. In line with the overall purpose of the general programme of work, the aim is to provide a rationale for why they have been chosen as priorities, and a vision and sense of direction for WHO itself over the next six years.

### Advancing universal health coverage

62. Universal health coverage is one of the most powerful ideas in public health. It combines two fundamental components: access to the services needed to achieve good health (promotion, prevention, treatment and rehabilitation, including those that address health determinants) with the financial protection that prevents ill health leading to poverty. It therefore provides a powerful unifying concept to guide health and development and to advance health equity in coming years. It is an area in which WHO's leadership, both technical and political, will be crucial to progress.

63. Universal health coverage is conceived not as a minimum set of services but as an active process of progressive realization in which countries gradually increase access to curative and preventive services as well as protecting increasing numbers of people from catastrophic financial consequences when they fall ill.

64. Ensuring that all people can take advantage of comprehensive and high quality health services through universal health coverage and access is a means to achieve better health outcomes. It is also a desirable goal that people value in its own right – the assurance that they have access to a health system that prevents and treats illness effectively and affordably within people’s homes, in their communities, and with referral to clinics and hospitals when required. Such a goal would seek to ensure that 100 million people do not fall into poverty each year due to the cost of health services they need (as they do today). Universal health coverage is important in reducing poverty, and promoting a stable and secure society. The outcome statement of the United Nations Conference on Sustainable Development (Rio+20)<sup>1</sup> has further emphasized the relationship between universal health coverage and the social, environmental and economic pillars of sustainable development.

65. Universal health coverage is a dynamic process. It is not about a fixed minimum package, it is about making progress on several fronts: the range of services that are available to people; the proportion of the costs of those services that are covered; and the proportion of the population that is covered. Few countries reach the ideal, but all – rich and poor – can make progress. It is thus relevant to all countries and has the potential to be a universal goal.

66. This point is critically important in the definition of a new generation of development goals. Universal health coverage has a strong link with sustainable development; it offers a way of sustaining gains and protecting investments in the current set of health-related Millennium Development Goals after 2015; and can accommodate both communicable and noncommunicable disease interests. Meaningful universal health coverage requires that people have access to all the services they need including those relating to noncommunicable diseases, mental health, infectious diseases, and reproductive health.

67. As a leadership priority for the next six years universal health coverage gives practical expression to WHO’s concern for equity and social justice and helps to reinforce the links between health, social protection and economic policy. In practical terms WHO will focus on responding to the groundswell of demand from countries in all parts of the world that seek practical advice on how to take this agenda forward in their own national circumstances. Universal health coverage will also provide a clear focus for WHO’s work on health system strengthening.

68. WHO will focus on health service integration, reflecting concerns for more people-centred services, efficiency, and value for money, and a general shift in emphasis away from categorical, disease-focused programmes. WHO will respond to the need for integration across the whole health care continuum from primary prevention through acute management to rehabilitation. Better links between medical, social and long-term care have significant benefits in terms of care for noncommunicable diseases, maternal and child health, and for the health of ageing populations.

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<sup>1</sup> “We also recognize the importance of universal health coverage to enhancing health, social cohesion and sustainable human and economic development. We pledge to strengthen health systems towards the provision of equitable universal coverage. We call for the involvement of all relevant actors for coordinated multisectoral action to address urgently the health needs of the world’s population.” See United Nations General Assembly resolution 66/288, Annex, paragraph 139.

69. As an essential element of extending universal health coverage, WHO will continue work on the collection, analysis and use of health data – including strengthening country information systems – as a prerequisite for making investment decisions and for enhancing efficiency and accountability. A particular focus will be the establishment of systems for vital registration in countries where they still do not exist. Similarly, critical shortages, inadequate skill mix and uneven geographical distribution of the health workforce pose major barriers to achieving universal health coverage and better health outcomes. Addressing this issue through advocacy, analysis and strategies to improve working conditions, training and remuneration for health workers will remain a priority.

70. Lastly, universal health coverage provides a focus and desirable outcome for WHO's work on national health policies, strategies and plans. Building on the work of the International Health Partnership (IHP+) WHO will use its comparative advantage as a convenor and facilitator at country level to involve all the main players in health policy and system strengthening. This reflects a fundamental shift away from fragmented small-scale health system projects and will instead ensure that all the health system building blocks including human resources and health system financing form part of an overall coherent strategy. In addition, WHO will support national authorities as they seek to ensure that the contributions of external partners as well as domestic funding are aligned to nationally-defined goals. Policy dialogue will increasingly involve actors from the private sector, civil society and nongovernmental organizations, and will extend to other sectors to ensure that the most important social determinants are addressed.

### **Health-related Millennium Development Goals: unfinished agenda and future challenges**

71. More than a decade after world leaders adopted the Millennium Development Goals and their targets, substantial progress has been made in reducing child and maternal mortality, improving nutrition, reducing morbidity and mortality due to HIV infection, tuberculosis and malaria, and increasing access to safe water and sanitation. Progress in countries that have the highest rates of mortality has accelerated in recent years. Polio, as a major cause of child death and disability, is close to eradication.

72. Nevertheless, much needs to be done through intensified collective action and expansion of successful approaches after 2015, to sustain the gains that have been made to date and to ensure more equitable levels of achievement across countries, populations and programmes. Indeed, it will be sometime after 2015 before achievements against the current set of goals can be fully assessed. There is therefore a need to continue to ensure progress against the current goals; to back national efforts with the advocacy needed to sustain the necessary political commitment and financial support; and, crucially, to maintain levels of investment in national and international systems for tracking resources and results.

73. The unfinished Millennium Development Goal agenda is a leadership priority for WHO for several reasons. As the debate on the next generation of goals begins, it is clear from the early consultations that learning from the experience of the current goals is vital. A vigorous debate about how the next generation of goals post-2015 began in 2012 and will only be finalized during the early years of this programme of work. However, countries at all levels of income have insisted that the debate about new goals does not undermine current efforts.

74. Secondly, work on the health goals represents one of the main ways in which WHO contributes to poverty reduction and a more equitable world. It is for this reason that the elimination or eradication

of selected neglected tropical diseases are included within this priority, given their role as a major cause of disability and loss of productivity among some of the world's most disadvantaged people.<sup>1</sup>

75. Thirdly, the Millennium Development Goal agenda integrates work across the Organization, bringing together under a single priority several aspects of WHO's work, particularly the need to build robust health systems and effective health institutions, not just as an end in themselves, but as a means to achieving sustainable and equitable health outcomes.

76. In shaping the vision for the coming six years, there are also specific priorities for what WHO will do. These include completing the eradication of wild poliovirus and putting in place everything needed for the polio end-game period. As work in HIV and AIDS moves from an emergency response to a long-term sustainable model for delivering services, WHO will focus on the development of simplified treatment regimes. In tuberculosis, better access to first line treatment in all high-burden countries will remain key to preventing further drug resistance. In malaria, the map is shrinking, but the people most at risk become harder to reach and services become expensive to deliver. Treatment based on rapid high-quality diagnosis will become increasingly important. In addition, WHO will be ahead of the curve in offering normative advice when an effective vaccine becomes available. Vaccines are the most cost-effective tool at our disposal for reducing child (and increasingly adult) deaths. The agenda for the general programme of work will be in line with the Decade of Vaccines, focusing in particular in ensuring that vaccination acts as entry point for other public health services.

77. Work to reduce maternal, child and newborn mortality will be a critical element of promoting health and well-being across the whole life course, from conception, to old age. Particular priorities include family planning, early childhood development, adolescent health and interventions in the 24 hours around delivery (management of labour, oxytocin after delivery, resuscitation of the newborn and early initiation of breast feeding).

78. One of the lessons of the Millennium Development Goals is that the way global goals are defined influences how the world understands development. Goals therefore shape political agendas and influence resource transfers. For these reasons WHO will give particular priority to securing the place of health in the post-2015 development agenda. While there are many strands to the discussion, there is little disagreement that health makes a direct contribution to poverty reduction, it benefits from better environmental policies and provides a robust means for measuring progress across the three pillars of sustainable development. The challenge is to develop a narrative that accommodates a broader health agenda (particularly in relation to noncommunicable diseases and health systems) and avoids competition among different sectoral interests.

### **Addressing the challenge of noncommunicable diseases and mental health, violence and injuries and disabilities**

79. The rationale for this leadership priority is becoming increasingly self-evident, in terms of the magnitude of the problem, demand from countries for WHO's leadership and the existence of a clear internationally agreed mandate.

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<sup>1</sup> Specific priorities are set out in the neglected tropical diseases road map, *Accelerating work to overcome the global impact of neglected tropical diseases: a roadmap for implementation*. Geneva, World Health Organization, 2012 (document WHO/HTM/NTD/2012.1).

80. The growing burden of noncommunicable diseases including disability, violence and injuries, will have devastating health consequences for individuals, families and communities and threatens to overwhelm health systems. Cited as one of the greatest overall global risks by the World Economic Forum, failure to act on noncommunicable diseases in the short-term will lead inexorably to massive cumulative output losses. The overall economic impact is matched by the financial consequences for health systems. In some countries, diabetes care alone can consume as much as 15% of the health care budget. However, sums in the order of US\$ 11 billion that are spent now on cost-effective interventions can prevent US\$ 47 trillion-worth of future damage to the world's economies by 2030. In short, actions taken now can demonstrate with evidence how better health can make a significant contribution to poverty reduction and economic development.

81. Each year, over five million people die as a result of violence and unintentional injuries. A quarter of these deaths are due to suicide or homicide, and road traffic crashes account for another quarter. The United Nations General Assembly declared a Decade of Action for Road Safety 2011–2020. Falls, drowning, burns and poisoning are also significant causes of death.

82. There are over 1000 million people with disabilities in the world, equal to 15% of the world's population. The prevalence of disability is growing because of ageing populations and the global increase in chronic health conditions. Across the world people with disabilities face extensive barriers, have worse health outcomes, and often do not receive needed health care.

83. Scaling-up work on noncommunicable diseases is a worldwide agenda. In low- and middle-income countries, the prevalence of noncommunicable diseases and mental health conditions is increasing not just among the growing number of the elderly, but also among individuals in their most productive years. This trend is most striking in Africa, where the burden of disease due to noncommunicable diseases is expected to exceed the total of communicable, maternal, perinatal and nutritional diseases and to become the most common cause of death by 2030.

84. WHO will focus primarily over the next six years on combating the four major noncommunicable diseases<sup>1</sup> and their major risk factors.<sup>2</sup> The approach for Member States, other partners and the WHO Secretariat is set out in the global action plan for the prevention and control of noncommunicable diseases, 2013–2020.

85. As part of this plan, the priority for WHO is to move from advocacy to multisectoral action in the next six years. Better control will focus on prevention, but technical support will also emphasize early detection of diseases, improving access to more affordable pharmaceutical products, reducing the suffering of people living with chronic disease, developing new products and technologies suitable for use in resource-constrained settings and simplifying treatment regimens to be delivered through primary health care.

86. In relation to mental health, the Secretariat will focus on information and surveillance; broadening the evidence base on mental health interventions; supporting Member States in the development of policies, strategies and legal instruments, with a particular focus on protection of rights; developing and integrating mental health services as part of primary care; and the provision of mental and psychosocial support in humanitarian emergencies.

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<sup>1</sup> Cardiovascular disease, cancers, chronic lung diseases, diabetes.

<sup>2</sup> Tobacco use, unhealthy diet, physical inactivity, and harmful use of alcohol.

87. In relation to violence and unintentional injuries, the Secretariat will focus on broadening the evidence base for their prevention, and scale up support to Member States on monitoring these problems and responses to them, and in capacity development; policy and planning; advocacy; prevention programming, and the provision of services including trauma care. With regard to work on disability, WHO will scale up its activities to improve disability data, strengthen health systems for the provision of rehabilitation and assistive technologies, and enhance community-based rehabilitation, in line with the WHO-wide action plan on disability, the High-level Meeting of the General Assembly on the Millennium Development Goals, and other internationally agreed development goals for persons with disabilities.

88. The fact remains, however, that real progress in relation to all noncommunicable conditions cannot depend on the health sector alone. Although this is true of many health conditions, an analysis of the causes and determinants of noncommunicable diseases points to a particularly wide and multi-layered range of interrelated determinants. These range from environmental exposure to harmful toxins, diet, tobacco use, excess salt and alcohol consumption and increasingly sedentary lifestyles. These in turn are linked to income, housing, employment, transport, agricultural and education policies, which themselves are influenced by patterns of international commerce, trade, finance, advertising, culture and communications.

89. It is possible to identify policy levers in relation to each of these factors individually, however, orchestrating a coherent response across societies remains one of the most prominent challenges in global health and thus it is a leadership priority for WHO. Success will require coordinated, multisectoral action at global, regional, national and local levels.

90. WHO's role is further illustrated by the requests made by Member States at the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases in 2011: to develop a comprehensive global monitoring framework and recommendations for a set of voluntary global targets; to articulate policy options for strengthening and facilitating multisectoral action, including through effective partnership; and to exercise leadership and a coordinating role in promoting global action in relation to the work of United Nations funds, programmes and agencies.

91. WHO's work in this area will draw heavily on its normative and capacity-building competencies, it is closely linked to work on social determinants, particularly in relation to nutrition (see below) and, perhaps most important, it is a prime example of WHO's growing role in health governance, at all levels of the Organization.

### **Implementing the provisions of the International Health Regulations (2005)**

92. WHO has a leadership role in establishing the systems that constitute the global defence against shocks arising from the microbial world.

93. The range of these shocks is increasing, particularly from zoonoses (with the interface between humans and animals now being the source of 75% of new diseases). Protection continues to rely on the systems and programmes that gather real-time intelligence about emerging and epidemic-prone diseases, that verify rumours, issue early alerts, and mount an immediate international response aimed at containing any threat at its source. The International Health Regulations (2005) constitute the key legal instrument needed to achieve collective security. However, the 2011 report of the Review Committee on the Regulations in relation to the H1N1 (2009) pandemic concluded that the world is ill-prepared to respond to a severe pandemic or to any similar global, sustained and threatening public health emergency.



94. The International Health Regulations (2005) and other instruments such as the Pandemic Influenza Preparedness Framework focus on threats to public health. However, giving priority to implementing their provisions will have a broader impact. This approach is consistent with the trend noted in Chapter 1 in favour of a more holistic response to emergency risk management that integrates prevention, emergency risk reduction, preparedness, surveillance, response and recovery, thereby reducing mortality, morbidity and the societal disruption and economic impact that can result from epidemics, natural disasters, conflicts, environmental and food-related emergencies.

95. The priority given to implementing the International Health Regulations (2005) is similarly supported by the finding that countries and communities that have invested in risk reduction, preparedness and emergency management are more resilient to other disasters and tend to respond more effectively, irrespective of the cause of the threat. Critically, however, deep disparities remain between Member States in their capacity to prepare for and respond to acute and longer-term threats.

96. In practical terms, the Secretariat will provide the support necessary for countries to put in place the core capacities required by Annex 1 of the International Health Regulations (2005) prior to the deadline in 2016. These include: national legislation, policy and financing; coordination and national focal point communications; surveillance; response; preparedness; risk communication; human resources; and laboratories. WHO will support national efforts and report on progress. In addition, WHO will strengthen its own systems and networks to ensure a rapid and well-coordinated response to future public health emergencies. This will include the further development and maintenance of the integrity of the policy guidance, information management and communication systems at global, regional and country level that are needed to detect, verify, assess and coordinate the response to acute public health events as and when they arise.

### **Increasing access to essential, high-quality, effective and affordable medical products**

97. New technology holds many promises: to make health professionals more effective, health care facilities more efficient, and people more aware of the risks and resources that can influence their health. Progress in meeting many of the world's most pressing health needs requires new medicines, vaccines and diagnostics. At the same time, growing demand for the newest and the best can contribute to rocketing costs. The value of health technology cannot be judged in isolation from the health system in which it is used. Electronic medical records can improve quality of care, with adequate safeguards to assure confidentiality. Scientific progress, ethical conduct and effective regulation have to go hand in hand to ensure that technology development is an ethical servant to the health needs of the world's poor.

98. Equity in public health depends particularly on access to essential, high-quality and affordable medical technologies: medicines, vaccines, diagnostics and other procedures and systems. Increasing access to these products is therefore a strategic priority for the period of the twelfth general programme of work.

99. More affordable prices ease health budgets everywhere, but are especially important in developing countries, where too many people still have to meet medical expenses out of pocket. Access to affordable medicines becomes all the more critical in the face of the growing burden of noncommunicable disease as individuals may require life-long treatment. Additionally, access to essential medicines early in the course of disease can prevent more serious consequences and costs later.

100. Improving access to medical products is central to the achievement of universal health coverage. Improving efficiency and reducing wastage is an important component of health financing policy. Strategies to improve access need also to be linked with the safety and quality assurance of all medical products, including work in health and other sectors to prevent the further development of antimicrobial resistance.

101. In practical terms, WHO will continue to promote rational procurement and prescribing that favour greater use of generic over originator brands. It will continue its normative work in relation to nomenclature, good manufacturing practice, biological standardization, specification of products and selection of essential medicines, diagnostics and other health technologies. It will promote research and development for the medical products needed by low-income countries and continue with the implementation of the global strategy and plan of action on public health, innovation and intellectual property. It will continue to support negotiations to establish mechanisms for the prevention and control of substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products.

102. Future work will encompass innovation to achieve affordable health technologies for use in maternal and child health as well those needed by older people and those living with chronic diseases in order to help them sustain their independence and overcome disability. A cross-cutting theme will be a focus on creating the conditions for greater self-reliance, especially in the countries of the African Region. In circumstances where local production offers real prospects for increasing access and affordability WHO will support technology transfer. Regional networks for research, development and innovation are already in place. The missing link in many countries therefore is adequate national regulatory capacity. Development and support for regional or national regulatory authorities will be a major element of this priority, gradually reducing reliance on global prequalification programmes as a means of facilitating market entry of manufacturers from the developing world.

### **Addressing the social, economic and environmental determinants of health as a means of reducing health inequities within and between countries**

103. Work on the social, economic and environmental determinants of health is not new in WHO. Its origins can be traced to the Alma Ata Declaration on Primary Health Care. Equally, WHO's decision to control tobacco use through the WHO Framework Convention on Tobacco Control is illustrative of an approach that addresses one of the most lethal determinants of death and disability rather than just its biomedical consequences. The work on social determinants has been given renewed emphasis and momentum as a result of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases in September 2011, the Commission on Social Determinants of Health, and the World Conference on Social Determinants of Health held in Rio, October 2011.<sup>1</sup>

104. Social determinants of health constitutes an approach and a way of thinking about health that requires explicit recognition of the wide range of social, economic and other determinants associated with ill-health as well as with inequitable health outcomes. Its purpose is to improve health outcomes and increase healthy life expectancy. The wider application of this approach – in line with the title of the draft twelfth general programme of work and in a range of different domains across the whole of WHO – is therefore a strategic priority for the next six years in its own right.

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

105. There are several practical implications of this priority. They include the need to build capacity and tools for policy coherence in order to mainstream the social determinants approach in the Secretariat and in Member States. In addition, a wide range of technical work will address health determinants and promote equity. This covers work on social health protection, disaster preparedness, setting standards in relation to environmental hazards, climate change, energy and transportation policy, food safety, nutrition, access to clean water and sanitation and many others. In addition, much of the work on noncommunicable diseases is based on the idea that health, and the reduction in exposure to key risk factors and determinants, is an outcome of policies in a range of other sectors and is a concrete expression of a whole of government or whole of society approach to health. Equally, there are outputs that seek to increase equity in access and outcome, particularly in relation to early childhood development, organization of health care services and the collection and dissemination of health data. Outputs in each part of the programme budget that address social and other determinants will be highlighted to demonstrate the range that they cover.

106. Implicit in the concept of the social determinants approach to health, as articulated in the Rio Political Declaration, is the need for better governance of health; both within national governments, and in relation to the growing number of actors active in the health sector. This is generally referred to as health governance. Equally, the social determinants approach promotes governance in other sectors in ways that positively impact on human health, referred to as governance for health. This latter perspective is well illustrated by the whole of society approach to noncommunicable diseases, as well as in a statement made in 2010 by the foreign ministers of the seven participating countries in the Foreign Policy and Global Health Initiative:<sup>1</sup> “Foreign policy areas such as security and peace building, humanitarian response, social and economic development, human rights and trade have a strong bearing on health outcomes”.<sup>2</sup> Health governance is discussed in more detail in the following chapter.

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<sup>1</sup> Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand.

<sup>2</sup> The Oslo Ministerial Declaration (2007).

## CHAPTER 4

### GOVERNANCE AND MANAGEMENT

107. This chapter addresses two priorities linked to two of the three components of WHO reform.

*Strengthening WHO's governance role:* Greater coherence in global health, with WHO playing a coordinating and directing role that enables a range of different actors to more effectively contribute to the health of all peoples.

*Reforming management policies, systems and practices:* An organization that pursues excellence; one that is effective, efficient, responsive, objective, transparent and accountable.

#### WHO's role in global health governance

108. Chapter 1 outlined several of the challenges of global health governance. In summary:

- there are a growing number of health-related issues in which agreement requires a careful negotiation in order to balance technical and political interests;
- the wider range of actors that are involved in global health challenges the coordinating and directing authority of WHO;
- and there is a growing interest in ensuring that governance in other sectors and policy arenas avoids compromising health and ideally has a positive impact on it.

109. With regard to the last point, the section above on social determinants distinguished governance of health, which is primarily a coordinating, directing and internal coherence function, from governance in other sectors in the interests of health, an advocacy function that incorporates the whole-of-government/society approach to improving health. WHO needs to be adept at both. Lastly, it is important to recognize that WHO's role in global health governance is expressed not just at headquarters, but increasingly at regional and country level as well.

110. The reforms address health governance both from the perspective of WHO's governing bodies and the role that WHO plays in coordination among other health actors, as well as WHO's role in governance for health.

#### Governing body reform

111. The objectives for the governing body reforms recognize that although WHO's governance by Member States has served it well in the past, the changing context, new demands, and the increasing number of players in global health necessitate changes in the way the Organization itself is governed. For the World Health Assembly, the Executive Board and the regional committees the aim is to foster a more strategic and disciplined approach to priority setting, to enhance strategic oversight of the programmatic and financial aspects of the Organization, to harmonize and align governance processes across the Organization, and to improve the efficiency and inclusivity of intergovernmental consensus building, by strengthening the methods of work of the governing bodies.

112. For the Executive Board, the focus will be on strengthening its executive, oversight roles and strategic role, and streamlining its methods of work. For the Health Assembly, a more strategic focus will help ensure that resolutions enable better priority setting. The work of the regional committees will be more closely linked to the global governance of WHO, particularly to the work of the Executive Board, and best practice will be standardized across different regions. To complement these changes the Secretariat will improve the support it provides to WHO's governance functions, including the briefing of new members as well as even higher quality and more timely documents.

113. One consequence of the growing political interest in health and the recognition of the connection between health and many other areas of social and economic policy is a growing demand for intergovernmental, rather than purely technical processes, in order to reach durable and inclusive agreements. In the draft general programme of work it is foreseen that this demand is unlikely to decrease. As a consequence, WHO will put in place the requisite capacities to prepare for meetings, to brief participants and manage these processes as effectively as possible.

114. Linked to governing body reform is the issue of national reporting. In order to base both national and global decision making on a stronger evidence base, WHO will streamline and strengthen national reporting on health data, national laws and policies and the implementation of World Health Assembly resolutions, making better use of modern information technology to gather and disseminate this information.

### **Hosted partnerships**

115. As a first step in extending the oversight role of WHO's governing bodies it was agreed in 2013 that the Programme, Budget and Administration Committee of the Executive Board would ensure that the arrangements for partnerships hosted by WHO would be regularly reviewed on a case-by-case basis. The review would examine their contributions to improved health outcomes and the effectiveness of their interactions with WHO. The Committee would then make any necessary recommendations to the Board through a standing item on the Board's agenda.

### **Non-State actors**

116. A further element of reform concerns WHO's engagement with the wide range of non-state actors that include nongovernmental organizations, civil society organizations, partnerships, foundations, academic institutions and private sector entities that all, in different ways, influence global health. To be a directing and coordinating authority logically argues for engagement. Although there are evident benefits that can accrue from a wider network of relationships, there are also important risks that have to be avoided – not least safeguarding WHO's normative function from any form of vested interest. Developing principles and practices to govern engagement with different types of non-state actors, recognizing in addition that interaction takes place for different purposes in different contexts, remains work in progress at the time of preparing the general programme of work. However, the intention is that such principles, procedures and oversight mechanisms be in place as early as possible in the six-year period.

### **Strengthening WHO's role in governance for health**

117. WHO's role in governance for health has many practical expressions. Two different perspectives are important for the general programme of work: positioning and promoting health in a range of global, regional and national processes; and consolidating the link between WHO's role in governance and the six leadership priorities.

## Positioning and promoting health

118. WHO will focus on promoting health concerns in a range of intergovernmental forums (foreign policy, trade negotiations, human rights, climate change agreements and others) that do not have health as their prime concern, but whose decisions can have an impact on health outcomes. WHO's role in these interactions will be to use evidence and influence to secure more positive health outcomes. In addition, WHO will continue to promote health as an issue of importance in the United Nations' Humanitarian response through the Inter-Agency Standing Committee, in the United Nations General Assembly and ECOSOC, the United Nations System Chief Executives Board and other bodies such as the G8, G20. Such approaches mean working at higher levels of government, reaching out to foreign ministers, finance ministers and heads of state and government.

119. *The post-2015 development agenda*: the framing of the next generation of global goals will have a major influence on development priorities and funding for some years to come. Ensuring that health is well-positioned and its role clearly articulated is a major health governance challenge and a priority for WHO. The environment in which negotiations are taking place is fluid, complex and competitive between the many sectoral interests that seek to be represented. The consultative process that is underway requires alignment across the levels of the Organization and consistency in messaging as WHO interacts with Member States and other stakeholders.

120. *Health and sustainable development*: Preparations for the Rio+20 Conference in June 2012 illustrated a related aspect of WHO's governance work: effective synergy on advancing health interests between the Secretariat, Member States and other stakeholders. The first draft of the Rio +20 outcome document made only passing reference to health. The WHO Secretariat at headquarters and at regional level therefore worked with Member States in Geneva and New York, as well as with nongovernmental organization groups to develop a convincing position on the role of health, which was eventually taken up by negotiators in Rio. The final text includes virtually all of WHO's health concerns.<sup>1</sup> In the follow-up to Rio+20 health provides an important link between the process of developing sustainable development goals and the post-2015 agenda. In addition, work with other sectors such as sustainable energy, water and sanitation, climate change and adaptation, food security and nutrition is showing the value of health indicators as a means of measuring progress across the three pillars of sustainable development.

121. *Health and United Nations reform*: WHO is committed to a more coherent approach to the United Nations work at country level, to aligning of support to national priorities, to promoting the place of health in United Nations Development Assistance Frameworks and One UN plans, and to coordinating the health cluster in emergencies. The recent independent evaluation of "Delivering as One" pilot countries has indicated that reform of United Nations operations has made some headway at country level, but that further progress will depend on whether Member States are

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<sup>1</sup> The outcome document from Rio +20 *The Future We Want* includes nine paragraphs on health and population. It begins "We recognize that health is a precondition for and an outcome and indicator of all three dimensions of sustainable development". This opening sentence is followed by references to the importance of universal health coverage, AIDS, tuberculosis, malaria, polio and other communicable diseases, noncommunicable diseases, access to medicines, strengthening health systems, sexual and reproductive health, protection of human rights in this context, and commitments to reducing maternal and child mortality.

ready to support greater integration at headquarters level. In these circumstances, WHO's priority is to strengthen the role of country offices to work as part of a United Nations Country Team, and to support regional UNDG teams and regional coordination mechanisms in those regions where they function effectively. At headquarters level, priority is given to high-level representation on the Chief Executives Board for Coordination (and the High Level Committee on Programmes) and much more selective engagement with the United Nations Development Group.

122. *Development Cooperation post-Busan*: As noted in Chapter 1, the Busan Partnership for Effective Development Cooperation that was formed after the meeting on development in the Republic of Korea in November 2011 signalled that a framework based on "aid" has given way to a broader, more inclusive, international consensus that emphasizes partnership approaches to cooperation, particularly South–South and triangular relationships. In the context of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, WHO has ensured that health has had a leadership and tracer role. It has demonstrated, through initiatives like the International Health Partnership (IHP+) and Health and Harmonization in Africa, that despite the many different players, coordination around national health strategies can be improved. Such approaches extend beyond the United Nations to include bilateral development agencies, development banks and nongovernmental organizations, and can show increases both in efficiency and in health outcomes. As the post-Busan Partnership begins to take shape WHO will play an active role, showing how better governance of health is linked to results, in ways that can provide a model for other sectors.

123. *Health and regional economic integration*: In all parts of the world, regional and subregional integration is a growing trend. Although many of these institutions tend to focus on primarily on economic development, they have the potential to be equally influential in health and social policy. The European Union, for example, coordinates in some aspects of foreign policy to an extent that makes the Union a major player in global health. It is likely that other regional bodies in time will also follow this pattern. WHO has a growing role to play in building networks of relationships with regional development banks, regional and subregional political groupings, and the United Nations Economic Commissions. The development banks and economic commissions have a particular advantage in being able to bring together ministers of health and ministers of finance.

### **Health governance and WHO's leadership priorities**

124. Given the diversity of the challenges in health and the growing number of actors, it is not surprising that the governance landscape is complex. Rather than "architecture" health governance is better described in terms of "overlapping and sometimes competing [*governance*] regime clusters that involve multiple players addressing different problems through diverse principles and processes".<sup>1</sup> This description is particularly apt in relation to completing work on the health-related Millennium Development Goals where overlapping circles of governance through United Nations agencies, partnerships, advocacy groups, and funding instruments compete for control, and, inevitably, for resources. Critically, however, ensuring the capacity to help countries that have many external development partners to manage that complexity and to decrease transaction costs is a key element of WHO reform.

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<sup>1</sup> Fidler, D. *The Challenges of Global Health Governance*, Council on Foreign Relations, May 2010.

125. Work on noncommunicable diseases, as noted in Chapter 3, illustrates the importance of the influence of other sectors and thus underlines the importance of governance for health. Similarly, the noncommunicable disease agenda shows how a particularly wide and multilayered range of inter-related social, economic and environmental determinants influence health outcomes. As alluded to above, although policy levers in relation to each of these determinants individually can be found, development of a coordinated response across societies remains one of the most prominent governance challenges in global health today.

126. From a health governance perspective universal health coverage is important in two ways. Firstly, at country level it represents a goal that is relevant to all countries as they seek to strengthen or reform their health systems. Secondly, in the debate about how to position health in the post-2015 agenda, it offers one way of defining a unifying goal that promotes equity and rights, combines concerns to finish work on the current Millennium Development Goals, while at the same time accommodating the need to address noncommunicable diseases and other causes of ill health.

127. Two of the other leadership priorities highlight an additional aspect of WHO's role in health governance: that the negotiation of international instruments needs to be linked to capacity building for implementation in countries. This is particularly evident in the case of the International Health Regulations (2005). The Regulations provide the key legal instrument needed to achieve collective health security, but their impact depends on all countries meeting the capacity requirements needed to detect, report and act on any new or emerging threat of international concern to public health.

128. Similarly, work on increasing access to medical products has been influenced by several international agreements including the Doha Declaration on the Agreement on Trade-Related Aspects of Intellectual Property Rights and Public Health (and its incorporation into the TRIPS agreement), and the subsequent global strategy and plan of action on public health, innovation and intellectual property. Other governance processes on substandard/spurious/falsely-labelled/falsified/counterfeit medical products and research and development financing are still on-going. As in the case of the International Health Regulations (2005), however, the full impact of governance decisions will depend on building or strengthening the institutions at country and regional level that are needed in order to implement the decisions, and on agreements being put into practice.

### **Building governance capacity**

129. Common to all aspects of governance is the need to build capacity across the Organization to manage this agenda more effectively. On the one hand the Secretariat needs to strengthen its own capacity and, on the other, offer support to Member States when it is required.

130. For the Secretariat, measures to increase capacity will include building a more sophisticated understanding of WHO's role and in the broader international system among managerial and technical staff, so that they become better able to understand the impact of governance issues on their work. Specifically, health diplomacy training, already mandatory for WHO Representatives, will be rolled out across other parts of the Organization. Training should include the use of tools from disciplines such as international relations and political science to enable better analysis of complex systems and stakeholder mapping.



131. In addition, WHO's influence will be enhanced by more effective internal coordination, across all levels of the Organization, so that WHO can present consistent and cogent positions in support of health in the various arenas described above.

132. For Member States, strategies to strengthen governance capacity that will be supported by WHO include strengthening international departments in health ministries; inter-ministerial coordination on global health policy issues; preparing a cross-ministry global health strategy; regular exchanges with academic, nongovernmental organizations and other entities on global health issues; staff exchanges between ministries and with international organizations; and staff training on health diplomacy and negotiation.

### **Reforming management policies, systems, and practices**

133. Management reform in WHO has many components, several of which will be implemented prior to the beginning of the period of the general programme of work. This section of the document therefore highlights priorities within the overall management agenda that will be particularly critical in shaping WHO's performance over the six years of the programme of work.

### **Organizational alignment: headquarters, regional, subregional and country offices**

134. Performance is affected by the relationship between the different levels of WHO. It has two fundamental elements, both of which are critical. First, it requires synergy and alignment when it comes to the development of policies, strategies and positions on global health issues. It also requires uniformity in the application of the rules relating to human resources and finance, and to administrative and reporting procedures. In this sense, all parts of WHO need to work as a single organization. Differentiation and division of labour, however, are critical when it comes to defining tasks, activities, and specific outputs. Without such differentiation it becomes impossible to define managerial responsibilities clearly or to put in place a meaningful accountability framework.

135. Different aspects of reform deal with these two aspects of alignment. Effective health leadership and governance require that all parts of WHO work to the same script, whether that is in terms of United Nations reform, framing new development goals, developing strategies for increasing access to medicines, or other areas. In contrast, the new planning, budgeting and resource allocation systems are the means for reinforcing and clearly specifying differentiation and division of labour at each level of WHO (as described in Chapter 2).

### **Enhancing performance in countries**

136. WHO's leadership at country level is a particularly important element of the reform agenda. This covers the policy, management, staff development and administrative services that increase the effectiveness of WHO Offices in countries, areas and territories, and, more broadly, that shape WHO's cooperation with countries where the Organization has no physical presence. In practice this means regularly updating the processes and tools needed for developing country cooperation strategies and in particular introducing a much sharper focus to the areas of collaboration so that they play a greater role in future priority setting. In all countries the country cooperation strategy needs to be closely aligned with national health policies, strategies and plans; and, where appropriate, its key components should be reflected in the United Nations Development Assistance Framework.<sup>1</sup>

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<sup>1</sup> Country cooperation strategies will also be developed in some countries where WHO has no country office.

137. Beyond the country cooperation strategy process, there is a need to facilitate the flow of information to, from and between country offices, providing technical guidance as required and keeping all country offices up to date with Organization-wide developments. Using greater connectivity as a means to increase the autonomy of country offices as they seek to access knowledge and resources from all parts of WHO and elsewhere is key to WHO's future vision of an effective country presence.

138. Country leadership requires a match between country needs, WHO priorities (as set out in the country cooperation strategy) and the staffing, skill mix and classification of the country office. Lastly, strengthening WHO in-country leadership capacity requires staff development services that are tailored to the needs of WHO Offices (particularly in health diplomacy as noted above); strengthened selection processes for the Heads of those Offices; and a roster of eligible candidates for them.

### **Strategic communications and knowledge management**

139. Access to up-to-date evidence, expert opinion and in-depth country knowledge will continue to be essential for building and maintaining the professional competence of WHO staff at all levels of the Organization. The means of ensuring such access and for the dissemination and management of professionally-relevant information are changing rapidly. A modern knowledge management strategy will focus on the cost-effective use of technology to enable staff to create, capture, store, retrieve, use and share knowledge relevant to their professional roles. As noted above, it is essential for an effective country presence.

140. Knowledge management also covers the policies and systems required to coordinate WHO's relationships with collaborating centres, expert advisory panels and committees; communication with and reporting by Member States; as well ensuring the quality and accessibility of WHO's published output.

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

### **Accountability, risk management and transparency**

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

## CHAPTER 5

### ORGANIZING WORK, MEASURING RESULTS AND MONITORING PERFORMANCE

143. This chapter sets out the framework for how WHO's work will be organized over the period of the general programme of work. It explains in some detail the results chain and the theory of change that underpins it. It sets out all the impacts and outcomes to which WHO's work will contribute, and complements the explanation in Chapter 3 about the relationship between the formal results chain and the leadership priorities. Lastly, it describes how a new approach to monitoring and evaluation will assess different aspects of WHO's performance.

#### Organization: categories of work and programme areas

144. At a meeting in February 2012 Member States agreed that WHO's work would be organized around a limited number of categories. Five are programmatic, dividing up the technical work of the Organization, the sixth covers all corporate services. They were articulated as follows:

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

145. Categories are divided into programme areas – both in the five technical categories and in the corporate services category – that provide the organizing framework of the programme budget.

146. The derivation of the technical programme areas reflects an iterative process of priority setting, which has taken place at different levels. As described in Chapter 3, the criteria, collectively, were used to arrive at WHO's leadership priorities. In addition, applying the priority-setting criteria to the five categories of work, with particular emphasis on the needs of individual countries and the current health situation, informed the development of the programmatic framework that is outlined in the proposed programme budget. Thus application of these criteria for priority setting within each category narrowed down what WHO will do out of all the things it could do.

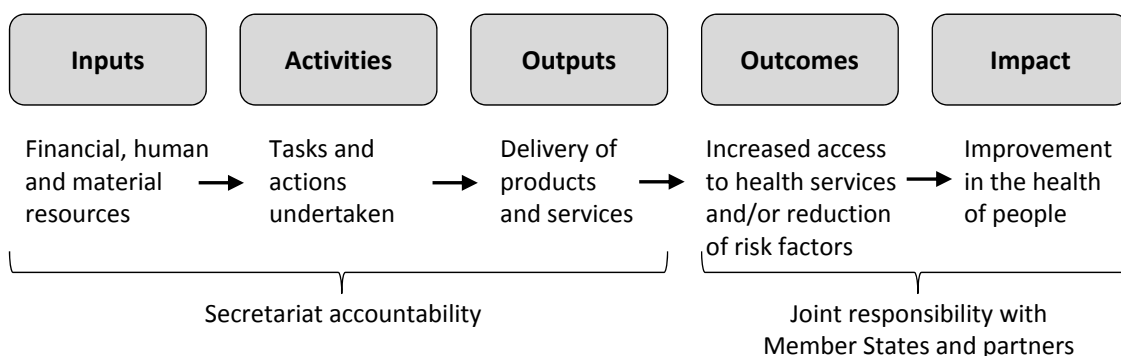
147. Finally, the application of the criteria, with their particular emphasis on the existence of evidence-based interventions, internationally agreed instruments, and WHO's comparative advantage, has shaped the formulation of WHO's focus and direction in each of the programme areas. The outputs described in the proposed programme budget are the expression of that focus and direction. The aim will be to maintain consistency in the way work is organized in order to support comparisons across the three bienniums of the programme of work.

## Results chain and the theory of change: how WHO makes a difference

### Results chain

148. Before detailing the impact and outcomes of WHO's work it is useful to briefly review the results chain as a whole. The basic logic of the results chain is set out in the figure below.

**Figure. The results chain framework**



### Outputs

149. In each of the 30 programme areas within the programme budget there are defined outputs. The outputs illustrate what the Secretariat will be accountable for delivering during the biennium concerned. Delivery success will be measured through an output indicator that links the activities of the Secretariat to the outcomes to be achieved. As noted in the core functions and division of labour section in Chapter 2, the programme budget will, in addition, define the contribution made by each level of the Organization in respect of each output. Each programme budget will also provide details of the resources needed to deliver the outputs in each programme area.

### Outcomes

150. At the next level in the chain, outputs contribute to the achievement of outcomes, which are the changes in countries to which the work of the Secretariat is expected to contribute. Progress

towards each outcome is measured in terms of changes in policies, institutional capacities, reduction of risk factors, and levels of service coverage or access.

151. Each programme area within the programme budget is associated with a specific outcome. The achievement of this outcome is dependent on some factors beyond the control of WHO (e.g. political and economic stability, financing of domestic budgets). However, there are important links across the results chain that are within WHO's influence. For example, outcomes resulting from work on social determinants, gender, equity and human rights (e.g. reducing stigma and increasing equitable access to care) combined with outcomes from the health systems category (e.g. human and financial resource policies, access to medicines etc.) help to ensure that the two HIV-specific outputs lead to the HIV outcome and the impact with which it is associated.

152. Outputs within each programme area contribute to the achievement of a single outcome in the programme area concerned. Some outputs have an influence on other programme areas as well, whether in the same category of work, or across categories. For example, WHO's outputs in relation to vaccine-preventable diseases contribute to increased vaccination coverage for hard-to-reach populations. Additionally, with a growing interest in the use of vaccines in the prevention of what have hitherto been considered as noncommunicable diseases, outputs within this programme area will also make a contribution to the outcome and impact of work on noncommunicable diseases.

## Impacts

153. At the highest level of the results chain, the outcomes contribute to the overall impact of the Organization, namely the sustainable changes in the health of populations to which the Secretariat and countries contribute. The eight impact goals to which these outcomes, and thus WHO's outputs, contribute are set out in the Annex. The relationship between outcomes and impacts is not strictly one-to-one: an outcome may contribute to more than one impact and, similarly, an impact can be the result of more than one outcome. For example, the achievement of a reduction in child mortality depends on outcomes in at least five programme areas (HIV, malaria, vaccine preventable diseases, nutrition, and reproductive, maternal, newborn and child health) underpinned by outcomes, as above, in relation to social determinants and health systems.

154. The complete universe of outcomes (indicators, baselines and targets) and the impacts to which WHO's outputs contribute within the results chain are set out in the Annex.<sup>1</sup>

## WHO's results – creating change

155. When examining how WHO's work creates change, it is useful to go beyond the visual representation of the results chain by setting out a narrative explanation of the way in which outputs combine to produce outcomes, and how outcomes combine in different ways to produce impacts. Such a narrative of what might be termed "WHO's comprehensive theory of change" provides, in addition, a space for explaining the assumptions and risks that will influence results.

156. This analysis, which can be termed WHO's comprehensive theory of change, is illustrated above in relation to selected outcomes and to the child mortality impact goal. For the most part a

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<sup>1</sup> Outcomes may need to be revised to accommodate future deliberations of WHO's governing bodies, including, for example, discussions related to the post-2015 development agenda.

fairly linear relationship can be drawn between the more normative work carried out at headquarters, the support to countries provided by regional and country offices and the results achieved on the ground. However, while this perspective tells part of the story, it misses some critical elements, which are of great importance in explaining how a normative, multilateral membership organization, like WHO, makes a difference. The following paragraphs seek to further enrich the theory of change particularly in relation to WHO's normative role.

157. The impact of the AIDS treatment guidelines can be seen either in a simple linear fashion, or in its more complex context of influence. In the results chain above, the new guidelines, in combination with the country support provided, increase access to treatment. But if the country situation is the only lens through which the story of impact is viewed, there is a risk that other equally important outcomes are overlooked. For example, the new treatment guidelines influence the funding policies of the Global Fund to fight AIDS, Tuberculosis and Malaria as well as other development partners. Influencing treatment policy in turn influences procurement, production and therefore also affects the price of treatment. The theory of change needs to accommodate the fact that these "network effects" amplify the main route by which guidelines influence health.

158. A further example comes from work on the prequalification of medicines, vaccines and diagnostics: a normative function which aims to bring more manufacturers into the market, particularly from developing countries and, thereby to lower prices. Prequalification has a major impact on the generic medicine industry, particularly in India. Lower prices have resulted, which help to stretch aid budgets, increasing access to treatment, notably in Africa. A more complete theory of change would go further and incorporate other effects, including the impact on nascent drug manufacturers in Africa and the growth in the capacity of national regulatory authorities.

159. Normative work can influence markets, positively and negatively. WHO's advice in response to the widespread sale of ineffective ELISA-based tuberculosis diagnostic kits resulted in the kits being banned from manufacture, sale and use in India, the world's largest market for these products. Other countries such as Cambodia have followed suit. On the opposite side of the coin, WHO's endorsement of the XPERT MTB/RIF rapid diagnostic kit for detection of pulmonary tuberculosis and rifampicin resistance in adults has resulted in uptake in 73 countries within the first two years following the issue of policy guidance.

160. A significant proportion of WHO's normative work derives from negotiated agreements and other legal instruments agreed between all Member States. The capacity to convene and help to broker such agreements is part of the *raison d'être* of WHO and needs to be part of the story of how WHO achieves results. For instance, a purely technical agency would merely advise countries on the measures that they could take to curb tobacco use. Instead WHO took the route of helping Member States negotiate a treaty, the WHO Framework Convention on Tobacco Control. Not all countries have ratified the treaty, and not all that have ratified it have fully acted on its provisions. Its very existence, however, enables those that wish to act, to do so with legitimacy and the backing of an internationally agreed instrument.<sup>1</sup>

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<sup>1</sup> Moreover, the fact that States have accepted international obligations on tobacco control for the protection of public health shapes the interpretation and implementation of their obligations under other areas of international law, notably on trade and intellectual property, and may thus have a significant influence on litigation arising therefrom. In this regard, WHO's normative functions have a demonstrable effect that transcend the boundaries of public health.

161. Turning to pandemic influenza, the traditional approach to evaluating impact would be to trace the link between technical guidance from WHO and the preparation of country preparedness plans. This is useful, but tells only part of the story. As WHO is not only a technical agency, it has been able to bring together Member States and a range of other partners to forge the Pandemic Influenza Preparedness (PIP) Framework. Agreed after four years of intense negotiation, the PIP Framework illustrates another aspect of the change narrative. In the long term, the Framework's success will be proven in the event of a new pandemic and the degree to which there is sharing of virus samples and more equitable access to vaccines and medicines. Meantime, the Framework has inherent value in its own right. It helps preparedness in case of a future outbreak of pandemic influenza by ensuring that countries and manufacturers contribute to national efforts as well as committing themselves to deploy stockpiles of vaccines and antiviral medicines.

162. Many of the points made above apply equally to the International Health Regulations (2005). One dimension of the impact of the Regulations is their effect on stimulating the required capacities in individual countries. The further dimension is that the Regulations provide an internationally agreed rule-based system that guides action in the event of an outbreak or emergency, which has inherent value in and of itself. As was the case with the Framework Convention on Tobacco Control, the International Health Regulations constitute a broad set of global rules on health protection underpinned by rigorous risk assessment and scientific evidence. Such a regime ensures a higher degree of consistency and complementarity with other rules of international law, notably in the field of trade, international security and human rights.

163. In late 2012 and early 2013, the importance of another aspect of normative work has come into focus: the development of a monitoring framework, defining indicators and setting voluntary global targets for the control and prevention of noncommunicable diseases. This was not a purely technical exercise as many other political and commercial interests were involved. A simple test of the framework's success would be to select countries and assess in a reasonable time frame whether they adopt or measure the agreed indicators. However, a theory of change would suggest a further dimension: that the added-value of WHO in this process is strongly evidenced by the fact that the world now can collectively monitor progress against a social, economic and political threat that faces all countries in a way that would not otherwise have been possible.

## **Measuring performance: a framework for monitoring and evaluation**

### **Monitoring performance using the results chain**

164. The results chain is the main instrument through which WHO's performance will be assessed. The questions that underpin the assessment are: within each biennium did the Secretariat use the resources allocated to deliver the outputs defined in the programme budget; and, as a result, has there been measurable progress in relation to the agreed outcomes and impacts to which WHO's work contributes?

165. Demonstrating how WHO's work contributes to or influences health outcomes and impacts is crucial, both to assess the effectiveness of the work of WHO, and in order to communicate the value of WHO's contribution in achieving better health overall. WHO will report on the outcomes, and will also assess and explain the link between its contribution and the achievement of those health outcomes. WHO will use existing methods and mechanisms, especially national systems, existing programmes and systems reviews, and harmonize its efforts with other partners, in order to assess its achievement of the outcomes and impacts.

166. Achievements at impact and outcome level clearly depend on collaboration with countries and other partners. In this regard, the general programme of work takes a clear stance. Although they are not attributable to WHO alone, they are results with which WHO's work is closely associated; achieved by WHO using its resources to leverage those provided by others; and by which the performance of the Organization as a whole should be judged.

167. Indicators, baselines and targets have been defined for each of WHO's outcomes, covering, where feasible, the full six-year period of the general programme of work. Where they exist, indicators (baselines and targets) that have been adopted by international agreement have been chosen. For example, in the programme area of noncommunicable diseases, the indicators and targets (for decrease in tobacco use, salt intake, increase in physical exercise, and reduction in alcohol consumption) are taken directly from the internationally-agreed global monitoring framework and the set of voluntary targets.

168. WHO's work combines to contribute to eight health impact goals. These are set out in the Annex. Indicators for these impact goals have been selected from those that have been internationally agreed. The exceptions in this case are the indicators chosen for the impacts concerned with the prevention of death and disability arising from disasters and outbreaks, and reduction in health inequities. Indicators for these two goals have been developed by WHO.

169. One drawback of using internationally agreed goals is that the time frame for their achievement does not coincide exactly with the time frame of the general programme of work and this will require the monitoring framework to accommodate some fine-tuning. For example, monitoring of progress towards achievement of the Millennium Development Goals will continue beyond 2015, recognizing that many countries will not have reached the targets related to the Goals by that point. WHO will review the need to adapt the monitoring framework in the light of what is agreed for the next generation of development goals. Conversely, the agreed time frame for the noncommunicable disease goal extends to 2025. In this instance, the monitoring framework will show progressively where countries are on- or off-track toward the ultimate goal.

### **Assessing progress against leadership and reform priorities**

170. The six programmatic leadership priorities in Chapter 3 give focus and direction to WHO's work. They are linked, as detailed in Chapter 4, to the Organization's role on health governance and highlight areas in which WHO's advocacy and technical leadership in the global health arena are most needed.

171. Individual components of the programmatic leadership priorities can, in theory, be mapped against the results chain. In this sense, the Millennium Development Goal leadership priority is measured through the impact goals on under-five and maternal mortality, and reductions in the number of people dying from AIDS, tuberculosis and malaria. However, assessment also needs to take into account the overall purpose of these priorities, both in programmatic terms, and as key areas for demonstrating WHO's leadership and integrating work across the Organization.



172. A similar approach is required in relation to the two priorities discussed in Chapter 4:– governance and management reform. The reform implementation plan defines high level results for each:

- *Strengthening WHO's governance role*: Greater coherence in global health, with WHO playing a coordinating and directing role that enables a range of different actors to more effectively contribute to the health of all peoples.
- *Reforming management policies, systems and practices*: An organization that pursues excellence; one that is effective, efficient, responsive, objective, transparent and accountable.

173. More detailed outputs for both governance and management reform are defined as part the reform implementation plan (and, in addition, appear as outcome indicators in category 6 of the programme budget). The high-level outcomes of governance and management reform will additionally be assessed by periodic stakeholder perception surveys.

#### **Accountability framework: monitoring and evaluation**

174. Monitoring will be based on a systematic assessment of progress towards the achievement of results with a focus on the delivery of outputs and the use of financial resources. An annual mid-term review will take place after the first year of the biennium and a more comprehensive programme budget performance assessment will take place following the close of the biennium. The comprehensive review will assess progress towards the outcome targets specified in the general programme of work, examining the extent to which WHO's work has contributed to their achievement as well as the extent to which WHO has helped to leverage the contribution of other partners.

175. To date both monitoring exercises have relied primarily on self-reporting. In future the intention is to introduce a greater degree of objectivity, with the use where appropriate of independent expertise. Monitoring progress will use national reporting on progress towards internationally agreed outcomes and impacts. It will also draw on the more qualitative methods referred to above in relation to leadership and reform priorities.

176. Priorities for more in-depth evaluation will be agreed by the Evaluation Management Group with Member States in the context of the new evaluation policy and may focus on programme areas, cross cutting themes or leadership priorities. In line with the evaluation policy, each evaluation exercise will be designed to ensure objectivity, using independent expertise as required.

177. It is fundamental to the utility of the accountability framework that the results of monitoring and evaluation are used to take corrective action to address under-performance; or to inform a strategic scale up of activities to achieve the results, as well as to provide instructive experience that guides the next planning cycle.

## CHAPTER 6

### FINANCIAL RESOURCES

178. Having set out what WHO will achieve over the period of the general programme of work, the final section outlines what resources will be needed in order to deliver these results.

#### **A new financing model**

179. A new approach to financing the work of WHO will align the priorities agreed by WHO's governing bodies with the monies available to finance them; and ensure greater predictability and stability of financing, thereby promoting more realistic results-based planning, effective resource management, and increased transparency and accountability.

180. Several constraints need to be overcome if these two objectives are to be realized. Firstly, there is a misalignment between the programme budget and the funds available to finance it, which results in part from a reliance on highly specified voluntary contributions. Second, this type of funding can be unpredictable. Third, there is a vulnerability that arises from dependence on a very narrow donor base. Fourth, there are heavy transaction costs and a certain lack of transparency associated with current approaches to resource mobilization and management. Lastly, the availability of the unspecified funding needed to bridge funding gaps and to respond to changing circumstances is limited. A new financing model will require changes in policy and practice on the part of the Secretariat and Member States. It is based on a new approach to estimating, mobilizing and allocating resources. With each successive biennium, outputs will be costed with increasing precision, using a series of benchmarks to arrive at appropriate unit costs. In this regard, the first biennium 2014–2015 will be a transitional period. Clear differentiation of responsibilities in the budget will then allow resource allocation between levels of WHO to be based more on functions and responsibilities for producing outputs, and less on fixed allocative formulae. As the transition progresses, so resource mobilization will be based on a fully-costed budget.

181. With regard to sources of finance, WHO's budgets will continue to be funded from a mixture of sources: from assessed and voluntary contributions, with the latter coming from State- and non-State donors. A new financing model will facilitate a greater alignment of resources to the programme budget and a greater degree of predictability and flexibility of resources. A broader and more diverse base of State donors and the possibility of tapping into selected new sources of non-State finance sources reduces vulnerability.

182. The approach also introduces a new and more transparent process in the form of a financing dialogue that will aim at securing a fully-financed and more predictable budget. Underpinning this approach is the principle that agreement on priorities and programmes is the exclusive prerogative of Member States. This starts with the regional committees and concludes with the World Health Assembly that precedes budget implementation. At that Health Assembly, Member States approve the programme budget in its entirety. This is an important shift from current practice where only the proportion of the budget financed from assessed contributions is approved. The change implies a greater degree of responsibility not only for the budget's programmatic content, but also for alignment of resources to the programme budget. Thereafter, following the approval of programmes and priorities, a structured and transparent process with Member States and other donors begins. Information on progress made in financing all parts of the budget is made available in as transparent a way as possible, using web technology, indicating who has funded what, and the degrees of specification and/or flexibility. This dialogue ends prior to the beginning of the financial year. Any remaining financing shortfalls then become targets for focused, coordinated Organization-wide resource mobilization.

183. Progress in financing the budget is reviewed by WHO's governing bodies during the budget period.

## Trends in financing 2014–2019

184. The general programme of work envisages a broadly constant financial envelope over the period of the general programme of work as a whole in the order of US\$ 12 billion dollars. This envelope will be distributed more or less equally among each of the three bienniums; meaning that roughly US\$ 4 billion will be available for each biennium.

185. At the same time, the evolving health agenda and the strategic priorities for the next years will require changes in the distribution of resources within WHO. In this regard, increases in some parts of the budget will have to be matched by decreases elsewhere. Given the high proportion of specialist staff, shifts towards newly defined priorities will necessarily be gradual and incremental. Lastly, human resource planning will need to take the same long-term perspective as the general programme of work itself, in order to ensure that the right balance is achieved between resources for staff and activities over the six-year period.

## Resource shifts within a stable budget

186. In relation to Category 1, communicable diseases, WHO will continue the development of global norms and standards, simplified treatment guidelines, prevention technologies, diagnostic tests, vaccine delivery platforms and preventive chemotherapy. WHO will also facilitate the formulation and evaluation of policies, strategies and plans by: working with Member States, partners and communities, including civil society, to develop and implement global policies, regional and national strategies, costed plans, and monitoring and evaluation frameworks. This will be supported by integrating information systems for better evidence-based decision-making and by monitoring the global, regional and country situations by collecting information, analysing it, projecting trajectories of disease burden, reporting, and certification where appropriate. **In view of the targeted and strategic approach WHO will take in respect of Category 1 over the course of this general programme of work, as well as progress expected to be made in the coming years, it is envisaged that a reduction in resources for this category will still enable WHO to achieve its objectives through 2019.**

187. The growing burden of noncommunicable diseases threatens to overwhelm health systems. It is inextricably linked to poverty, and the stunting of economic development at macroeconomic and household levels that leads to inequalities between countries and populations. WHO will provide the technical support needed to promote widespread implementation of evidence-based packages of cost-effective “best buy” policy interventions. These will have the potential to treat people with noncommunicable conditions, protect those at high risk of developing them, and reduce risk across populations. This is aimed at strengthening governments’ capacity to: develop national targets; establish and implement multisectoral national programmes and plans across the health and non-health sectors that involve all government departments and civil society; provide guidelines and norms for the management of noncommunicable diseases; provide services for early detection and treatment in strengthened health systems with renewed efforts to ensure access to the essential medicines required; and measure results, taking into account tools endorsed by the World Health Assembly. **It is envisaged that an increase in emphasis and resources will be required in Category 2 over the course of the twelfth general programme of work in order to position WHO to adequately support countries in confronting this emerging epidemic.**

188. In relation to Category 3, WHO will provide integrated policies and packages of interventions, fostering synergies between sexual and reproductive, maternal, newborn, child, and adolescent health interventions and other public health programmes. WHO will develop evidence-based norms, standards, and tools for scaling up equitable access to quality care services within a rights- and gender-based framework. WHO will also support the generation and synthesis of evidence, including specific studies on how to deliver interventions to achieve the highest population coverage, as well as new

technologies to enhance the effectiveness and reach of intervention delivery; strengthening research capacity in low-income countries; as well as epidemiology, monitoring and accountability, including implementation of the recommendations of the Commission on Information and Accountability, improving maternal death reviews, surveillance and response, and monitoring quality of care. WHO will also provide leadership on healthy and active ageing by increasing awareness of the importance of demographic change, the accumulation of exposures and vulnerabilities across the life-course, and by increasing knowledge of evidence-informed responses. **In order to provide this strategic support to countries in relation to the programmatic areas within Category 3, it is envisioned that a modest increase in resources will be required over the course of the twelfth general programme of work.**

189. In relation to category 4, WHO will provide Member States and the global health community with evidence-informed norms, standards and policy options and, where needed, technical and policy support. It will also facilitate the sharing of experiences across countries and the results of research to allow countries to learn from others on the path to universal health coverage. This will be done in ways that buttress reforms that move towards universal access to people-centred services and equitable financial risk protection; and enhance efforts to improve health systems performance and the capacity to regulate and steer the health sector. Efforts will be intensified to improve access to medicines and medical products and technologies, and will increasingly focus on creating the conditions for greater self-reliance. Development and support for regulatory authorities is also a major priority for WHO's future work in this category. **In this regard, it is envisaged that an increase in resources over the course of the twelfth general programme of work for this category will be required, in order to support countries in strengthening their access to services and the affordability of those services, based on the principles of primary health care.**

190. In relation to category 5, WHO will support Member States in their efforts to meet and sustain capacities in the areas of the International Health Regulations (2005) and intersectoral health coordination. WHO will continue to generate evidence on the dynamics of health risks and the impact of response activities, and to keep abreast of emerging developments that impact health, such as the effect of climate change and new technologies. WHO will support the improvement of national policies for the identification and reduction of risks to human health, as well as prevention, preparedness, response and early recovery capacities. WHO will also provide direct support to any country requesting support, giving priority to those most vulnerable to emergencies and that have low or limited capacity to manage the risks and respond. WHO will support Member States through their ministries of health to develop effective and integrated national health emergency risk management programmes through technical consultations, workshops, expert assessments and guidance. **It is envisaged that WHO's strategic support to countries in this category over the course of this general programme of work can be achieved while maintaining a stable level of resources in this category through 2019.**

191. Category 6, which includes the leadership and corporate services required to maintain the integrity and efficient functioning of WHO, enables the other five categories to deliver, and addresses challenges identified in the governance and management components of WHO reform. This category includes the leadership functions that enable WHO to play a more effective role in global health governance, forging partnerships and mobilizing both the scientific and financial resources to improve the health of populations. It includes overseeing the process of reform and ensuring synergy and coherence across the Organization. It encompasses a variety of essential services that contribute to organizational integrity, an enabling work environment, and managing the work at country, regional office and headquarters. **The initial investment in WHO reform is envisaged to lead to cost-efficiencies and savings thus necessitating a reduced resource requirement in this category over the course of the twelfth general programme of work.**

## ANNEX

Impact goal	Impact indicator	Impact target
Reduce under-five child mortality	Under-five child mortality rate	Reduction by 2/3 by 2015 compared with the 1990 baseline
Reduce maternal mortality	Maternal mortality ratio	Reduction by 75% by 2015 compared with the 1990 baseline
Reduce the number of people dying from AIDS, tuberculosis and malaria	Number of people dying from AIDS, tuberculosis and malaria	Reduction of 25% in the number of people dying from AIDS by 2015 compared with the 2009 baseline (i.e. 1.425 million)
		Reduction of 50% in the number of people dying from tuberculosis by 2015 compared with the 1990 baseline
		Reduction of 75% in the number of people dying from malaria by 2015 compared with the 2000 baseline
Reduce premature mortality from noncommunicable diseases	Premature mortality from noncommunicable diseases	Reduction in the probability of dying from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases for people aged 30–70 years by 25% by 2025
Eradicate polio	Eradication of polio	Eradication of polio completed by the end of 2014
Eradicate dracunculiasis	Eradication of dracunculiasis	Eradication of dracunculiasis completed by 2015
Prevention of death, illness and disability arising from emergencies	Percentage of major acute emergencies in which the crude mortality rate (CMR) return to accepted baseline levels within 3 months	70% of emergencies
Reduction in rural-urban difference in under-five mortality	Reduction in rural-urban difference in under-five mortality	Reduction in the absolute gap in under-five mortality between rural and urban areas by 25% in 2015-2020

## NOT MERELY THE ABSENCE OF DISEASE

Category	Programme area	Outcome	Outcome indicator	Baseline	Target
1	HIV/AIDS	Increased access to key interventions for people living with HIV	Number of new paediatric HIV infections (ages 0-5)	330 000 (2011)	< 43 000 (2015)
			Number of people living with HIV on antiretroviral treatment	8 million (2011)	15 million (2015)
			Percentage of HIV+ pregnant women provided with antiretroviral treatment (ARV prophylaxis or ART) to reduce mother-to-child transmission during pregnancy and delivery	57% (2011)	90% (2015)
			Cumulative number of voluntary medical male circumcisions performed in 14 priority countries	1.4 million (2011)	20.8 million (2016)
	Tuberculosis	Increased number of successfully treated tuberculosis patients	Cumulative number of tuberculosis patients successfully treated in programmes that have adopted the WHO-recommended strategy since 1995	51 million (2011)	70 million (2015)
			Annual number of tuberculosis patients with confirmed or presumptive multidrug-resistant tuberculosis (including rifampicin-resistant cases) placed on multidrug-resistant tuberculosis treatment worldwide	55 597 (2011)	270 000 (by 2015)
	Malaria	Increased access to first-line antimalarial treatment for confirmed malaria cases	Percentage of confirmed malaria cases in the public sector receiving first-line antimalarial treatment according to national policy	50% (2011)	70% (2015)
	Neglected tropical diseases	Increased and sustained access to essential medicines for neglected tropical diseases	Number of Member States certified for eradication of dracunculiasis	183 (2014)	194 (2019)
			Number of Member States having achieved the recommended target coverage of population-at-risk of lymphatic filariasis, schistosomiasis and soil-transmitted helminthiasis through regular anthelmintic preventive chemotherapy	25 (2012)	100 (2020)
	Vaccine-preventable diseases	Increased vaccination coverage for hard- to-reach populations and communities	Global average coverage with three doses of diphtheria, tetanus and pertussis vaccines	83% (2011)	≥ 90% (2015)
			WHO regions that have achieved measles elimination	1 (2011)	4 (2015)
			Proportion of the 75 countdown countries that have introduced pneumococcal, rotavirus or HPV vaccines and concurrently scaled up interventions to control pneumonia, diarrhoea or cervical cancer	0%	50%

## NOT MERELY THE ABSENCE OF DISEASE

Category	Programme area	Outcome	Outcome indicator	Baseline	Target
2	Noncommunicable diseases (4 diseases and 4 risk factors)	Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors	At least a 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context	–	10% reduction by 2025
			A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years	–	A 30% reduction by 2025
			A 10% relative reduction in prevalence of insufficient physical activity	–	10% reduction by 2025
			A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure according to national circumstances	–	25% relative reduction by 2025
			Halt the rise in diabetes and obesity	–	TBD
			At least 50% of eligible people receiving drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes	–	At least 50% coverage (2025)
			A 30% relative reduction in mean population intake of salt sodium as measured by: age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years	–	30% reduction by 2025
			An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities	–	At least 80% coverage (2025)
	Mental health and substance abuse	Increased access to services for mental health and substance use disorders	Proportion of persons with a severe mental disorder (psychosis; bipolar affective disorder; moderate-severe depression) who are using services	TBD (under development)	20% increase by 2020
			Suicide rate per year per 100 000 population	TBD (under development)	10% reduction by 2020
Violence and injuries	Reduced risk factors for violence and injuries with a focus on road safety, child injuries, and violence against children, women and youth	Global indicator (s) on reduction of risk factors on road safety to be developed as part of the Decade of Action for Road Safety (2011-2020)	–	–	
Disabilities and rehabilitation	Increased access to services for people with disabilities	Global indicator (s) on increase access to services for people with disabilities to be developed as part of the global plan of action on disability	–	–	
Nutrition	Reduced nutritional risk factors	Number of stunted children below five years of age	165 million (2011)	102 million (2025)	
		Proportion of women of reproductive age (15–49 years) with anaemia	30% (2015)	15% (2025)	

## NOT MERELY THE ABSENCE OF DISEASE

Category	Programme area	Outcome	Outcome indicator	Baseline	Target
3	Reproductive, maternal, newborn, child and adolescent health	Increased access to interventions for improving health of women, newborns, children and adolescents	Number of women using contraception for family planning in the 69 poorest countries	260 million	320 million (2015)
			Skilled attendant at birth (percentage of live births attended by skilled health personnel);	69% (2011)	75% (2015)
			Postnatal care for mothers and babies (percentage of mothers and babies who received postnatal care visit within two days of childbirth);	46% (2010)	60% (2015)
			Exclusive breastfeeding for six months (percentage of infants aged 0–5 months who are exclusively breastfed);	37% (2011)	40% (2015)
			Antibiotic treatment for pneumonia (percentage of children aged 0–59 months with suspected pneumonia receiving antibiotics).	47%	60% (2015)
			Adolescent birth rates (per 1000 girls aged 15–19 years)	50 per 1000 girls (2009)	45 per 1000 girls (2015)
	Ageing and health	Increased proportion of older people who can maintain an independent life	Global indicator (s) will be developed as part of a global framework on monitoring ageing and health to be developed by December 2014	–	–
	Gender, equity and human rights mainstreaming	Gender, equity and human rights integrated into the Secretariat's and countries' policies and programmes	Evaluation processes are in place to ensure gender, equity and human rights are measured in Secretariat programmes	No	Yes
	Social determinants of health	Increased intersectoral policy coordination to address the social determinants of health	Net primary education enrolment rate (MDG target 2A)	90% (2008)	100% (2015)
			Number of slum dwellers with significant improvements in their living conditions (MDG target 7D)	Not applicable	100 million (2020)
	Health and the environment	Reduced environmental threats to health	Proportion of the population without access to improved drinking-water sources	11% (2010)	9% (2015)
			Proportion of the population without access to improved sanitation	37% (2010)	25% (2015)
			Proportion of the population relying primarily on solid fuels for cooking	41% (2010)	38% (2015)



## NOT MERELY THE ABSENCE OF DISEASE

Category	Programme area	Outcome	Outcome indicator	Baseline	Target
4	National health policies, strategies and plans	All countries have comprehensive national health policies, strategies and plans updated within the last 5 years	Number of countries that have a comprehensive national health sector strategy with goals and targets updated within the last 5 years	115 (2013)	135 (2015)
	Integrated people-centred health services	Policies, financing and human resources are in place to increase access to people-centered integrated health services	Number of countries that are implementing integrated service strategies	50 (2014)	65 (2015)
			Proportion of countries facing critical health workforce shortages	30% (2006)	20% (2014)
	Access to medicines and health technologies and strengthening regulatory capacity	Improved access to and rational use of safe, efficacious and quality medicines and health technologies	Availability of tracer medicines in the public and private sectors	48% (2011)	80% (2015)
Health systems, information and evidence	All countries have properly functioning civil registration and vital statistics systems	Number of countries that report cause of death information using the International Classification of Diseases, 10th revision	108 (2013)	112 (2015)	
5	Alert and response capacities	All countries have the minimum core capacities required by the International Health Regulations (2005) for all-hazard alert and response	Number of countries meeting and sustaining International Health Regulations (2005) core capacities	80 (2013)	195 (2016)
	Epidemic- and pandemic-prone diseases	Increased capacity of countries to build resilience and adequate preparedness to mount a rapid, predictable and effective response to major epidemics and pandemics	Percentage of countries with a national strategy in place that covers resilience and preparedness for major epidemics and pandemics	40% (2011)	50% (2015)
	Emergency risk and crisis management	Countries have the capacity to manage public health risks associated with emergencies	Percentage of countries with minimum capacities to manage public health risks associated with emergencies	Not applicable	80% (2019)
	Food safety	All countries are adequately prepared to prevent and mitigate risks to food safety	Number of countries that have adequate mechanisms in place for preventing or mitigating the risks to food safety	116/194 (2013)	136/194 (2015)
	Polio eradication	No cases of paralysis due to wild or type-2 vaccine-related poliovirus globally	Number of countries reporting cases of paralysis due to any wild poliovirus or type-2 vaccine-related poliovirus in the preceding 12 months	8 (2012)	0 (2019)
	Outbreak and crisis response	All countries adequately respond to threats and emergencies with public health consequences	Percentage of countries that demonstrated adequate response to an emergency from any hazard with a coordinated initial assessment and a health sector response plan within five days of onset	Not applicable	100%

## NOT MERELY THE ABSENCE OF DISEASE

Category	Programme area	Outcome	Outcome indicator	Baseline	Target
6	Leadership and governance	Greater coherence in global health, with WHO taking the lead in enabling the many different actors to play an active and effective role in contributing to the health of all people	Level of satisfaction of stakeholders with WHO's leading role in global health issues	High (based on composite rating from the Stakeholder Survey (November 2012))	At least high (Stakeholder survey 2015)
	Transparency, accountability and risk management	WHO operates in an accountable and transparent manner and has well-functioning risk-management and evaluation frameworks	Proportion of corporate risks with response plans approved and implemented	Not applicable	100% (2015)
	Strategic planning, resource coordination and reporting	Financing and resource allocation aligned with priorities and health needs of the Member States in a results-based management framework	Alignment of income and expenditure with approved programme budget by category and major office	Not fully aligned	100% aligned
	Management and administration	Effective and efficient management administration established across the Organization	The level of performance of WHO management and administration	Adequate	Strong (2015)
	Strategic communications	Improved public and stakeholders understanding of the work of WHO	Percentage of Member States and other stakeholder representatives evaluating WHO's performance as excellent or good	77% (2013)	85% (2015)

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**World Health  
Organization**

**Annex B**

**SIXTY-SIXTH WORLD HEALTH ASSEMBLY  
Provisional agenda item 12.3**

**A66/7  
19 April 2013**

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**PROPOSED PROGRAMME BUDGET 2014–2015**



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## FOREWORD BY THE DIRECTOR-GENERAL

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The proposed programme budget for 2014–2015 is a transitional budget that responds to the ongoing programmatic and managerial reforms at WHO. Its content and structure provide greater transparency and accountability in the Organization's work, and a strengthened framework for results-based management.

The views of Member States have strongly shaped the proposed budget. They have led the review and refinement of the priority-setting mechanisms, and supported a more precise analysis and presentation of the work of WHO at all three levels and for all expected results.

The budget reflects the vision set out in the draft twelfth general programme of work,<sup>1</sup> including the need for stronger WHO engagement within countries, and has been constructed with the flexibility to shift the Organization's resources to meet evolving health needs at national as well as at global levels.

The currently proposed budget is US\$ 3977 million, which aligns with requests for a realistic budget based on income and expenditure over the past three bienniums.

In the proposed budget, assessed contributions remain at their 2012–2013 level, representing zero nominal growth, and accounting for 23% of the programme budget. The remaining 77% will need to be financed through voluntary contributions.

For the first time, the budget provides a view of all the resources, from all sources, that are needed to support the Organization's programme of work for 2014–2015, thus giving Member States an opportunity to approve and subsequently monitor the budget in its entirety.

Supporting documents provide a more detailed overview of the Organization's total assets, including human and financial resources, and illustrate the way in which these are deployed across programme areas and at global, regional, and country level.

The reform of WHO and its financing is a step-wise process. The current proposed budget, as a transitional step, reflects our efforts so far to improve WHO's transparency and accountability as well as its programming and financing, but further improvements are needed, and will be made.

We need to give more detail on the cost of outputs. We need to strengthen bottom-up planning, as countries have asked. We also need to develop a more robust monitoring and evaluation framework. The proposed programme budget for 2016–2017 will incorporate many of these further improvements.

Although there is still ample room for improvement, I believe that this text represents a significantly more coherent presentation of proposals, and is underpinned by solid ongoing work in the areas of monitoring and evaluation that will continue to shape the way we see and run our Organization.



Dr Margaret Chan  
Director-General

Geneva, 19 April 2013

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<sup>1</sup> See document A66/6.

## INTRODUCTION

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1. WHO's proposed programme budget for 2014–2015 is the first of three biennial budgets to be formulated within the draft twelfth general programme of work for the period 2014–2019. It presents the Organization's expected deliverables and budget requirements for the 2014–2015 biennium within the broader context of the programme of reform.
2. A key product of the Member State-led programmatic reforms, the proposed programme budget aims to facilitate WHO's governing bodies' approval and oversight of the full scope of the Organization's resources.
3. It reflects robust Member State engagement, particularly in relation to the establishment of Organizational priorities. The proposed programme budget also responds to Member State requests for a clearly defined results chain, and delineation of the contribution by each level of the Organization to WHO's outputs. Finally, this proposed programme budget addresses Member States' wishes for a realistic budget based on previous income and expenditure patterns, thus accurately presenting expected costs for agreed Organizational deliverables.
4. The introduction of these changes now positions WHO's proposed programme budget to fulfill multiple roles. In addition to acting as a primary tool for programming WHO's work, it is anticipated that this programme budget will provide the basis through which to measure WHO's performance through its output delivery as well as through its contribution to health outcomes. This programme budget will play a fundamental role in advancing new approaches to WHO's financing and resource mobilization, as well as facilitating a better matching of available resources with WHO's implementation capacity and agreed programmatic deliverables.

### WHO'S PRIORITIES

5. In February 2012, a meeting of Member States mandated by the Executive Board established the following criteria and categories of work to be used in setting priorities in WHO and organizing WHO's work:<sup>1</sup>

#### Criteria for priority-setting

- The current health situation including: demographic and epidemiological trends and changes, urgent, emerging and neglected health issues; taking into account the burden of disease at the global, regional and/or country levels.
- Needs of individual countries for WHO support as articulated, where available, through the country cooperation strategy, as well as national health and development plans.
- Internationally agreed instruments that involve or impact health such as declarations and agreements, as well as resolutions, decisions and other documents adopted by WHO's governing bodies at the global and regional levels.
- The existence of evidence-based, cost-effective interventions and the potential for using knowledge, science and technology for improving health.

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<sup>1</sup> Decision EBSS2(1).

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

### Categories for programmes and priority setting

**Communicable diseases:** reducing the burden of communicable diseases, including HIV/AIDS, tuberculosis, malaria and neglected tropical diseases.

**Noncommunicable diseases:** reducing the burden of noncommunicable diseases, including heart disease, cancer, lung disease, diabetes, and mental disorders as well as disability, and injuries, through health promotion and risk reduction, prevention, treatment and monitoring of noncommunicable diseases and their risk factors.

**Promoting health through the life-course:** reducing morbidity and mortality and improving health during pregnancy, childbirth, the neonatal period, childhood and adolescence; improving sexual and reproductive health; and promoting active and healthy ageing, taking into account the need to address determinants of health and internationally agreed development goals, in particular the health-related Millennium Development Goals.

**Health systems:** supporting the strengthening of health systems with a focus on the organization of integrated service delivery; financing to achieve universal health coverage; strengthening human resources for health; health information systems; facilitating transfer of technologies; promoting access to affordable, quality, safe, and efficacious health technologies; and promoting health systems research.

**Preparedness, surveillance and response:** supporting the preparedness, surveillance and effective response to disease outbreaks, acute public health emergencies and the effective management of health-related aspects of humanitarian disasters to contribute to health security.

**Corporate services/enabling functions:** organizational leadership and corporate services that are required to maintain the integrity and efficient functioning of WHO.

6. These priority-setting criteria and categories of work have had important implications for the development of WHO's six-year vision as it has been articulated in the draft twelfth general programme of work, as well as for the two-year workplan outlined in this programme budget. The categories of work are the structure around which the work of WHO will be organized for this and successive programme budgets housed under WHO's twelfth general programme of work (there are five programmatic categories of work plus an additional category for corporate services and enabling functions). The priority-setting criteria have been employed iteratively and in different combinations with different purposes to establish the spectrum of Organizational priorities.



7. First, the priority-setting criteria, collectively, have been used as the starting point for arriving at the six programmatic leadership priorities that are detailed in the draft twelfth general programme of work. These leadership priorities are the intended emphases for the six-year period of the programme of work, highlighting where WHO aims to enhance visibility and to shape the global conversation, extending its role in global health governance.

### Leadership priorities

**Advancing universal health coverage:** enabling countries to sustain or expand access to essential health services and financial protection and promoting universal health coverage as a unifying concept in global health.

**Health-related Millennium Development Goals:** addressing unfinished and future challenges: accelerating the achievement of the current health-related Goals up to and beyond 2015. This priority includes completing the eradication of polio and selected neglected tropical diseases.

**Addressing the challenge of noncommunicable diseases** and mental health, violence and injuries and disabilities.

Implementing the provisions of the **International Health Regulations:** ensuring that all countries can meet the capacity requirements specified in the International Health Regulations (2005).

Increasing access to essential, high-quality and affordable **medical products** (medicines, vaccines, diagnostics and other health technologies).

Addressing the **social, economic and environmental determinants** of health as a means of reducing health inequities within and between countries.

8. Within the Secretariat, these priorities transcend the fixed structure necessary for organizing WHO's work within the programme budget, by catalysing and driving horizontal integration of work across the Organization. For example, WHO's work to ensure that all people can take advantage of comprehensive and high quality health services through universal health coverage and access cannot be restricted to one category within the organizing framework. It is instead predicated upon WHO's work across several categories.

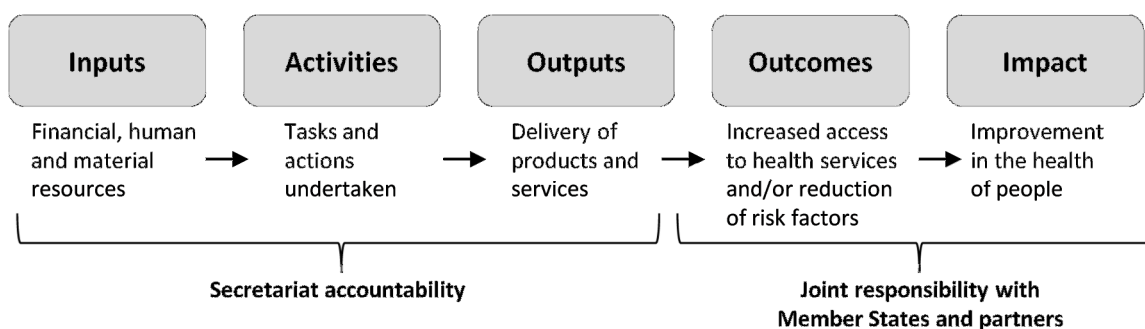
9. Second, the use of the priority-setting criteria in combination with the agreed categories of work have given rise to definition of 30 programme areas across the categories of work (there are 25 health-related priorities in the programmatic categories 1–5). With emphasis placed on the needs of individual countries and the current health situation, application of the criteria to five technical categories of work has shaped the proposed programme budget's programmatic framework and has narrowed the scope of work within each category. Application of the criteria for priority setting within each category has pinpointed what WHO *will* do out of all the things it *could* do.

10. Third, the use of the priority-setting criteria – with particular emphasis on the existence of evidence-based interventions, internationally agreed instruments, and WHO's comparative advantage – have informed the formulation of the outputs that WHO will use its resources to deliver, and the methods and strategic approaches to be used in order to achieve results in each of the programme areas.

11. What has emerged as a result of these priority-setting exercises is WHO's proposed programme budget for 2014–2015, which encompasses 82 programmatic outputs, and reflects a targeted and strategic approach that is in concert with WHO's institutional priorities.

## RESULTS BASED FRAMEWORK FOR PROGRAMMING AND BUDGETING

12. The implementation of a clear results chain based on standard terminology is an additional key element of reform that has been integrated into the proposed programme budget. The results chain links the work of the Secretariat (outputs) to the health and development changes to which it contributes, both in countries and globally (outcomes and impact). The basic logic of the results chain is illustrated in the diagram below.



13. In each of the 30 programme areas, there are defined outputs. The outputs define what the Secretariat will be accountable for delivering during the biennium. Delivery success will be measured through an output indicator that links the activities of the Secretariat to the outcomes to be achieved. In addition, deliverables that are specific to each level of the Organization that will contribute to the overall achievement of the output have been defined.

14. Not every country will have deliverables for a particular programme area, only those where there is an agreed technical cooperation programme for that area. In line with the overall division of labour among the three levels of the Organization, technical support will primarily be delivered through the WHO offices in countries, territories and areas, supported as necessary by the regional office and by headquarters in cases where the country level lacks sufficient capacity.

15. Outputs within programme areas contribute to outcomes, which are the changes in countries to which the work of the Secretariat is expected to contribute. Progress towards each outcome is measured in terms of changes in policies, practices, institutional capacities, reduction of risk factors, service coverage or access. Outputs within each programme area contribute to the achievement of a single outcome in the programme area concerned, however, some outputs have an influence on other programme areas as well, whether in the same category of work, or across categories.

16. At the highest level of the results chain, the outcomes contribute to the overall impact of the Organization, namely the sustainable changes in the health of populations to which the Secretariat and countries contribute. The eight impact goals to which these outcomes, and thus WHO's outputs, contribute are set out in the draft twelfth general programme of work.<sup>1</sup> Notably, the relationship between outcomes and impacts is not strictly one-to-one: an outcome may contribute to more than one impact and similarly an impact is the result of more than one outcome.

17. Although the structure of categories and programme areas provides an organizing framework for WHO's work, it does not capture the complexity of how different outputs contribute to multiple outcomes, and, in turn, multiple impact goals. WHO's work in programme areas such as: social determinants of health; national health policies, strategies and plans; integrated people-centred health services; access to medical products and strengthening regulatory capacity; and health

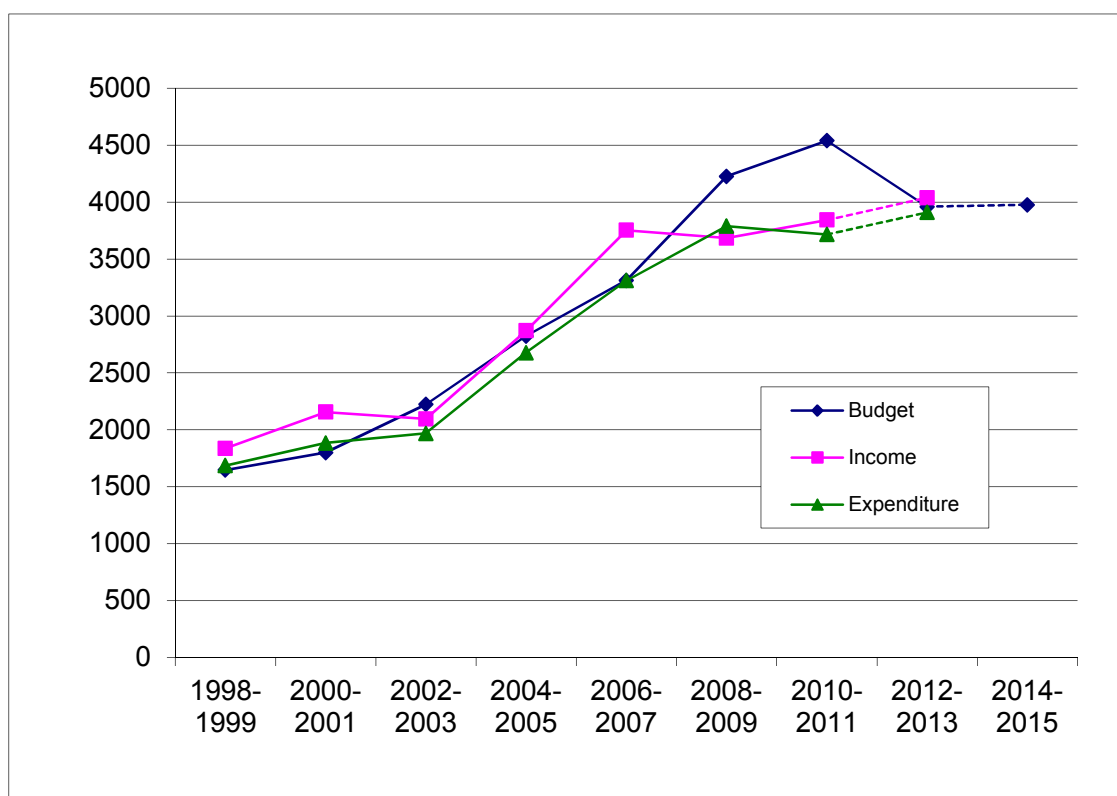
<sup>1</sup> Document A66/6.

systems information and evidence, have a foundational or cross-cutting nature, and directly or indirectly contribute to the achievement of all of WHO's anticipated outcomes and associated impact goals. Accordingly, from a performance measurement perspective, WHO's performance will be measured by the Secretariat's delivery of expected outputs as well as, in the wider context, being gauged in the context of the results chain that ultimately evaluates the contribution of WHO's outputs to defined outcomes and impact goals.

## BUDGET OVERVIEW

18. Based on an analysis of previous income and expenditure patterns (see the figure below), the budget level reflected in the proposed programme budget is realistic for the expected scope of WHO's work and delivery of outputs. The total proposed programme budget for 2014–2015 amounts to US\$ 3977 million, as summarized in Table 1. Tables 2 and 3 provide a breakdown of the proposed programme budget by programme area and by major office, respectively (the Annex provides a consolidated view). Table 4 provides a breakdown of proposed financing of the programme budget by funding type.

**Figure. Trends in WHO biennial budgets, income and expenditure, 1998–2015 (US\$ million)<sup>1</sup>**



19. The programme budgets in 2010–2011 and 2012–2013 were broken down into three segments: base programmes, special programmes and collaborative arrangements, and outbreak and crisis response. The special programmes and collaborative arrangements segment, in particular, was created to accommodate a number of hosted partnerships that had activities contributing to WHO's results. However, as the activities in these partnerships were undertaken in collaboration with

<sup>1</sup> Income and expenditure data exclude in-kind contributions. For the biennium 2012–2013 income and expenditure are projected.

## PROPOSED PROGRAMME BUDGET 2014–2015

partners and were guided by joint strategic decisions, WHO did not always have full control of the results and deliverables. In the proposed programme budget for 2014–2015, all hosted partnerships have been excluded and the earlier segmentation has been updated.<sup>1</sup> The proposed programme budget for 2014–2015 is presented along budget lines that correspond to the agreed categories of work and programme areas described above.

20. Polio eradication and Outbreak and crisis response, although related to Category 5 (Preparedness, surveillance and response) and contributing to results within that category, from a budget perspective will be treated under the emergencies component, in order to allow a more flexible approach to managing the budgets. Polio eradication is currently considered a programmatic emergency for global public health, and as such there needs to be flexibility for budget increases at short notice in order to accommodate programmatic needs. The budget for polio eradication has been set for 2014–2015 at US\$ 700 million, based on the estimation of the WHO component of the Polio Eradication and Endgame Strategic Plan (2013–2018) for the biennium. Similarly, the activities in outbreak and crisis response are governed by acute external events. The resource requirements are normally significant and difficult to predict; for this reason, budgeting in this area is an uncertain process. The requirements for the biennium 2014–2015 have been estimated at US\$ 228 million, based on projected expenditure for 2012–2013, a level considerably below the budgeted amount for 2012–2013.

**Table 1. Proposed programme budget 2014–2015 by category (US\$ million)**

Category	Programme budget 2012–2013 <sup>a</sup>	Percentage of total	Proposed programme budget 2014–2015	Percentage of total	Change in Proposed programme budget 2014–2015 to 2012–2013	Percentage change in Proposed programme budget 2014–2015 to 2012–2013
1. Communicable diseases	913	23.1	<b>841</b>	21.1	-72	-7.9
2. Noncommunicable diseases	264	6.7	<b>318</b>	8.0	54	20.5
3. Promoting health through the life-course	353	8.9	<b>388</b>	9.8	35	9.9
4. Health systems	490	12.4	<b>531</b>	13.4	41	8.4
5. Preparedness, surveillance and response	218	5.5	<b>287</b>	7.2	69	31.7
6. Corporate services/enabling functions	622	15.7	<b>684<sup>c</sup></b>	17.2	62	10.0
Emergencies						
Polio eradication	596	15.1	<b>700</b>	17.6	104	17.4
Outbreak and crisis response	469	11.8	<b>228</b>	5.7	-241	-51.4
<b>Total</b>	<b>3 959<sup>b</sup></b>	<b>100</b>	<b>3 977</b>	<b>100</b>	<b>18</b>	<b>0.5</b>

<sup>a</sup> The programme budget was approved by the World Health Assembly in resolution WHA64.3.

<sup>b</sup> The total for the Programme budget 2012–2013 includes US\$ 28.8 million for the Stop TB Partnership and US\$ 5 million for the European Observatory on Health Systems and Policies. For comparative purposes they have been removed from Categories 1 and 4 respectively.

<sup>c</sup> Category 6 represents the costs of the Organization for corporate services and enabling functions within the programme budget. In addition, US\$ 139 million is charged directly to all Categories to recover the costs of administrative services directly attributable to these programmes through a Post Occupancy Charge as an integral component of standard staff costs. The full cost of Category 6 is therefore US\$ 823 million.

<sup>1</sup> Hosted partnerships are no longer included in the programme budget.

21. Table 1 shows the areas of strategic emphasis and de-emphasis for 2014–2015 in relation to the approved budget for 2012–2013. For example, WHO's work in 2014–2015 to support countries in combatting the emerging epidemic of noncommunicable diseases will require a growth in emphasis and resources for this category, as well as over the course of the whole six-year programme of work. Similarly, WHO's work in supporting countries to strengthen health systems, moving towards universal access to people-centred services and equitable financial risk protection, will also require increased resources. In order to maintain a stable budget envelope, the increases to reflect emphasis are matched by decreases in communicable diseases, where a targeted and strategic approach will allow WHO to achieve its objectives despite reduced resources.

22. In relation to governance and management, WHO will focus on implementing the reform-related initiatives which, although initially requiring some increases in resources in 2014–2015, particularly in relation to accountability and risk management, will result in efficiency savings, and thus a reduced resource requirement during the six-year period of the general programme of work.

**Table 2. Proposed programme budget 2014–2015 by category and programme area in relation to the Programme budget 2012–2013 (US\$ million)**

Category and programme area	Programme budget 2012–2013 <sup>a</sup>	Proposed programme budget 2014–2015	Percentage change in proposed programme budget 2014–2015 compared to 2012–2013
<b>1. Communicable diseases</b>			
HIV/AIDS	138	131	-5.1
Tuberculosis	147	131	-10.9
Malaria	89	92	3.4
Neglected tropical diseases	83	91	9.6
* <i>Tropical disease research</i>	103	49	-52.4
Vaccine-preventable diseases	353	347	-1.7
<b>Subtotal</b>	<b>913</b>	<b>841</b>	<b>-7.9</b>
<b>2. Noncommunicable diseases</b>			
Noncommunicable diseases	162	192	18.5
Mental health and substance abuse	32	39	21.9
Violence and injuries	27	31	14.8
Disabilities and rehabilitation	10	16	60.0
Nutrition	33	40	21.2
<b>Subtotal</b>	<b>264</b>	<b>318</b>	<b>20.5</b>
<b>3. Promoting health through the life-course</b>			
Reproductive, maternal, newborn, child and adolescent health	184	190	3.3
* <i>Research in human reproduction</i>	34	43	26.5
Ageing and health	4	9	125.0
Gender, equity and human rights mainstreaming	12	14	16.7
Social determinants of health	28	30	7.1
Health and the environment	91	102	12.1
<b>Subtotal</b>	<b>353</b>	<b>388</b>	<b>9.9</b>
<b>4. Health systems</b>			
National health policies, strategies and plans	116	126	8.6
Integrated people-centered health services	137	151	10.2
Access to medicines and health technologies and strengthening	137	146	6.6
Health systems information and evidence	100	108	8.0
<b>Subtotal</b>	<b>490</b>	<b>531</b>	<b>8.4</b>

## PROPOSED PROGRAMME BUDGET 2014–2015

Category and programme area	Programme budget 2012–2013 <sup>a</sup>	Proposed programme budget 2014–2015	Percentage change in proposed programme budget 2014–2015 compared to 2012–2013
<b>5. Preparedness, surveillance and response</b>			
Alert and response capacities	66	98	48.5
Epidemic- and pandemic-prone diseases	59	68	15.3
Emergency risk and crisis management	66	88	33.3
Food safety	27	33	22.2
<b>Subtotal</b>	<b>218</b>	<b>287</b>	<b>31.7</b>
<b>6. Corporate services/enabling functions</b>			
Leadership and governance	208	228	9.6
Transparency, accountability and risk management	19	50	163.2
Strategic planning, resource coordination and reporting	24	35	45.8
Management and administration	335	334	-0.3
Strategic communications	36	37	2.8
<b>Subtotal</b>	<b>622</b>	<b>684</b>	<b>10.0</b>
<b>Emergencies</b>			
Polio eradication	596	700	17.4
Outbreak and crisis response	469	228	-51.4
<b>Subtotal</b>	<b>1 065</b>	<b>928</b>	<b>-12.9</b>
<b>Total</b>	<b>3 959<sup>b</sup></b>	<b>3 977</b>	<b>0.5</b>

<sup>a</sup> The Programme budget 2012–2013 was approved by the World Health Assembly in resolution WHA64.3.

<sup>b</sup> The total for the Programme budget 2012–2013 includes US\$ 28.8 million for the Stop TB Partnership and US\$ 5 million for the European Observatory on Health Systems and Policies. For comparative purposes they have been removed from Categories 1 and 4 respectively.

**Table 3. Proposed programme budget 2014–2015 by major office (US\$ million)**

Major office	Programme budget 2012–2013 <sup>a</sup>	Percentage of total	Proposed programme budget 2014–2015	Percentage of total	Change in Proposed programme budget 2014–2015 compared to 2012–2013	Percentage change in Proposed programme budget 2014–2015 compared to 2012–2013
Africa	1 093	27.6	1 120	28.2	27	2.5
The Americas	173	4.4	176	4.4	3	1.7
South-East Asia	384	9.7	340	8.5	-44	-11.5
Europe	208	5.3	225	5.7	17	8.2
Eastern Mediterranean	554	14.0	560	14.1	6	1.1
Western Pacific	246	6.2	270	6.8	24	9.8
Headquarters	1 267	32.0	1 286	32.3	19	1.5
<b>Total</b>	<b>3 959<sup>b</sup></b>	<b>100</b>	<b>3 977</b>	<b>100</b>	<b>18</b>	<b>0.5</b>

<sup>a</sup> The Programme budget 2012–2013 was approved by the World Health Assembly in resolution WHA64.3.

<sup>b</sup> The total for the Programme Budget 2012–2013 includes US\$ 28.8 million for the Stop TB Partnership and US\$ 5 million for the European Observatory on Health Systems and Policies. For comparative purposes they have been removed from headquarters and the European Region respectively.

23. One of the expected consequences of a priority-driven, results-based budgeting process is a more strategic allocation of resources. In pursuit of this objective, the Executive Board in 2006 agreed a results-based budget framework based on the following principles: results determined after

an Organization-wide planning process; a bottom-up budgeting process; allocations rooted in the principles of equity and in support of countries in greatest need, in particular the least developed countries, due consideration being given to performance, definition of resource needs to reflect Organizational priorities, the core functions of the Organization, and where in the Organization's work is best and most effectively performed. It also proposed that the outcome of the planning process should be appraised and justified against a validation mechanism that would provide indicative resource ranges for headquarters and each region. These allocations were for the six-year period 2008–2013, to be reviewed periodically.

24. Implementing the proposed framework has been a source of frustration for all offices. Priorities have been largely driven by available resources, outputs have not always reflected a clearly defined division of labour among the major levels and offices, and performance has not been an explicit criteria in resource allocation. The allocations in the last three programme budgets have not followed the validation ranges. This, coupled with the significant changes in the economic fortunes of many countries, and the progress in capacities and health needs in many low- and middle-income countries, indicates the need for a review of the validation. In order to respond to the overwhelming consensus that a new approach is required, the proposed programme budget 2014–2015 does not employ the strategic resource allocation validation mechanism.

25. Instead, the proposed programme budget 2014–2015 is based on a realistic assessment of income and WHO's implementation capacity, grounded in agreed Organizational deliverables and reflecting programmatic shifts in emphasis based on health priorities. Ongoing work on the division of labour across the three levels of the Organization has allowed a better definition of deliverables across the three levels of the Organization at the output level. Although high-level costing has informed the proposed programme budget, work is under way on a more complete scrutiny, based on performance of work, and linked to costed outputs and to division of labour across the three levels of the Organization. This new approach of a fully costed budget framework aims to align costs, results, and resources across the different levels of the Organization and will be implemented for 2016–2017.

#### **FINANCING THE PROGRAMME BUDGET**

26. WHO's new approaches to financing the programme budget aim to achieve a fully funded programme budget that is costed, realistic, and driven by the priorities and expected outputs agreed by Member States.

27. In December 2012, the Programme, Budget and Administration Committee of the Executive Board, at its second extraordinary session, decided to recommend to the Board a number of proposals to better align contributions across the programme budget as a way to increase the predictability of funding and enhance the matching of resources with expected outputs.<sup>1</sup>

28. Among the recommendations of the Committee, the approval of the future programme budgets in their entirety would facilitate the matching of funding to a realistic and credible programme budget.

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<sup>1</sup> See document EB132/3.

**PROPOSED PROGRAMME BUDGET 2014–2015**

29. The programme budget for 2014–2015, once approved, would also serve as the central instrument for a structured and transparent financing dialogue with potential contributors in 2013 (subject to the endorsement of the Sixty-sixth World Health Assembly of this process), with a view to putting in place the appropriate financing.

30. Following the financing dialogue, and proceeding under the assumption that a significant portion of the programme budget would be assured before the start of the biennium, any remaining financial gaps would then become targets for coordinated, Organization-wide resource mobilization to be conducted in 2014–2015 at all levels of the Organization. The resource mobilization plan of action that will be developed following the financing dialogue will unite all three levels of the Organization around a common resource mobilization agenda that is grounded in the aim of funding the remaining gaps in the programme budget for 2014–2015. Regular reports on progress will be submitted to the governing bodies for their review of the available resources and budget implementation, so that reallocation of resources and reprogramming, where necessary, can be deliberated by WHO's Member States.

31. With regard to sources of financing, WHO's programme budgets will continue to be funded from a mixture of sources: from assessed and voluntary contributions, with the latter coming from both State- and non-State donors.

**Assessed contributions**

32. The Director-General is proposing that there be zero nominal growth in the level of assessed contributions in 2014–2015 (Table 4). Funding for the proposed programme budget is anticipated to be at a level of 23% from assessed contributions and 77% from voluntary contributions, with most of the latter being earmarked funding. This continues the trend of an increasing proportion of the WHO programme budget being funded from voluntary resources. It is proposed that the level of assessed contributions remains as in the biennium 2012–2013.

**Table 4. Percentage changes in the sources of financing between the Programme budget 2012–2013 and proposed programme budget 2014–2015, (US\$ million)**

Sources of financing	2012–2013	2014–2015	Percentage change
Assessed contributions	929	929	0.0
Member States' non-assessed income <sup>1</sup>	15	–	–
Total assessed contributions	944	929	–
Voluntary contributions	3 015	3 048	1.1
<b>Total all sources of financing</b>	<b>3 959</b>	<b>3 977</b>	<b>0.5</b>

<sup>1</sup> Member States' non-assessed income is derived mainly from interest earnings on assessed contributions, collection of arrears of assessed contributions, and unspent assessed contributions at the end of the biennium. In 2014–2015 non assessed income is not budgeted as a result of the move to International Public Sector Accounting Standards (IPSAS).

**Voluntary contributions**

33. Voluntary contributions remain the main source of financing for the Organization. Most are received for development work and humanitarian assistance and are specified in nature. They come mainly from bilateral and multilateral development agencies and a few foundations. Several constraints need to be overcome. Firstly, there is a misalignment between the programme budget and the funds available to finance it, which results in part from a reliance on highly specified voluntary contributions. Second, this type of funding can be unpredictable. Third, there is a vulnerability that arises from dependence on a very narrow donor base. Fourth, there are heavy



transaction costs and a certain lack of transparency associated with current approaches to resource mobilization and management. Lastly, the availability of the unspecified funding needed to bridge funding gaps and to respond to changing circumstances is limited.

34. The core voluntary contributions account, comprising fully and highly flexible funds, is becoming an important component of WHO's financing model. For the biennium 2010–2011, US\$ 235 million were received for the core voluntary contributions account from 14 donor countries. Thanks to the core voluntary contributions account, less-well-funded key activities are benefiting from a better flow of resources; the implementation bottlenecks that arise when immediate financing is lacking are also eased. The core voluntary contributions account thus contributes to both greater alignment and to improved efficiency.

#### **Carry forward**

35. The Organization routinely carries forward a balance on voluntary contributions in order to meet future commitments for planned salary and activity costs. The value of the funds carried forward contributes to the financing of the programme budget. These funds include income received as multi-year contributions that cover more than one biennium; funds received towards the end of a biennium; and funds linked to lower implementation that are carried forward to the following biennium. It is difficult to make a precise estimation of the opening carry-forward balance at the start of a biennium. Variables include the amount and degree of specification of income received for the remainder of the current biennium, and the extent to which some existing contribution balances can be redeployed to under-funded areas, while respecting the donor agreement conditions.

36. In the light of the proposed financing dialogue, it is envisaged that a significant amount of funds that were previously labelled as being carried forward at the start of the biennium will now be recorded as funds in support of the programme budget for 2014–2015. The exact amount will be reported to Member States during the two meetings of the financing dialogue, and again in the update report on the implementation of the programme budget for 2014–2015 to the Programme, Budget and Administration Committee and to the Executive Board in January 2014.

#### **Financing of Category 6**

37. Financing of Category 6 is complicated and requires some additional clarification. The total budgeted expenses for category 6 are US\$ 823 million. The funding comes from assessed contributions and programme support charges on voluntary contributions. An additional post occupancy charge, taken against both assessed and voluntary contributions, proportionate to salary expenses, is used to pay for those expenses within category 6 that are most closely linked to occupancy, including security, premises and information technology costs. Part of the post occupancy charge is also used for financing the Real Estate Fund. A study into management and administration costs at WHO, conducted by an external consultant, has recently been completed,<sup>1</sup> and recommendations on budgeting and cost control will be incorporated in the future reporting under this category. Recommendations on possible changes to cost recovery approaches will also be considered further for eventual incorporation in future budgets.

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<sup>1</sup> Document EBPBAC18/3.

### **Financing the safety and security of staff**

38. In view of the different types of safety and security expenditures borne by the Organization and the results of an analysis of the relevant cost drivers, the Secretariat has put in place the following financing mechanisms:

- (a) Set-up costs (indirect fixed costs) to allow for a minimum standard of security staffing and infrastructure will be financed through assessed contributions (including Member States' non-assessed income) and the Special Account for Servicing Costs (subject to availability of funds).
- (b) Emergency costs due to unforeseen circumstances (indirect variable costs), such as emergency evacuation of staff or other emergency costs relating to enhanced security measures during unforeseen emergencies, will be financed through the Security Fund.
- (c) Costs directly driven by the number of staff alone (direct costs), such as the WHO contribution to the United Nations Security Management System and the malicious acts insurance policy, are included in the post occupancy charge.
- (d) Costs of doing business at a particular field location (direct costs) as a consequence of programme implementation will be included as an integral component of workplans at a particular location.

39. The Secretariat will include security costs in donor agreements, i.e., should the security situation at a location change during implementation, resources may be reallocated accordingly. WHO is establishing a mechanism to charge these costs directly. Examples of such costs include: staff-related expenditures, such as residential security in the field, and hazard allowances; and infrastructure and operations security costs, such as those for communications and other special equipment.

### **Financing the Capital Master Plan**

40. The 10-year Capital Master Plan for all main locations provides a clear picture of global needs for major renovation of existing office buildings and staff housing, land acquisition and infrastructure-related works for the period and helps to manage the priorities.

41. Routine maintenance and repair work is financed on a biennial basis, principally through the assessed contributions and occasionally through special appropriation, whereas capital expenditure for major construction work tends to be financed by the Real Estate Fund or deferred payment agreements that are repaid from the assessed contributions.

42. Major repairs and renovations have not been adequately addressed using either of these mechanisms. In recognition of this, since 2010, 1% of the fire insurance value of the capital stock has been routinely set aside in the Real Estate Fund to cover major repair and maintenance needs. In addition, the Real Estate Fund is credited at the end of each financial period with up to US\$ 10 million from the Member States' non-assessed income.

### **MONITORING AND REPORTING, EVALUATION, ACCOUNTABILITY AND TRANSPARENCY**

43. Performance monitoring and assessment are essential for the proper management of the programme budget and for informing the revision of policies, strategies and implementation in order to ensure that WHO is achieving the results to which it has committed. The new results chain presented in the programme budget provides the basis on which the performance of WHO will be

assessed. This has two aspects: a clear articulation of the results for which WHO is accountable and how attainment will be measured; and a logical demonstration of how WHO's contribution is linked to achievements in health outcomes and impacts.

44. Monitoring will be based on a systematic assessment of progress towards the achievement of results as reflected in the programme budget. The focus will be on the delivery of outputs and the use of strategically allocated financial resources. For the proposed programme budget for 2014–2015, the existing process for assessment and review will be used, although well-defined tools and processes will be applied to further enhance its rigour.

45. A monitoring framework will be developed outlining in more detail how the 82 outputs will be measured. This will include greater definition of the indicators, baselines and targets, how they will be measured, the tools for measuring and means for verifying the indicators, baselines and targets, and describing how each of the levels of the Organization are contributing, or have contributed, to results. As the outputs represent the results for which the Secretariat is accountable, measuring the achievement of the results through indicators should be closely linked to demonstrable effort or resources invested by the Organization. This concept will be reflected clearly in the monitoring framework, including the selection of the indicators through which the results will be measured.

46. Indicators, baselines and targets have been defined for each of WHO's outcomes, covering, where feasible, the full six-year period of the general programme of work. Where they exist, indicators (baselines and targets) that have been adopted by international agreement have been chosen. For example, in the programme area of noncommunicable diseases, the indicators and targets (for decreases in tobacco use and salt intake, increase in physical exercise, and reduction in alcohol consumption) are taken directly from the internationally-agreed global monitoring framework and the set of voluntary targets. One drawback of using internationally-agreed goals is that the time frame for their achievement does not coincide exactly with the time frame of the programme budget, and this will require the monitoring framework to accommodate some fine-tuning. For example, monitoring of progress towards achievement of the Millennium Development Goals will continue beyond 2015, recognizing that many countries will not have reached the targets related to the Goals by that point. WHO will review the need to adapt the monitoring framework in the light of what is agreed for the next generation of development goals. Conversely, the agreed time frame for the noncommunicable disease goal extends to 2025. In this instance, the monitoring framework will show progressively where countries are on- or off-track toward the ultimate goal.

47. The monitoring framework for the programme budget will be the primary tool for the annual review process, which will be coordinated to ensure consistency of monitoring across the Organization. The annual mid-term review will take place after the first year of the biennium and a more comprehensive programme budget performance assessment will take place following the close of the biennium. The reporting frequency and methodology of the review process will remain unchanged, but the substance, clarity, and coherence of the assessment will be enhanced by the clear results chain and division of labour in the programme budget.

48. To date, the routine monitoring exercises have relied primarily on self-reporting. In future the intention is to introduce a greater degree of objectivity, with the use, where appropriate, of independent expertise and more robust methodologies in line with WHO's evaluation policy.

49. Priorities for more in-depth evaluation will be agreed with Member States by the Evaluation Management Group in the context of the new evaluation policy, and may focus on programme areas, cross-cutting themes or leadership priorities. In line with the evaluation policy, each evaluation exercise will be designed to ensure objectivity, using independent expertise as required.

50. It is fundamental to the utility of the accountability framework that the results of monitoring and evaluation are used to take corrective action to address under-performance or to inform a strategic scale up of activities to achieve the results, as well as to provide instructive experience that guides the next planning cycle.

51. The demonstration of how WHO's work contributes to, or influences health outcomes and impacts is crucial, both in order to assess the Organization's effectiveness and to communicate the value of its contribution to the achievement of better health overall. WHO will report on the health outcomes, and will assess and explain the link between its contribution and the achievement of those outcomes. It will use existing methods and mechanisms, especially national systems, existing programme and system reviews, and harmonize its efforts with other partners, in order to assess the achievement of the outcomes and impacts. A more rigorous monitoring mechanism will be described in detail in the monitoring framework for the programme budget, and will draw on existing efforts and methodologies.

## CATEGORY 1. COMMUNICABLE DISEASES

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### *Reducing the burden of communicable diseases, including HIV/AIDS, tuberculosis, malaria, neglected tropical diseases and vaccine-preventable diseases.*

This category specifically covers HIV/AIDS, tuberculosis, malaria, neglected tropical diseases and vaccine-preventable diseases.

#### **HIV/AIDS**

The world has made significant progress towards attaining the key targets set by the United Nations in its Political Declaration on HIV and AIDS in 2011: new infections with HIV have decreased by 20% in the past 10 years, antiretroviral therapy has been expanded to reach more than eight million people in 2011, and new HIV infections in children have dropped by more than 40% since 2003. Yet, despite global progress, major concerns persist: the African Region remains the worst-affected, with 68% of global new infections and 72% of AIDS-related deaths; some countries – in particular in the European Region and the Eastern Mediterranean Region – report increasing rates of HIV transmission; and in most regions certain population groups continue to be vulnerable and/or marginalized, with compromised access to essential services.

Building on advances in the biennium 2012–2013, new opportunities exist for: using antiretroviral medicines more strategically with the aim of maximizing their benefits for the prevention of HIV transmission; accelerating technological innovation in medicines and diagnostics to allow for simpler, safer, more affordable therapeutic regimens and decentralized service delivery; ensuring quality and reinforcing patient retention across the continuum of diagnosis, care and treatment; linking and integrating HIV services with those for tuberculosis, hepatitis, maternal and child health, drug dependence and other programmes; and monitoring the impact of expansion of treatment on HIV incidence and drug resistance. Important opportunities exist for leveraging broader health outcomes through HIV responses, by linking HIV programmes with other health areas, such as noncommunicable diseases, maternal and child health, chronic care and health systems.

In the biennium 2014–2015, WHO will focus its efforts on supporting countries to implement and monitor the global health sector strategy on HIV/AIDS 2011–2015, as well as preparing a post-2015 strategy and strengthening capacity for HIV policy and programme implementation. Moreover, WHO will consolidate and update policy guidance on the prevention and treatment of HIV infection, for all age groups and key populations, with a focus on integrating HIV and other health programmes.

#### **TUBERCULOSIS**

Globally, the annual number of new cases of tuberculosis has been slowly falling since 2006 and the Millennium Development Goal target that tuberculosis incidence rates should be falling by 2015 is on track to be achieved. Major progress has been made in expanding access to treatment of tuberculosis, but poverty, migration and other forms of social vulnerability exacerbate the epidemic. The rise of noncommunicable diseases, including diabetes and tobacco-associated disease, means that more immune-compromised individuals are at risk of falling ill with tuberculosis. The global response to detect and successfully treat drug-resistant tuberculosis, including multidrug-resistant tuberculosis, will influence future prospects for tuberculosis control worldwide. Basic programmes and integrated services, and an increasing level of community, civil society and private sector engagement, together provide a good platform for ensuring more rapid access and effective use of

the new diagnostics and medicines that are now available or in the pipeline for prevention and treatment of tuberculosis, HIV-associated tuberculosis and drug-resistant tuberculosis.

Work on the post-2015 global strategy for the prevention and control of tuberculosis and associated targets will continue focusing on innovative care, bold policies, supportive systems and intensified research. Challenges for countries, the Secretariat and partners include closing major gaps in financing, especially for low-income and lower-middle-income countries, overcoming constraints in health services, human resources and supply changes, and eliminating the catastrophic impacts on those affected by the disease.

In the biennium 2014–2015, WHO's normative, surveillance, technical support and partnership roles will be crucial in controlling the epidemic. The Secretariat will focus on building capacity to implement the Stop TB Strategy at national and regional levels in order to reach vulnerable populations, ensure adequate access to new tools and guidelines for prevention and treatment of all forms of tuberculosis and access to first- and second-line treatment, and strengthen surveillance systems and use of data. Furthermore, it will update and consolidate policy and technical guidance, for example on rapid diagnostic tools and laboratory practices, delivery of care for patients with multidrug-resistant tuberculosis and integrated community-based management of tuberculosis, and will work with countries to adapt policies and guidance to national and regional contexts.

#### **MALARIA**

About half the world's population is at risk of malaria. There were an estimated 216 million cases of malaria in 2010, of which approximately 81%, or 174 million cases, were in the African Region. Although mortality rates for malaria have fallen by more than 25% globally since 2000, in order to reach the goals set for 2015 a massive extension of access to malaria prevention is required, especially sustainable vector control, as well as access to quality-assured diagnostic testing and effective antimalarial treatment. The risk of malaria resurgence due to decreasing international funding for prevention and control, as well as to resistance to artemisinin and insecticides, demands sustained strategic investments from both donors and the countries in which malaria is endemic. In addition, strengthened surveillance systems are needed to target limited resources appropriately and to evaluate the progress and impact of control measures.

In the biennium 2014–2015, the Secretariat will support countries in which malaria is endemic by developing approaches to capacity building for malaria prevention, control and elimination, as well as for strengthening surveillance and identifying both threats to malaria control and elimination, as well as new opportunities for action. A global technical strategy for malaria control and elimination for the period 2016–2025 will be developed with the aim of helping to guide countries and implementing partners in sustaining the successes of the past decade. Furthermore, the Secretariat will update policy and technical guidance on vector control, diagnostic testing and antimalarial treatment, as well as on malaria control and elimination.

#### **NEGLECTED TROPICAL DISEASES**

One billion people are infected with one or more neglected tropical diseases, with two billion at risk in tropical and subtropical countries/areas. Those most affected are the poorest, often living in remote rural areas, urban slums or in conflict zones. Neglected tropical diseases are a major cause of disability and loss of productivity among some of the world's most disadvantaged people. In this regard, neglected tropical diseases cannot be seen as a health issue alone. They are inextricably linked with health as a human right, with poverty reduction and with effective governance. Although their impact is felt more strongly in some regions than others and their contribution to overall

mortality rates is not as high as that of other diseases, reducing their health and economic impact is a global priority, because new and more effective interventions are available, because their reduction can help to accelerate economic development, and because the Secretariat is particularly well-placed to convene and nurture partnerships between governments, health-service providers and pharmaceutical manufacturers.

The road map for accelerating work to overcome the impact of neglected tropical diseases sets out a detailed timetable for the control and, where appropriate, elimination and eradication of the 17 specific diseases. Partnerships with manufacturers are important in securing access to high-quality medicines. Sustaining the current momentum for tackling these diseases requires not only commodities and financing but also political support.

In the biennium 2014–2015 WHO will focus on increasing access to essential medicines for neglected tropical diseases, expanding preventive chemotherapy and innovative and intensified disease management. Additionally, strengthening national capacity for disease surveillance and certification/verification of the elimination of selected neglected tropical diseases will remain a central concern.

The UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR), in the context of its 2012–2017 strategy, will focus on two key priorities: strengthening local research capacity, and implementation research that addresses country needs. Ensuring that countries play a leading role in establishing priorities is essential, as TDR will continue to focus on least developed countries and vulnerable populations in order to ensure sustainable research capability. Evidence from intervention and implementation research will be used to inform policy decision-making and public health practice.

#### **VACCINE-PREVENTABLE DISEASES**

Some 2.5 million children under the age of five years die from vaccine-preventable diseases each year, or more than 6800 child deaths every day. Immunization is one of the most successful and cost-effective public health interventions. Globally, more children than ever before are being immunized. The protection afforded by vaccines prevents more than two million deaths annually. The priority given to current and future vaccine-preventable diseases is reflected in the international attention to this subject as part of the Decade of Vaccines and WHO's associated global vaccine action plan.

Several new vaccines are becoming available and routine immunization is being extended, from the focus on infants and pregnant women as the sole target groups, to the inclusion of adolescents and adults. The introduction of new vaccines is increasingly being done in coordination with other programmes as part of a package of interventions to control disease, especially pneumonia, diarrhoea and cervical cancer. However, up to one fifth of children born each year are hard to reach and are thus at risk of being excluded from immunization programmes. By scaling up the use of existing vaccines and the introduction of more recently licensed vaccines, nearly one million additional deaths could be averted each year. The development and licensing of additional vaccines promise to improve the prevention of mortality and morbidity.

In the biennium 2014–2015, the focus will be on implementing and monitoring the global vaccine action plan by supporting the development of national immunization plans, strengthening national capacity for monitoring immunization programmes and ensuring adequate supplies and financing for immunization programmes. Additionally, efforts will be intensified towards both the elimination of measles and rubella and the control of hepatitis B.

**LINKAGES WITH OTHER PROGRAMMES AND PARTNERS**

Efforts and deliverables related to work on the prevention and control of communicable diseases carry wider benefits for health and development. For example, work related to the prevention of mother-to-child transmission of HIV means expanding HIV services for women, pregnant women, mothers, children and families to ensure that the goal of elimination of new HIV infections in children is achieved by 2015. Similarly, work on preventing and treating some neglected tropical diseases, including schistosomiasis and soil-transmitted helminthiasis, will improve female and maternal health and birth outcomes. Expanding the use of quality-assured rapid diagnostic tests for malaria will provide an entry point for improving the management of all causes of fever, notably pneumonia and diarrhoeal diseases, and ensure their proper treatment. Enhancement of surveillance activities in line with the goals of control, elimination and eradication of vaccine-preventable diseases will support efforts to prevent and respond to outbreaks of vaccine-preventable disease. There are also linkages to the work on the core requirements of the International Health Regulations (2005) for strengthening public laboratories and for foodborne diseases. Health systems based on primary care that support universal health coverage are important in preventing and controlling the major communicable diseases. Achieving the goals for communicable diseases depends on well-functioning health systems and on tackling the social determinants of health.

Moreover, communicable disease work streams entail joint efforts, complementarity and support to relevant organizations in the United Nations system and key partnerships. These include UNAIDS, UNICEF, the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the International Drug Purchase Facility, the Foundation for Innovative New Diagnostics, the United States of America's President's Emergency Plan for AIDS Relief, the Stop TB Partnership, the Roll Back Malaria Partnership, the GAVI Alliance, the Measles and Rubella Initiative, the Medicines for Malaria Venture, the African Programme for Onchocerciasis Control, the Global Alliance for the Elimination of Lymphatic Filariasis, as well as bilateral agencies and major foundations.



## HIV/AIDS

### Outcome 1.1. Increased access to key interventions for people living with HIV

Outcome indicators	Baseline	Target
Number of new paediatric HIV infections (ages 0–5 years)	330 000 (2011)	<43 000 (2015)
Number of people living with HIV on antiretroviral treatment	8 million (2011)	15 million (2015)
Percentage of HIV+ pregnant women provided with antiretroviral treatment (ARV prophylaxis or ART) to reduce mother-to-child transmission during pregnancy and delivery	57% (2011)	90% (2015)
Cumulative number of voluntary medical male circumcisions (VMMC) performed in 14 priority countries	1.4 million (2011)	20.8 million (2016)

#### Output 1.1.1. Implementation and monitoring of the global health sector strategy on HIV/AIDS 2011–2015 through policy dialogue and technical support at global, regional and national level

Output indicator	Baseline	Target
Number of countries that have developed and are implementing national HIV/AIDS strategies in line with the global health sector strategy on HIV/AIDS	To be finalized after the review of national HIV health sector strategies in 2013	57/57 (2015)

#### *Country office deliverables*

- Support countries to adapt region-specific strategies and action plans into national policies and plans, including the expansion of health sector response to achieve universal access to HIV prevention and treatment
- Strengthen the country's capacity to generate and systematically use strategic information through national information systems and routine programme monitoring, in line with global norms and standards
- Support countries in mapping national HIV technical assistance needs and facilitate provision of adequate, high-quality technical assistance for programme management, governance, implementation and domestic and foreign resource mobilization

#### *Regional office deliverables*

- Facilitate the development of regional HIV/AIDS strategies and action plans in support of implementation of the global health sector strategy on HIV/AIDS, and provide support for their adoption at country level and mobilization of resources for their implementation
- Track progress in implementation of regional strategies in regular reviews and reports
- Develop regional networks of WHO quality assured technical assistance providers; support identified operational research priorities; particularly on HIV prevention strategies

#### *Headquarters deliverables*

- Provide global leadership and coordination for implementation of the global health sector strategy on HIV/AIDS, and facilitate development of the post-2015 global HIV health sector agenda, targets and plans through stakeholder dialogue

## PROPOSED PROGRAMME BUDGET 2014–2015

- Monitor and report on progress of the health sector response to HIV prevention, treatment and care, HIV/tuberculosis coinfection, elimination of mother-to-child-transmission and HIV drug resistance with key contributions from regional and country levels; provide normative guidance on strategic information
- Facilitate roll-out of normative and policy guidance in highly specialized areas through international partnerships, events and in priority countries

### **Output 1.1.2. Adaptation and implementation of most up-to-date norms and standards in preventing and treating paediatric and adult HIV infection, integrating HIV and other health programmes, and reducing inequities**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries that have adopted/adapted 2013 guidelines on the use of antiretroviral medicines for the treatment and prevention of HIV infection	Not applicable	57/57 (2015)

#### ***Country office deliverables***

- Support the development of national comprehensive guidelines, protocols and standard operating procedures adapted from global and regional guidelines in the areas of HIV prevention, care and treatment and integration of HIV related services
- Facilitate national policy dialogue on prioritization, adoption/adaptation of evidence-based policies, particularly in relation to HIV testing, access to services for key populations, and integration with other health sector programmes in framework of health system strengthening
- Develop national operational research agenda related to identified challenges in country HIV programme scale-up, and strengthen capacity in operational research

#### ***Regional office deliverables***

- Work with country offices to advocate and provide technical support in the roll-out of global guidelines, including developing region-specific adaptations with focus on key populations and service integration
- Develop and promote regional policies and practices for increasing equitable access to HIV services, service integration and health system strengthening
- Identify regional research priorities and advocate and promote with regional partners and countries to strengthen country capacity for undertaking operational research and using their results

#### ***Headquarters deliverables***

- Update consolidated guidelines to prevent and treat paediatric and adult HIV, including on HIV testing, pre-exposure prophylaxis and other strategic use of ARVs, male circumcision, male and female condoms, HIV medicines and diagnostics, blood and injection safety, harm reduction, drug procurement and use
- Develop and promote policy options and guidance for prioritization of interventions to achieve an equitable HIV health sector response to integrate HIV and other health programmes and to strengthen critical health system components
- Stimulate and implement innovation in HIV by establishing short-, medium- and long-term priorities for HIV-related drugs, diagnostics and vaccines and identify research gaps in consultation with partners

## TUBERCULOSIS

### Outcome 1.2. Increased number of successfully treated tuberculosis patients

Outcome indicators	Baseline	Target
Cumulative number of tuberculosis patients successfully treated in programmes that have adopted the WHO-recommended strategy since 1995	51 million (2011)	70 million (2015)
Annual number of tuberculosis patients with confirmed or presumptive multidrug-resistant tuberculosis (including rifampicin-resistant cases) placed on multidrug-resistant tuberculosis treatment worldwide	55 597 (2011)	270 000 (by 2015)

### Output 1.2.1. Intensified implementation of Stop TB Strategy to scale up care and control, with focus on reaching vulnerable populations, strengthening surveillance, and alignment with health sector plans facilitated

Output indicator	Baseline	Target
Number of priority countries <sup>1</sup> that have up-to-date tuberculosis strategic plans	54/95 (2012)	85/95 (2015)

#### Country office deliverables

- Support the implementation of national tuberculosis control plans focused on reaching vulnerable populations, their alignment with health sector plans, and promotion of intersectoral, interagency and private sector collaboration
- Strengthen country capacity for tuberculosis surveillance and for conducting tuberculosis prevalence surveys where relevant and use of data is in line with WHO standards
- Support the development of national tuberculosis control plans beyond 2015 that are in line with post-2015 global tuberculosis strategy and new targets
- Facilitate the country need-based planning and provision of technical support and long-term capacity building for implementing tuberculosis control strategies

#### Regional office deliverables

- Provide regional platform to strengthen countries' capacity to implement the Stop TB Strategy and for multi-stakeholder collaboration, including the private sector and non-health sectors
- Facilitate active engagement of countries in the post-2015 global tuberculosis strategy and the adoption of new targets, and support countries to prepare robust plans for implementing the post-2015 strategy
- Publish by the annual tuberculosis regional report and report on progress to donors and regional governing bodies
- Coordinate the provision of country-need based technical support from regional and global levels, including regional support mechanisms, e.g. the Tuberculosis Technical Assistance Mechanism (TBTEAM), WHO collaborating centres

#### Headquarters deliverables

- Provide global leadership and coordination of global stakeholders to achieve impact in tuberculosis prevention, care and control through the Stop TB Strategy, including managing the global partner networks for technical cooperation and resource mobilization

<sup>1</sup> Countries with a high burden of tuberculosis, multidrug-resistant tuberculosis, tuberculosis/HIV coinfection and regional priority countries.

## PROPOSED PROGRAMME BUDGET 2014–2015

- Develop guidance and a body of knowledge on good policies and best practices in tuberculosis care and control, including strengthened surveillance, and provide a platform for sharing this across regions
- Support strengthening of strategic information at regional and country levels, and sustain capacity for reporting at the global level, e.g. publishing the *Global tuberculosis report*, and reporting on progress to the WHO governing bodies
- Develop a robust post-2015 global tuberculosis strategy and new targets, including implementation guidance

### **Output 1.2.2. Updated policy guidance and technical guidelines on HIV-related tuberculosis, delivery of care for patients with multidrug-resistant tuberculosis, tuberculosis diagnostic approaches, tuberculosis screening in risk groups and integrated community-based management of tuberculosis**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries in which the WHO-recommended rapid diagnostic for tuberculosis and drug-resistant tuberculosis is being implemented	77/145 (2012)	110/145 (2015)

#### ***Country office deliverables***

- Support countries in adapting and implementing the updated global tuberculosis guidelines, including tools and methodologies
- Provide technical support to ensure that the national strategies and plans are adapted and implemented with their health services delivery in line with international best practice
- Strengthen systems to collect, analyse, disseminate and use data for tuberculosis operational research at the country level

#### ***Regional office deliverables***

- Advocate with and monitor countries on their implementation of the updated tuberculosis guidelines, including policies and practices on diagnosis and treatment
- Complement country capacity to support the adaptation and implementation of global guidelines, strategies and tools
- Manage the regional technical support mechanisms, including the Regional Green Light Committee, regional laboratory initiatives
- Adopt and adapt the global road map for priorities in tuberculosis research for regional and country settings

#### ***Headquarters deliverables***

- Update tuberculosis guidelines on introduction of new drugs and treatment; preventive therapy; HIV-related tuberculosis; multidrug-resistant tuberculosis; tuberculosis screening in risk groups; and integrated community-based management
- Update and promote tuberculosis laboratory best practices (including biosafety, accreditation and introduction of rapid diagnostic methods); monitor and evaluate practices
- Organize and lead the Global Task Force for updating the road map for priorities in tuberculosis research to improve tuberculosis prevention, care and control

**MALARIA****Outcome 1.3. Increased access to first-line antimalarial treatment for confirmed malaria cases**

<b>Outcome indicators</b>	<b>Baseline</b>	<b>Target</b>
Percentage of confirmed malaria cases in the public sector receiving first-line antimalarial treatment according to national policy	50% (2011)	70% (2015)

**Output 1.3.1. Countries enabled to implement malaria strategic plans, with focus on improved diagnostic testing and treatment, therapeutic efficacy monitoring and surveillance through capacity strengthening**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of malaria-endemic countries where an assessment of malaria trends is done using routine surveillance systems	58/99 (2013)	68/99 (2015)

**Country office deliverables**

- Support national malaria programmes to identify capacity-building needs and support countries to strengthen technical and management capacity in malaria prevention, control and elimination
- Support countries in further strengthening monitoring and reporting of the therapeutic efficacy of malaria drugs and insecticide resistance; improve malaria surveillance, including tracking of malaria control through national health information systems and the use of those data
- Support strong national strategies and programmatic gap analyses to facilitate fund-raising

**Regional office deliverables**

- Assess common priority capacity-building needs across countries and facilitate regional and intercountry capacity building; share best practices that build long-term capacity in countries
- Provide intercountry technical support, where additional capacity is needed in special areas of malaria control and elimination, and health system strengthening (e.g. Health Management Information System, laboratory and Procurement and Supply Management), including brokering support through regional mechanisms and partnerships (e.g. WHO collaborating centres)
- Strengthen country capacity for gathering strategic information, including risk mapping, information for better malaria stratification, monitoring and analysis of regional trends, and use of malaria surveillance, programme and health-related data

**Headquarters deliverables**

- Provide expertise where additional capacity is needed in the regions to support specialized areas of malaria prevention, control and elimination
- Manage strategic global information on malaria, including establishing databases on insecticide and drug resistance, and report on progress in global malaria control
- Provide programmatic and training tools to support regions and countries to build human capacity for implementing WHO recommended strategies and surveillance

**Output 1.3.2. Updated policy recommendations, strategic and technical guidelines on vector control, diagnostic testing, antimalarial treatment, integrated management of febrile illness, surveillance, epidemic detection and response**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Proportion of malaria-endemic countries that have adapted policy recommendations, strategic and technical guidelines in their implementation of malaria strategies and plans	81/99 (2011)	89/99 (2015)

**PROPOSED PROGRAMME BUDGET 2014–2015****Country office deliverables**

- Provide technical support to countries for national adoption/adaptation of the updated technical guidelines on vector control, diagnostic testing and treatment, including for special populations, and integrated management of febrile illness
- Support the development of national malaria prevention, control and elimination strategies, and malaria programme reviews
- Support policy and strategic dialogue at country level to monitor the implementation of malaria strategies, discuss capacity gaps and plan for effective implementation of malaria control and elimination

**Regional office deliverables**

- Provide proactive support for the development of global malaria strategy post-2015 to guide regional and country level action plans as appropriate
- Provide expertise to countries where additional capacity is needed to implement regional responses to artemisinin and insecticide resistance

**Headquarters deliverables**

- Develop and launch the global technical strategy for malaria control and elimination post-2015 with key contributions from regional and country offices
- Update technical guidelines on vector control, diagnostic testing and treatment, including for special populations, integrated management of febrile illness; develop tools to support the adaptation and implementation of the guidelines
- Work with regional offices to strengthen technical support in highly specialized areas of malaria control, prevention and treatment, including artemisinin resistance

**NEGLECTED TROPICAL DISEASES****Outcome 1.4. Increased and sustained access to essential medicines for neglected tropical diseases**

<b>Outcome indicators</b>	<b>Baseline</b>	<b>Target</b>
Number of countries certified for eradication of dracunculiasis	183/194 (2014)	194/194 (2019)
Number of disease-endemic countries having achieved the recommended target coverage of population-at-risk of lymphatic filariasis, schistosomiasis and soil-transmitted helminthiasis through regular anthelmintic preventive chemotherapy	25/125 (2012)	100/125 (2020)

**Output 1.4.1. Implementation and monitoring of the WHO road map for neglected tropical diseases facilitated**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of disease-endemic countries adopting and implementing neglected tropical disease national plans in line with the road map to reduce the burden of priority neglected tropical diseases	40/125 (2013)	100/125 (2015)

**Country office deliverables**

- Provide technical support in developing and implementing the neglected tropical disease control, elimination and eradication policies, strategies and integrated plans of action at the country level
- Support the strengthening of national monitoring and evaluation to guide policy, implementation decisions and report on progress of national neglected tropical disease control and elimination
- Support countries in ensuring availability and access to quality-assured neglected tropical disease drugs at all levels of health care, including integration into essential medicines procurement, and by supporting resource mobilization
- Support strengthening of national capacity to scale up preventive chemotherapy, innovative and intensified disease management and integrated vector management interventions

**Regional office deliverables**

- Facilitate regional dialogue between governments, service providers, manufacturers and technical partners for the implementation of the road map at country level
- Coordinate regional programme review groups and meeting of programme managers to monitor progress and update national neglected tropical disease plans
- Support strengthening of capacity of countries in the region for monitoring and evaluation, particularly in surveillance, and use of operational research, certification/verification of selected neglected tropical disease elimination

**Headquarters deliverables**

- Develop tools and support capacity strengthening at regional and country level for implementing the action points in the WHO road map on neglected tropical diseases
- Coordinate certification of elimination/eradication in relevant countries
- Strengthen monitoring and evaluation and reporting, including developing neglected tropical disease database, and publication of the global neglected tropical disease report and statistics
- Conduct global advocacy for neglected tropical disease control, elimination and eradication, mobilize resources, and coordinate and monitor global procurement of donated and non-donated neglected tropical disease essential medicines

**Output 1.4.2. Implementation and monitoring of neglected tropical disease control interventions facilitated by evidence-based technical guidelines and technical support**

Output indicator	Baseline	Target
Number of disease-endemic countries that have adopted WHO norms, standards and evidence to implement neglected tropical disease diagnosis and treatment	20/125 (2013)	100/125 (2015)

**Country office deliverables**

- Provide technical support to countries in designing relevant clinical trials; adapt technical guidance for neglected tropical disease diagnosis, treatment, case management, transmission control and surveillance
- Provide technical support in the development or revision of national guidelines for mass drug administration for control and prevention of specific diseases (soil-transmitted helminth infections, small liver fluke), conducting quality assurance and pharmaco-vigilance

**Regional office deliverables**

- Adapt global guidelines towards improved prevention, case detection, case management and control of neglected tropical diseases in the regional context
- Harness support from WHO collaborating centres, research institutions and research networks in the region
- Complement country offices' capacity to support countries in developing or adapting guidelines, quality assurance systems and other specific areas of neglected tropical disease control, elimination/eradication
- Assist headquarters in developing technical guidelines with region-specific inputs on monitoring and evaluation of neglected tropical diseases intervention and vector control

**Headquarters deliverables**

- Update technical norms and standards on neglected tropical diseases at global level using expert committees and study groups
- Facilitate development of rapid and simple diagnostic tests for neglected tropical diseases (such as Buruli Ulcer, human African trypanosomiasis, leishmaniasis, Chagas disease, yaws, fascioliasis and dengue)

**Output 1.4.3. New knowledge, solutions and implementation strategies that respond to the health needs of disease-endemic countries developed through strengthened research and training**

Output indicator	Baseline	Target
Number of new and improved tools, solutions and implementation strategies developed and successfully applied in disease-endemic countries	Not applicable	8 (2015)

**Headquarters deliverables**

- Facilitate setting of research agenda on infectious diseases of poverty, and convene stakeholders to agree on recommendations and practices with input from key disease-endemic countries
- Develop high-quality intervention and implementation research evidence on infectious diseases of poverty with involvement of key disease-endemic countries; develop methods, solutions and strategies for effective treatment and control of neglected tropical diseases
- Support research capacity strengthening (individual and institutional) in disease-endemic countries, reflective of regional and country priorities

**VACCINE-PREVENTABLE DISEASES****Outcome 1.5. Increased vaccination coverage for hard-to-reach populations and communities**

Outcome indicators	Baseline	Target
Global average coverage with three doses of diphtheria, tetanus and pertussis vaccines	83% (2011)	≥ 90% (2015)
WHO regions that have achieved measles elimination	1 (2011)	4 (2015)
Proportion of the 75 countdown countries that have introduced pneumococcal, rotavirus or HPV vaccines and concurrently scaled up interventions to control pneumonia, diarrhoea or cervical cancer	0% (2013)	50% (2015)



**Output 1.5.1. Implementation and monitoring of the global vaccine action plan as part of the Decade of Vaccines Collaboration strengthened with emphasis on reaching the unvaccinated and under-vaccinated populations**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries with immunization coverage <70% that develop and implement strategies within their national immunization plans to reach unvaccinated and under-vaccinated populations	5/19 (2013)	7/19 (2015)

***Country office deliverables***

- Support countries to develop and implement national multi-year plans and annual implementation plans (including micro-planning for immunizations) with a focus on under-vaccinated and unvaccinated populations
- Support countries in mobilizing resources for vaccines and other related needs for the implementation of the vaccine action plan
- Support the strengthening of country capacity in surveillance and use of immunization data for programme monitoring and reporting

***Regional office deliverables***

- Coordinate regional vaccine-preventable disease surveillance, and develop/adapt strategies to improve quality and use of immunization monitoring data
- Support countries in establishing and implementing policies and strategies for ensuring the sustainability of immunization programmes
- Provide expertise to countries, where additional capacity is needed, to develop strategies to reach unvaccinated and under-vaccinated populations, and in introducing new vaccines

***Headquarters deliverables***

- Update guidance frameworks for development of national multi-year and annual plans and the associated monitoring framework for implementation of the global vaccine action plan; report on progress in implementation of the global plan annually
- Update policy recommendations and introduction guidelines for new and underutilized vaccines
- Establish global standards for vaccine-preventable disease surveillance and programme impact monitoring with key contributions from regional and country levels

**Output 1.5.2. Intensified implementation and monitoring of measles and rubella elimination, and hepatitis B control strategies facilitated**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of priority countries that have conducted supplementary immunization activities to achieve their measles elimination or control goal	0/68 (2013)	34/68 (2015)

***Country office deliverables***

- Support countries in developing and implementing national strategies for measles, rubella/congenital rubella syndrome, neonatal tetanus and hepatitis B elimination/control
- Support the strengthening of country capacity for measles and rubella/congenital rubella syndrome surveillance, including technical support to countries in attaining accreditation for their measles/rubella laboratory
- Support national verification committees on elimination and control of vaccine-preventable diseases

**Regional office deliverables**

- Review and update regional strategies for measles elimination, rubella/congenital rubella syndrome elimination/control and hepatitis B control; backstop country offices with their implementation
- Strengthen regional capacity in measles and rubella/congenital rubella syndrome case-based surveillance with laboratory confirmation, including coordination of regional measles/rubella laboratory network
- Facilitate establishment of and support regional bodies and processes for verification of measles and rubella/congenital rubella syndrome elimination and hepatitis B control

**Headquarters deliverables**

- Provide expertise where additional technical capacity is needed in implementing disease elimination/control and for verification of elimination/control
- Coordinate global measles and rubella laboratory network
- Monitor and report on global outcomes and trends in measles/rubella incidence and hepatitis B control

**Output 1.5.3. Target product profiles for new vaccines and other immunization-related technologies defined and research priorities to develop vaccines of public health importance and overcome barriers to immunization agreed**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of new preferred product characteristics for new vaccines and policy recommendations for their use	Not applicable	At least one

**Country office deliverables**

- Work with country stakeholders to define country needs for new vaccine products, related implementation research and data to inform decisions
- Support countries in determining needs for new vaccine products, and immunization-related technologies based on in-country dialogue and supported by country-level evidence

**Regional office deliverables**

- Coordinate vaccine-related demonstration/pilot studies for new vaccine introduction in the region
- Conduct systematic collection of evidence of vaccine performance and impacts in different settings/target groups for regionally-adapted vaccination policies
- Facilitate establishment of research priorities that are relevant to strengthening immunization programmes in the region

**Headquarters deliverables**

- Establish research priorities for immunization through building scientific consensus and track progress of implementation
- Provide the evidence base and recommendations for policy development including target product profiles for new vaccines and immunization-related technologies, e.g. malaria, dengue, influenza and typhoid vaccines
- Facilitate the development of clinical evaluation of specific priority vaccines

**BUDGET BY MAJOR OFFICE AND PROGRAMME AREA(US\$ MILLION)**

Programme area	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
HIV/AIDS	45.9	4.0	14.2	5.8	9.6	10.1	41.9	<b>131.5</b>
Tuberculosis	16.9	1.1	30.4	11.0	20.9	14.4	36.2	<b>130.9</b>
Malaria	21.3	0.5	13.4	1.1	13.8	12.6	28.9	<b>91.6</b>
Neglected tropical diseases	19.4	4.6	8.6	0.4	6.3	8.3	43.7	<b>91.3</b>
<i>* Tropical disease research</i>	–	–	–	–	–	–	48.7	<b>48.7</b>
Vaccine-preventable diseases	163.2	9.3	40.8	12.3	39.3	26.1	55.8	<b>346.8</b>
<b>Subtotal</b>	<b>266.7</b>	<b>19.5</b>	<b>107.4</b>	<b>30.6</b>	<b>89.9</b>	<b>71.5</b>	<b>255.2</b>	<b>840.8</b>

## CATEGORY 2. NONCOMMUNICABLE DISEASES

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***Reducing the burden of noncommunicable diseases, including cardiovascular diseases, cancers, chronic lung diseases, diabetes, and mental disorders, as well as disability, violence and injuries, through health promotion and risk reduction, prevention, treatment and monitoring of noncommunicable diseases and their risk factors.***

This category covers the four primary noncommunicable diseases (cardiovascular disease, cancers, chronic lung disease and diabetes) and their major risk factors (tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol), mental disorders and disabilities as well as the consequences of violence, injuries, substance abuse and poor nutrition.

### NONCOMMUNICABLE DISEASES

Of the 57 million deaths that occurred globally in 2008, 36 million – almost two thirds – were due to noncommunicable diseases, comprising mainly cardiovascular diseases, cancers, diabetes and chronic lung diseases. Nearly 80% of deaths from these diseases occur in low- and middle-income countries. Noncommunicable diseases have recently become a prominent part of the global health agenda. Success will require coordinated, multisectoral action at global, regional, national and local levels. Member States emphasized WHO's leadership role in this task in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases in September 2011 in which WHO was requested to: develop a comprehensive global monitoring framework and recommendations for a set of voluntary global targets; articulate policy options for strengthening and facilitating multisectoral action, including through effective partnership; and exercise leadership and a coordinating role in promoting global action in relation to the work of United Nations funds, programmes and agencies.

The Secretariat will provide support for enhancing the capacity of national surveillance systems and for standardizing data collection tools to monitor exposure to noncommunicable disease risk factors, noncommunicable disease-specific mortality and morbidity, and the health system response to these diseases. Building on the WHO Framework Convention on Tobacco Control and the global strategy to reduce the harmful use of alcohol, the Secretariat will support countries in developing and implementing effective public health measures to tackle important risk factors, decreasing tobacco consumption and reducing the harmful use of alcohol. WHO will also support countries that are attacked through legal actions brought by the tobacco industry.

In the biennium 2014–2015, WHO will ensure that provision of health care for chronic diseases is dealt with in the context of overall health system strengthening, including appropriate policies, trained human resources, adequate access to essential medicines and basic technologies, standards for primary health care, and well-functioning referral mechanisms. More specifically, WHO will focus on working with countries to reduce the social and economic impact of noncommunicable diseases by: implementing evidence-based approaches, including “best buy” and cost-effective interventions to address noncommunicable diseases and their risk factors and social determinants; by adapting policy recommendations for early detection, diagnosis and disease management to national contexts; and by adapting the global monitoring framework on noncommunicable diseases to national contexts, including agreed global indicators and voluntary global targets. Country capacity for surveillance and monitoring of noncommunicable diseases will be strengthened to support this effort. Steps will also be taken to promote the use of immunization in the prevention of certain cancers.

## MENTAL HEALTH AND SUBSTANCE ABUSE

In 2002, 154 million people suffered from depression globally, 25 million people from schizophrenia and over 100 million people from alcohol or drug abuse disorders. Close to 900 000 people die from committing suicide each year. Current evidence indicates that eight priority mental health conditions make the largest contribution to overall morbidity in the majority of developing countries: depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to use of illicit drugs, and mental disorders in children. Mental health conditions can be tackled through the provision of good-quality treatment and care; however, relatively little attention has been devoted to the provision of adequate care and treatment in low-income settings.

In the biennium 2014–2015, work will focus on the major determinants and causes of morbidity, particularly dementia, alcohol and drug use disorders, autism and other development disorders, bipolar disorders and mental health conditions of children, including strategies for preventing suicide in young people. Work will strengthen country capacity to provide responsive treatment and care and social welfare in community-based services. Protecting and promoting the human rights of people with mental health conditions from human rights violations and gender-based discrimination is equally critical. Technology can change the way that health care is provided for all noncommunicable diseases; however, it is particularly relevant for people with mental, neurological and substance use disorders, especially elderly people with dementia (see also ageing and health).

## VIOLENCE AND INJURIES

Each year, over five million people die as a result of violence and unintentional injuries. Road traffic crashes account for one quarter of these deaths, with children, pedestrians, cyclists and the elderly among the most vulnerable of road users. Another quarter of these deaths are due to suicide and homicide. For every person who dies due to violence many more are injured and suffer from a range of physical, sexual, reproductive and mental health problems. Falls, drowning, burns and poisoning are also significant causes of death and disability. In May 2011, in resolution 64/255, the United Nations General Assembly proclaimed the period 2011–2020 as the Decade of Action for Road Safety with a goal to stabilize and then reduce the forecast level of road traffic fatalities around the world by 2020, saving five million lives.

In the biennium 2014–2015, the Secretariat will continue to raise the profile of the preventability of violence and unintentional injuries. Work will focus on: strengthening the evidence regarding policies, programmes, and laws that are effective in addressing the underlying causes of violence, road traffic injuries, drowning, and other unintentional injuries; supporting selected Member States in implementing such policies, programmes and laws; and supporting sustainable improvements in the care of the injured through the WHO Global Alliance for the Care of the Injured.

## DISABILITIES AND REHABILITATION

The first-ever *World report on disability*<sup>1</sup> reveals that of the more-than one billion people in the world who are disabled, 110–190 million encounter significant difficulties in their daily lives. A lack of attention to their needs means that they are confronted with numerous barriers. These include stigma and discrimination; lack of adequate health care and rehabilitation services; and lack of access to transport, buildings and information.

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<sup>1</sup> World Health Organization and World Bank. *World report on disability*. Geneva, World Health Organization, 2011.

In 2014–2015, the Secretariat will work with governments and their partners to: facilitate access for people with disabilities to services; invest in programming to meet specific identified needs of people with disabilities; and adopt a national disability strategy and plan of action. Importantly, people with disabilities should be consulted and involved in the design and implementation of these initiatives. Particular attention will be given to supporting the development of national eye health policies, plans and programmes, and strengthening service delivery as part of wider health system capacity building in developing countries, where 80% of the world's visually impaired live. The elimination of onchocerciasis and blinding trachoma will also remain a priority.

#### **NUTRITION**

Underweight and obesity are both among the top 10 leading risk factors for the global burden of disease. Malnutrition has been responsible, directly or indirectly, for 60% of the 10.9 million deaths annually among children under five years of age. Nutrition is an important determinant of health outcomes in relation to communicable and noncommunicable diseases. Preventing undernutrition and overweight is central to the achievement of global development goals. Essential nutrition interventions need to be integrated into primary care services. Global nutrition targets have been agreed for the reduction of childhood stunting, wasting, low birth weight and overweight and women's anaemia and for the improvement of exclusive breastfeeding rates.

In the biennium 2014–2015, support to countries will include developing and updating the evidence base for effective nutrition interventions; monitoring progress towards the achievement of the global targets and the implementation of agreed programmes; and providing the necessary practical knowledge and capacities required to scale up actions.

#### **LINKAGES WITH OTHER PROGRAMMES AND PARTNERS**

The five priority areas within the noncommunicable diseases category have linkages with all other categories in the proposed programme budget for 2014–2015. Communicable diseases, including vaccine-preventable diseases are, for example, an important cause of some cancers and there are strong linkages between tuberculosis, HIV/AIDS and mental health. Unhealthy environments and behaviours in the newborn, child and adolescent stages of life affect all the priority areas of this category. These include tobacco use and the harmful use of alcohol, and the risks of violence and injuries. Preventing undernutrition and overweight is central to the promotion of health through the life-course. Responding to the social determinants of health and reducing poverty are critical for all programme areas in this category. The promotion of healthy living and working environments is important, for example, in improving road safety, and preventing burns and drowning.

Health systems based on primary care that support universal health coverage are important in preventing and controlling the major noncommunicable diseases and their risk factors, together with the other noncommunicable conditions that are covered under the five programme areas in this category. There will be close collaboration with health system information and evidence to improve WHO's cardiovascular and cancer estimates as well as those for injury- and violence-related mortality and disability, and to lessen the impact of conditions that affect mental health and substance abuse. The increasing number of people in the world with noncommunicable diseases and mental health conditions means that care for these populations is increasingly important in planning for, and responding to, emergencies and disasters. Violence and injuries rise in emergency settings and undernutrition is a common consequence of humanitarian disasters.

The 2011 Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, the resolutions adopted by the United Nations General Assembly on improving global road safety in 2005 and 2010,<sup>1</sup> and the comprehensive implementation plan on maternal, infant and young child nutrition endorsed by the Health Assembly in 2012,<sup>2</sup> all highlight the importance of WHO working with the United Nations, civil society and private sector partners. WHO is collaborating with ITU, UNICEF, UNDP, UNFPA, UNODC, UNAIDS, and other United Nations agencies to scale up joint programming for noncommunicable diseases at global, regional and national levels in order to support national policy and planning, stronger and more integrated health systems, and access to new technologies. United Nations country teams will be encouraged to include noncommunicable diseases in United Nations Development Assistance Frameworks in order to support this effort. Initial steps will also be taken to explore the growing potential of immunization in the prevention of cancers. WHO will continue to chair the United Nations Ad Hoc Interagency Task Force on Tobacco Control and to host the global coordinating mechanism for nutrition (the United Nations Standing Committee on Nutrition), which promotes cooperation among United Nations agencies and partner organizations in support of global efforts to end malnutrition.

The United Nations Road Safety Collaboration supports a number of global networks, including a network of young road safety advocates, a network of nongovernmental organizations and a network of private companies. WHO's Mental Health Gap Action Programme (mhGAP) brings partners together to scale up services for mental, neurological and substance use disorders, with an emphasis on low- and middle-income countries. Through the comprehensive implementation plan on maternal, infant and young child nutrition, the Secretariat is engaging closely with various partners. Work with the Bloomberg Philanthropies and the Bill & Melinda Gates Foundation is supporting Member States in the reduction of tobacco use among their populations. WHO is an active member of the Scaling Up Nutrition movement, bringing together high-level representatives from Member States, donors, the United Nations and civil society. WHO works with a number of nongovernmental organizations to improve eye health. WHO collaborating centres also enable the Organization to respond to the challenge of reducing the disease burden in all priority areas of this category and delivering the outputs described below.

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<sup>1</sup> United Nations General Assembly resolutions 60/5 and 64/255.

<sup>2</sup> Resolution WHA65.6.

**NONCOMMUNICABLE DISEASES****Outcome 2.1. Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors**

<b>Outcome indicators</b>	<b>Target</b>
At least a 10% relative reduction in the harmful use of alcohol, <sup>1</sup> as appropriate, within the national context	10% reduction by 2025
A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years	30% reduction by 2025
A 10% relative reduction in prevalence of insufficient physical activity	10% reduction by 2025
A 25% relative reduction in the prevalence of raised blood pressure, or contain the prevalence of raised blood pressure, according to national circumstances	25% reduction by 2025
Halt in the rise in diabetes and obesity	TBD
At least 50% of eligible people receiving drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes	At least 50% coverage (2025)
A 30% relative reduction in mean population intake of salt/sodium <sup>2</sup>	30% reduction by 2025
An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities	At least 80% coverage (2025)

**Output 2.1.1. Development of national multisectoral policies and plans for implementing interventions to prevent and control noncommunicable diseases facilitated**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries that that have established national multisectoral action plans for the prevention and control of noncommunicable diseases	80/194 (2011)	115/194 (2015)

**Country office deliverables**

- Provide technical support to develop and implement country-led national multisectoral plans in line with the WHO global action plan for the prevention and control of noncommunicable diseases (2013–2020)
- Convene and coordinate multisectoral dialogues and policy development on the implementation of core noncommunicable disease interventions based on evidence generated at country level

**Regional office deliverables**

- Develop regional policy frameworks as appropriate, taking into account the action plans, global frameworks and strategies, and legal instruments related to noncommunicable diseases and their modifiable risk factors

<sup>1</sup> In WHO's global strategy to reduce the harmful use of alcohol, the concept of the harmful use of alcohol encompasses drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large, as well as the patterns of drinking that are associated with increased risk of adverse health outcomes.

<sup>2</sup> WHO's recommendation is an intake of less than 5 grams of salt or 2 grams of sodium per person per day.



- Complement country office capacity to provide technical support in implementation of the global action plan for the prevention and control of noncommunicable diseases
- Support knowledge networks at the regional level to provide a platform for dialogue and sharing best practices and results of operational research on noncommunicable diseases

#### **Headquarters deliverables**

- Conduct a review of international experience in the prevention and control of noncommunicable diseases, including successful approaches for multisectoral action and identify and disseminate lessons learnt
- Develop a technical assistance toolkit to support Member States in translating the recommended actions included in the global action plan for the prevention and control of noncommunicable diseases into concrete results
- Convene a global consultation and develop guidelines for prioritizing national research agendas for the implementation of cost-effective interventions for noncommunicable disease prevention and control

#### **Output 2.1.2. High-level priority given to the prevention and control of noncommunicable diseases in national health planning processes and development agendas**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries that have integrated work on noncommunicable diseases into their United Nations Development Assistance Framework	Indicator data being collected through the noncommunicable disease country capacity survey in April 2013	To be confirmed once baseline is established

#### **Country office deliverables**

- Raise awareness, especially among policy-makers about the links between noncommunicable diseases and sustainable development; support countries in integrating noncommunicable diseases into health planning processes and national development agendas
- Integrate noncommunicable diseases into United Nations Development Assistance Frameworks and other joint programmes such as the WHO/ITU mHealth initiative to combat noncommunicable diseases
- Support countries in meeting applicable legal obligations under international law related to noncommunicable diseases, such as the WHO Framework Convention on Tobacco Control
- Support the development of innovative approaches to financing noncommunicable disease prevention and control plans with support from regional offices and headquarters

#### **Regional office deliverables**

- Support advocacy for noncommunicable disease prevention and control by engaging regional networks and regional governance mechanisms to promote such prevention and control in their action plans
- Train heads of WHO Offices in countries, territories and areas to integrate noncommunicable diseases into WHO country cooperation strategies, United Nations Development Assistance Frameworks, and other instruments, and support them in doing so

**Headquarters deliverables**

- Support efforts to integrate noncommunicable diseases into the global governing bodies of United Nations Agencies and global health initiatives
- Advocate for high-level political commitment to the prevention and control of noncommunicable diseases, including during global consultations on the post-2015 development agenda
- Establish mechanisms to implement the specific recommendations of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases
- Develop training materials on the training of heads of WHO Offices in countries, territories and areas on integration of noncommunicable diseases into existing country strategic planning

**Output 2.1.3. Monitoring framework implemented to report on progress in realizing the commitments made in the Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and the global action plan for the prevention and control of noncommunicable diseases (2013–2020)**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries reporting on the 9 voluntary targets	27/194 (2013)	51/194 (2015)

**Country office deliverables**

- Support the development and adoption of national targets and indicators for noncommunicable disease prevention and control; coordinate inclusion of key indicators into national health information systems; support countries in monitoring, including mortality and risk factor exposure
- Support strengthening of capacity for surveillance of risk factors and in monitoring and evaluating noncommunicable disease programmes, in line with global standards

**Regional office deliverables**

- Monitor and evaluate regional health situation in terms of noncommunicable diseases and their risk factors and related trends, including by development of regional databases, and analysis and publication of data
- Support country offices in adapting tools and instruments for monitoring mortality, risk factor exposure and health systems capacity to respond to disease burden, including implementation and dissemination of relevant surveys

**Headquarters deliverables**

- Develop technical guidelines on strengthening of countries' capacity for surveillance and monitoring of the noncommunicable disease burden
- Monitor implementation of cost-effective interventions for prevention of noncommunicable diseases globally, including by rolling out a global country capacity survey to assess the capacity of countries to respond to noncommunicable diseases in 2015
- Prepare global status reports on noncommunicable diseases in order to inform policy-makers of the status of global action required to address such diseases and develop appropriate policies
- Expand existing global information systems to handle new information on subjects such as national noncommunicable disease policies and plans

**MENTAL HEALTH AND SUBSTANCE ABUSE****Outcome 2.2. Increased access to services for mental health and substance use disorders**

<b>Outcome indicators</b>	<b>Baseline</b>	<b>Target</b>
Proportion of persons with a severe mental disorder (psychosis; bipolar affective disorder; moderate-severe depression) who are using services	TBD (under development)	20% increase (by 2020)
Suicide rate per year per 100 000 population	TBD (under development)	10% reduction (by 2020)

**Output 2.2.1. Countries' capacity to develop and implement national policies and plans in line with the 2013–2020 global mental health action plan strengthened**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries with a national policy and/or plan for mental health that is in line with the 2013–2020 global mental health action plan	60/194 (2013)	70/194 (2015)

**Country office deliverables**

- Work with partners to support the development and implementation of national mental health policies, laws and regulations and plans in line with regional and global mental health action plans and with human rights standards
- Support the collection, analysis, dissemination and use of data on national magnitude, trends, consequences and risk factors of mental and neurological disorders; support countries in strengthening evidence and research to guide policy development and planning

**Regional office deliverables**

- Coordinate the implementation of regional plans based on adaptation of the global mental health action plan
- Collect, analyse and report regional data following a core set of global mental and neurological health indicators

**Headquarters deliverables**

- Provide guidance on implementing a core set of indicators for monitoring mental health situation in countries and publish a biennial assessment on progress towards implementation of the 2013–2020 global mental health action plan
- Provide guidance and tools for mental health-related policies, laws, resource planning and stakeholder collaboration

**Output 2.2.2. Mental health promotion, prevention, treatment and recovery services improved through advocacy, better guidance and tools on integrated mental health services**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries with functioning programmes for intersectoral mental health promotion and prevention	70/194 (2013)	90/194 (2015)

**Country office deliverables**

- Support organization of mental health and social care services and their integration into primary care
- Promote and support implementation of mental health guidelines covering treatment, recovery, prevention and promotion

**Regional office deliverables**

- Compile and disseminate regional evidence on the (cost-) effectiveness of interventions for treatment, recovery, promotion and prevention
- Implement regional strategies to strengthen delivery of mental health programmes

**Headquarters deliverables**

- Develop and disseminate expanded guidance and tools for service organization and the provision of an integrated and responsive health and social care in community settings, including interventions for mental and neurological disorders
- Develop and disseminate guidance and tools for coordinating multisectoral strategies for promotion and prevention in the areas of mental health
- Develop and disseminate guidance and tools for suicide prevention

**Output 2.2.3. Expansion and strengthening of country strategies, systems and interventions for disorders due to alcohol and substance use enabled**

Output indicator	Baseline	Target
Number of countries with prevention and treatment strategies, systems and interventions for substance use disorders and associated conditions	60/194 (2013)	70/194 (2015)

**Country office deliverables**

- Support countries in adapting and implementing WHO strategies, action plans, guidelines and other technical tools on reducing the harmful use of alcohol, and on the prevention and treatment of substance use disorders

**Regional office deliverables**

- Facilitate networks for exchange of experiences and practices and develop regional actions plans in line with the global strategy to reduce the harmful use of alcohol
- Coordinate the implementation of regional action plans aimed at prevention and treatment of substance use and substance use disorders

**Headquarters deliverables**

- Develop and disseminate guidelines and other technical tools to strengthen health services' response to alcohol use disorders in support of implementation of the global strategy to reduce the harmful use of alcohol
- Facilitate and strengthen public health aspects of policy dialogues and international efforts addressing substance abuse, such as dialogue with UNODC
- Develop and disseminate guidelines, treatment and research protocols and other technical tools to strengthen prevention and treatment strategies, systems and other interventions for disorders due to alcohol and drug use

**VIOLENCE AND INJURIES****Outcome 2.3. Reduced risk factors for violence and injuries with a focus on road safety, child injuries, and violence against children, women and youth**

<b>Outcome indicators</b>	<b>Baseline</b>	<b>Target</b>
Global indicator(s) on reduction of risk factors on road safety to be developed as part of the Decade of Action for Road Safety (2011–2020)		

**Output 2.3.1. Development and implementation multisectoral plans and programmes to prevent injuries, with a focus on achieving the targets set under the Decade of Action for Road Safety (2011–2020)**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Percentage of countries with comprehensive laws tackling five key risk factors for road safety	15% (2013)	20% (2015)

**Country office deliverables**

- Coordinate the strengthening of country capacity to develop national model programmes that focus on achieving the targets set under the Decade of Action for Road Safety (2011–2020)
- Convene policy dialogue at country level to promote multisectoral collaboration in developing and implementing policies and programmes on road safety
- Support the identification, assessment and compilation of evidence base and best practices for quality and safety improvement in trauma care

**Regional office deliverables**

- Consolidate the validated regional results of monitoring the Decade of Action for Road Safety, and coordinate with international regional agencies
- Develop a regional strategy for prevention, trauma care and data collection, based on regional and global commitments

**Headquarters deliverables**

- Support the organization of the Second Global Ministerial Conference on Road Safety; and coordinate global initiatives on road safety and injury prevention including the United Nations Global Road Safety Collaboration, the secretariat for the Decade of Action for Road Safety, and the Global Alliance for the Care of the Injured
- Publish the third global status report on road safety as a tool for monitoring the Decade of Action for Road Safety
- Review and compile evidence and best practices for quality and safety improvement in trauma care

**Output 2.3.2. Countries and partners enabled to develop and implement programmes and plans to prevent child injuries**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries implementing policies addressing the prevention of at least one mechanism of child injuries consistent with WHO guidance	Baseline survey under development in 2013	To be confirmed once baseline is established

**PROPOSED PROGRAMME BUDGET 2014–2015*****Country office deliverables***

- Provision of technical support to countries to develop plans to prevent child injuries that are consistent with WHO guidance
- Convene partners at the country level to promote public policies that prevent child injuries

***Regional office deliverables***

- Support intercountry capacity building on the prevention of child injuries, including facilitating the convening of regional training workshops
- Advocate for the integration of child injury and violence prevention into maternal and child health programmes

***Headquarters deliverables***

- Establish and coordinate a global network of partners to increase the global visibility of child injury
- Publish a global report on drowning with key contributions from regional and country levels

**Output 2.3.3. Development and implementation of policies and programmes to address violence against women, youth and children facilitated**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries that have submitted a complete assessment of their national violence prevention status to WHO	60/194 (2013)	120/194 (2015)

***Country office deliverables***

- Strengthen country capacity to develop and implement programmes that address violence against children, women and youth, and monitor their implementation

***Regional office deliverables***

- Conduct regional or intercountry training workshops for countries on policy and programme development and monitoring
- Produce regional fact sheets on violence prevention

***Headquarters deliverables***

- Formulate normative guidance and training materials on violence prevention
- Convene partners of the Violence Prevention Alliance and strengthen activities undertaken by the Alliance
- Publish a global progress report on violence prevention

**DISABILITIES AND REHABILITATION****Outcome 2.4. Increased access to services for people with disabilities**

<b>Outcome indicators</b>	<b>Baseline</b>	<b>Target</b>
Global indicator(s) on increased access to services for people with disabilities to be developed as part of the global plan of action on disability		

**Output 2.4.1. Implementation of the recommendations of the *World report on disability* and the High-level Meeting of the General Assembly on Disability and Development**

Output indicator	Baseline	Target
Number of countries that have comprehensive policies on health and rehabilitation	7/130 (2012)	31/130 (2020)

***Country office deliverables***

- Support countries in developing national policies and implementation of community-based rehabilitation in line with WHO, ILO, UNESCO and International Disability and Development Consortium guidelines on community-based rehabilitation, and regional community-based rehabilitation action plans
- Support countries in strengthening rehabilitation services, including assistive technologies, such as wheelchairs
- Support countries in the collection, analysis, dissemination and use of national disability data for policy, programming and monitoring

***Regional office deliverables***

- Identify and support pilot countries for implementing the model disability survey
- Support regional community-based rehabilitation congresses to collect and share best practices

***Headquarters deliverables***

- Convene stakeholders and pursue the agreement on the global plan of action on disability
- Provide policy and technical guidance on strengthening health and rehabilitation services for people with disabilities; develop guidelines on monitoring and evaluating community-based rehabilitation
- Develop model disability survey questionnaire and manual

**Output 2.4.2. Countries are able to strengthen the provision of services to reduce disability due to visual impairment and hearing loss through more effective policies and integrated services**

Output indicator	Baseline	Target
Number of countries implementing eye and ear health promoting policies and services that are in line with WHO recommendations	96/194 (2013)	117/194 (2015)

***Country office deliverables***

- Provide support to countries to develop, implement and monitor national eye- and ear-health plans, including integration with other health services, such as linkages with noncommunicable diseases
- Support countries to collect information on indicators within national health information systems

***Regional office deliverables***

- Promote data collection and inclusion of indicators and targets into national health information systems; compile eye- and ear-health data at regional level to be used for advocacy purposes

***Headquarters deliverables***

- Participate in and lead global partnerships and alliances for eye and ear health, including trachoma and onchocerciasis elimination
- Develop standardized approach to the collection, analysis and dissemination of information on eye and ear health

**NUTRITION****Outcome 2.5. Reduced nutritional risk factors**

<b>Outcome indicators</b>	<b>Baseline</b>	<b>Target</b>
Number of stunted children below five years of age	165 million (2011)	102 million (2025)
Proportion of women of reproductive age (15–49 years) with anaemia	30% (2014)	15% (2025)

**Output 2.5.1. Countries enabled to develop, implement and monitor action plans based on the maternal, infant and young child nutrition comprehensive implementation plan**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries that are implementing national action plans consistent with the comprehensive implementation plan on maternal, infant and young child nutrition	Currently being developed	To be confirmed once baseline is established

**Country office deliverables**

- Support countries in developing and monitoring national action plans on maternal, infant and young child nutrition, in line with the comprehensive implementation plan on maternal, infant and young child nutrition
- Mobilize commitment to achieve national goals for food and nutrition security; support countries in adopting international norms and standards and evidence-based interventions
- Provide technical support in strengthening synergies between nutrition and other programmes, in order to enhance efforts to meet the needs of countries on food and nutrition security

**Regional office deliverables**

- Develop regional action plans on maternal, infant and young child nutrition
- Provide expertise at country level in specialized areas, such as adoption of legal instruments that ensure national application of international norms and standards and evidence-based interventions
- Support national efforts on food security and nutrition through advocacy at regional level
- Promote interagency and multisectoral coordination in food security and nutrition initiatives at regional level, and catalyse partnerships by linking with stakeholders especially from non-health sectors at the regional level
- Develop and strengthen regional food and nutrition security information systems

**Headquarters deliverables**

- Contribute to the development of the post-2015 global nutrition agenda through the International Conference on Nutrition, the Committee on World Food Security and other global forums
- Facilitate the global interagency dialogue in the United Nations Standing Committee on Nutrition, the Renewed Efforts Against Child Hunger initiative, the Scaling Up Nutrition Movement, and the Secretary-General's High-Level Task Force on the Global Food Security Crisis
- Develop guidelines and tools that will help countries implement legal instruments (e.g. the International Code of Marketing of Breast-milk Substitutes, marketing of complementary foods)
- Develop models for strengthening nutrition surveillance; develop a global report on progress towards achieving the global nutrition targets



**Output 2.5.2. Norms and standards on maternal, infant and young child nutrition, population dietary goals, and breastfeeding updated, and policy options for effective nutrition actions for stunting, wasting and anaemia developed**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries adopting, where appropriate, guidelines on effective nutrition actions for stunting, wasting and anaemia	Currently being determined	To be confirmed once baseline is established

**Country office deliverables**

- Support the development, adaptation and updating of national guidelines on nutrition, based on the updated global norms and standards and guidelines (e.g. food-based dietary guidelines, guidelines on micronutrient supplementation and fortification)
- Support countries in implementing effective interventions for different issues and situations, delivery of services at primary levels (including promotion of healthy infant feeding, management and treatment of severe cases of malnutrition and others)
- Strengthen human resource capacity at country level on nutrition, including supporting training programmes for health and education staff, extension and community workers

**Regional office deliverables**

- Provide intercountry support to translate global and regional guidance into effective interventions to promote nutrition
- Provide expertise in countries, where additional capacity is needed in special areas, such as legislation, standards and specifications on food labelling and fortification of food with micronutrients
- Introduce innovative approaches for application of food standards and WHO guidelines

**Headquarters deliverables**

- Update technical norms and standards, and guidelines on population dietary goals
- Provide technical guidance and scientific advice on nutrition and food labelling to contribute to the Codex Alimentarius
- Develop policy options and strategies on effective and evidence-based nutrition actions to address stunting, wasting, anaemia and childhood obesity

**BUDGET BY MAJOR OFFICE AND PROGRAMME AREA(US\$ MILLION)**

<b>Programme area</b>	<b>Africa</b>	<b>The Americas</b>	<b>South-East Asia</b>	<b>Europe</b>	<b>Eastern Mediterranean</b>	<b>Western Pacific</b>	<b>Headquarters</b>	<b>Total</b>
Noncommunicable diseases	48.0	13.2	15.9	16.4	16.3	28.2	54.1	<b>192.1</b>
Mental health and substance abuse	2.3	2.6	1.4	7.2	2.8	4.3	18.6	<b>39.2</b>
Violence and injuries	1.4	2.2	0.9	6.7	1.0	4.2	14.7	<b>31.1</b>
Disabilities and rehabilitations	0.9	0.9	0.6	0.5	0.4	2.3	9.9	<b>15.5</b>
Nutrition	3.9	2.8	3.0	2.0	3.0	3.1	22.2	<b>40.0</b>
<b>Subtotal</b>	<b>56.5</b>	<b>21.7</b>	<b>21.8</b>	<b>32.8</b>	<b>23.5</b>	<b>42.1</b>	<b>119.5</b>	<b>317.9</b>

### CATEGORY 3. PROMOTING HEALTH THROUGH THE LIFE-COURSE

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***Promoting good health at key stages of life, taking into account the need to address social determinants of health (the societal conditions in which people are born, grow, live, work and age) and gender, equity and human rights.***

This category brings together strategies for promoting health and well-being from conception to old age. It is concerned with health as an outcome of all policies and with health in relation to the environment, and includes leadership and capacity building on the social determinants of health, gender and human rights, and mainstreaming of these programme areas across the Organization.

The category is by its nature cross-cutting. It addresses population health needs with a special focus on key stages in life. This approach enables the development of integrated strategies that are responsive to evolving needs, changing demographics, epidemiological, social, cultural, environmental and behavioural factors, and widening health and gender inequities. The life-course approach considers how multiple determinants interact and affect health throughout life and across generations. Health is considered as a dynamic continuum rather than a series of isolated health states. The approach highlights the importance of transitions, linking each stage to the next, defining protective risk factors, and prioritizing investment in health care and social determinants. Moreover, the work undertaken in this category contributes to the achievement of internationally agreed goals such as Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health).

#### REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH

Each day about 800 women die from pregnancy- or childbirth-related events. Each year 6.9 million children die before their fifth birthday, more than 40% of them during their first four weeks of life. Effective interventions exist for improving health and reducing maternal, neonatal and child mortality. The challenges are to implement and expand those interventions, making them accessible for all during pregnancy, childbirth and the early years of life, and ensuring the quality of care. For mothers and newborn infants, the first 24 hours are critical because half of maternal deaths, one third of neonatal deaths and one third of stillbirths, as well as most of the complications that can lead to death of the mother or the newborn infant, occur in the 24 hours around delivery. It is also within this same period that the most effective interventions to save the lives of mothers and babies can be delivered: management of labour, administration of oxytocin after delivery, resuscitation of the neonate and early initiation of breastfeeding. Work in this area has high-level commitment as a result of its inclusion in Millennium Development Goals 4 and 5, and the establishment of the Commission on Information and Accountability for Women's and Children's Health.

In the biennium 2014–2015, the Secretariat will continue to work on promoting effective interventions that already exist to reduce under-five mortality rates in developing countries to levels approaching those in wealthier countries, and to reduce disparities between the poorest and wealthiest children within nations, with particular attention being given to treatment of pneumonia and diarrhoea, linkages to early child development, and effective coordination with related programmes for vaccine-preventable diseases.

For adolescents, the work will focus both on their sexual and reproductive health needs and health risk behaviours, given that many behaviours that start in adolescence affect health in later life. Family planning can prevent up to one third of maternal deaths, but in 2012 more than 200 million women – of whom a significant number were adolescents – had unmet needs for contraception.

Adolescent sexual and reproductive health will continue to be a focus for research. A consultative exercise is currently under way to determine priorities in this regard.

#### **AGEING AND HEALTH**

Between 2000 and 2050, the number of people aged 60 years and over is expected to increase from 605 million to 2 billion. Population ageing is a global phenomenon that will change society in many ways creating both challenges and opportunities. Healthy ageing is integral to the work in this category. In the biennium 2014–2015, the Secretariat will give new emphasis to the health of older people, with particular attention to maintaining independence and end-of-life care. Strong links with programmes on noncommunicable diseases, hearing and visual disabilities and mental health, as well as those on health systems and technical innovation, will reduce costs, simplify care, help to maintain independence and support disability.

#### **GENDER, EQUITY AND HUMAN RIGHTS MAINSTREAMING**

Discrimination on the basis of their sex leads to many health hazards for women, including physical and sexual violence, sexually transmitted infections, HIV/AIDS, malaria and chronic obstructive pulmonary disease. Institutional mainstreaming of gender, equity and human rights at all levels of the Organization aims to create structural mechanisms that enable programmatic mainstreaming to succeed, and to support countries realizing gender equality, health equity and the right to health for all. It will include effective integration of gender, equity and human rights in the analysis and actions of programmes, and putting in place institutional and accountability mechanisms to ensure sustainability. WHO will also report regularly on the indicators linked to the United Nations system-wide action plan on gender equality and women's empowerment.

#### **SOCIAL DETERMINANTS OF HEALTH**

The bulk of the global burden of disease and the major causes of health inequities arise from the conditions in which people are born, grow, live, work, and age. The social determinants of health are therefore significant in all areas of WHO's work. Health determinants and the promotion of health equity will be the subject of continued emphasis throughout 2014–2015, in each of the five categories. In addition, capacity building for mainstreaming the social determinants of health approach in the work of the Secretariat and of Member States will continue. Tools are needed, such as guidelines to implement health-in-all-policies and to build greater awareness of the value added by the social determinants approach; and a standard set of indicators to monitor action on social determinants of health. In addition, work is needed to implement and monitor the joint workplan with other organizations in the United Nations system on this subject.

Finally, as articulated in the Rio Political Declaration on Social Determinants of Health, the Secretariat will focus on the need for better governance of the growing number of actors present in the health sector, an area generally referred to as "health governance". The social determinants approach to health promotes governance in other sectors in ways that positively affect human health. Global governance for health has become increasingly prominent through the efforts of the Foreign Policy and Global Health initiative.

#### **HEALTH AND THE ENVIRONMENT**

Environmental determinants of health are responsible for about one quarter of the global burden of disease and an estimated 13 million deaths each year. Those mainly affected are poor women and children who live and work in the world's most polluted and fragile ecosystems and whose health is

at risk from diverse factors such as chemicals, radiation, lack of safe water and sanitation, air pollution and climate change.

Work in 2014–2015 will aim to further increase the recognition of how public health is affected by policies in sectors outside health such as transport, energy, urban planning and employment (through occupational health) and to work through those sectors to achieve improved health. The Secretariat will also continue to work with countries and partners on tackling a broad range of environmental risks to health, including the longer-term threats posed by climate change, loss of biodiversity, scarcity of water and other natural resources, and pollution.

#### **LINKAGES WITH OTHER PROGRAMMES AND PARTNERS**

The category has many linkages with other WHO programmes, such as those on communicable diseases, vaccines, nutrition, integrated people-centred health services for reducing maternal and child mortality and morbidity, as well as with programmes dealing with risk behaviours in adolescence and noncommunicable diseases in adults. The Secretariat's response to the health needs of older populations is multifaceted and involves all parts of the Organization. Particularly important will be close collaboration with programmes on noncommunicable disease and mental disorders in older people and older people's access to health care and long-term care. Equally important is the link with efforts to ensure the health of women, children and the elderly during emergency situations.

Additionally, by its very nature, work on this category – namely, efforts in support of health across the life-course and cross-cutting issues such as the social determinants of health, health and the environment, and the Organization-wide mainstreaming of gender, equity and human rights – contributes to, and benefits from, work on all the other categories. The category will serve as the hub of efforts to ensure that technical work in these cross-cutting areas is mainstreamed in all of WHO's programmes.

The work will be undertaken in the context of the Secretary-General's Global Strategy for Women's and Children's Health, under the framework of the Every Woman Every Child movement, with WHO's partners such as the other H4+ agencies (UNAIDS, UNFPA, UNICEF, UN Women and the World Bank) and those of the Partnership for Maternal, Newborn and Child Health, as well as other United Nations bodies, such as UNDP and the United Nations Population Division, academic and research institutions, civil society, and development partners. The work will also be undertaken in the context of the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, as well as with the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the GAVI Alliance, in order to ensure complementarity and to accelerate action in the final push towards achieving Millennium Development Goals 4 and 5.

With the experience it has gained on the work of the United Nations platform on social determinants of health in 2012–2013 with ILO, UNAIDS, UNDP, UNFPA, UNICEF, the Organization is well placed to advocate for action on social determinants of health, including their integration into post-2015 development goals, as well as to provide technical support to Member States on the subject. Moreover, a network of institutions will be established to strengthen capacities of Member States in implementing the five action areas enshrined in the Rio Political Declaration on Social Determinants of Health.

WHO will maintain its role within UN-Water, strengthen its collaboration with UNICEF on global monitoring of water and sanitation, and initiate a new collaborative framework with UN-HABITAT on urban environmental health issues. The Organization will continue to act as the secretariat for, and

participate in, the Inter-Organization Programme for the Sound Management of Chemicals. WHO will further strengthen the representation of health within the overall United Nations response to climate change, through the United Nations System Chief Executives Board for Coordination and High-Level Committee on Programmes. The Organization will provide the technical health input to programmes under the United Nations Framework Convention on Climate Change, and to specific partnerships with other organizations in the United Nations system.

**REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH****Outcome 3.1. Increased access to interventions for improving health of women, newborns, children and adolescents**

<b>Outcome indicators</b>	<b>Baseline</b>	<b>Target</b>
Number of women using contraception for family planning in the 69 poorest countries	260 million	320 million (2015)
Skilled attendant at birth (percentage of live births attended by skilled health personnel)	69% <sup>1</sup>	75% (2015)
Postnatal care for mothers and babies (percentage of mothers and babies who received postnatal care visit within two days of childbirth)	46% <sup>1</sup>	60% (2015)
Exclusive breastfeeding for six months (percentage of infants aged 0–5 months who are exclusively breastfed)	37%	40% (2015)
Antibiotic treatment for pneumonia (percentage of children aged 0–59 months with suspected pneumonia receiving antibiotics).	47% <sup>2</sup>	60% (2015)
Adolescent birth rates (per 1000 girls aged 15–19 years)	50 per 1000 girls (2009)	45 per 1000 girls (2015)

**Output 3.1.1. Further expansion enabled of access to and quality of effective interventions from pre-pregnancy to postpartum focusing on the 24-hour period around childbirth**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countdown countries that have expanded access to skilled attendance at birth	0/75 (2013)	75/75 (2015)

**Country office deliverables**

- Conduct policy dialogue among partners at country level on the overall strategy and plans to expand access to and quality of interventions, including adaptation and implementation of guidelines and assessing innovative initiatives to increase access to quality care
- Support capacity building for improving health information on maternal and perinatal health including developing and implementing the road map for the Commission on Information and Accountability for Women's and Children's Health (COIA), maternal and perinatal death surveillance and response, and national plan review
- Generate and document best practices on improving access and quality of interventions, and the dissemination and use of them

**Regional office deliverables**

- Convene and provide a platform for advocacy and sharing of policy options, experiences and best practices in increasing access to high-quality interventions, especially in the 24-hour period around childbirth
- Adapt clinical guidelines and guidelines on monitoring, including for maternal death surveillance and response, and perinatal death reviews; and provide support for their implementation in countries

<sup>1</sup> Global figure *World Health Statistics 2012*. Geneva, World Health Organization, 2012.

<sup>2</sup> Median range of country values, *World Health Statistics 2012*. Geneva, World Health Organization, 2012.

**Headquarters deliverables**

- Develop policies to expand access to and quality of effective interventions (including prevention of mother-to-child transmission of HIV) from pre-pregnancy to the postpartum period, including guidelines and tools for their adaptation, implementation, and monitoring; conduct global technical consultations for analysis and review of evidence
- Strengthen collaborative work with partners, including H4+ (UNAIDS, UNFPA, UNICEF, UN Women, WHO, and the World Bank) and the Partnership for Maternal, Newborn and Child Health
- Strengthen global monitoring of maternal and perinatal mortality, including developing guidelines on maternal/perinatal death surveillance and response, and on near-miss obstetric complications; establish clear indicators and publish global reports

**Output 3.1.2. Countries' capacity strengthened to expand high-quality interventions to improve child health and early child development and end preventable child deaths, including from pneumonia and diarrhoea**

Output indicator	Baseline	Target
Number of countdown countries that are implementing an integrated plan for the prevention and control of pneumonia and diarrhoea	5/75 (2013)	20/75 (2015)

**Country office deliverables**

- Support countries in developing policies and strategies including the integrated management of childhood illness and adapting/adopting and implementing guidelines and tools for preventing child deaths
- Establish a working mechanism for collaboration between reproductive, maternal, newborn, child health and relevant programmes such as immunization, and for holistic approaches to improving child health, including pneumonia and diarrhoea control
- Strengthen national capacity for collection, analysis, and use of data on child morbidity, mortality and causes of child deaths, in line with the overall strengthening of health information systems

**Regional office deliverables**

- Facilitate regional policy and strategic dialogue among countries and partners on expanding effective integrated interventions to improve child health and early child development and ending preventable child deaths; and support implementation and monitoring at regional and country level
- Work with countries and partners towards creating synergies between different programme areas; sharing experiences and best practices for prevention and management of diarrhoea and pneumonia; and promoting child health and development

**Headquarters deliverables**

- Develop policies on improving child health, on early child development and on preventing child deaths from pneumonia and diarrhoea and other conditions, including guidance and integrated tools to support policy implementation and monitoring
- Develop and update integrated guidelines and tools on early child development and on prevention and management of childhood illness, including diarrhea and pneumonia
- Develop and maintain a monitoring framework, global databases (including the Global Health Observatory, Countdown); and publish global reports (i.e., the Child Health Epidemiology Reference Group, the Countdown to 2015: Tracking Progress in Maternal, Newborn and Child Survival, the Commission on Information and Accountability for Women's and Children's Health report etc.)

**Output 3.1.3. Countries enabled to implement and monitor effective interventions to cover the unmet needs in sexual and reproductive health and to reduce adolescent risk behaviour**

Output indicator	Baseline	Target
Number of countries that are implementing and monitoring effective interventions to cover the unmet needs in family planning	0/69 (2013)	25/69 (2015)

**Country office deliverables**

- Work with partners to support countries in adopting/adapting guidelines for sexual and reproductive health with linkages to HIV and congenital syphilis, adolescent health policies and strategies and adolescent health friendly services; and to provide support for implementation
- Support countries in implementing and monitoring interventions on family planning, prevention of unsafe abortions, reproductive tract infections and gynecological cancers, including strengthening linkages of activities with other programmes, such as noncommunicable diseases
- Strengthen the national information system through the inclusion of sexual and reproductive health and adolescent health indicators

**Regional office deliverables**

- Facilitate intercountry technical cooperation for promoting the implementation of effective interventions, guidelines and tools to cover unmet needs in sexual and reproductive health, including HIV, as well as the focus on reducing adolescent health risk behaviour, including prevention of noncommunicable disease risk factors
- Facilitate regional policy dialogue on issues related to sexual and reproductive health and adolescent health, revitalization of family planning in countries, and convene regional consultations as a platform for sharing of best practices in these areas
- Support the implementation of policies and guidelines relating to sexual and reproductive health and adolescent health

**Headquarters deliverables**

- Develop evidence-based policies, technical and clinical guidelines to cover unmet needs in sexual and reproductive health, including family planning, sexually transmitted infections, HIV, and reduction of adolescent health risk behaviours
- Develop strategies for building synergies across the other programme areas that promote sexual and reproductive health and adolescent health
- Develop a standard framework for reporting on sexual and reproductive health and on adolescent health with disaggregated data

**Output 3.1.4. Research undertaken, and evidence generated and synthesized to design key interventions in reproductive, maternal, newborn, child and adolescent health, and other conditions and issues linked to it**

Output indicator	Baseline	Target
Number of new and improved tools, solutions, and implementation strategies successfully applied to reproductive, maternal, newborn and child health	Not applicable	8 (2015)



**Country office deliverables**

- Support systematic reviews and research priorities at regional and global level and the application of their results at country level
- Conduct operational research at country level especially that which will inform national policy and strategies, as well as the management and implementation of programmes
- Strengthen national capacity for research in reproductive, maternal, newborn, child and adolescent health areas, especially in national institutions, including through linking these institutions with WHO collaborating centres

**Regional office deliverables**

- Support the strengthening of research capacity in countries, including facilitating engagement and support from WHO collaborating centres and national institutions; identify regional research priorities and support research
- Plan and facilitate the conduct, sharing and use of results, especially for multicountry research work; maintain and update a regional database

**Headquarters deliverables**

- Develop a comprehensive research agenda, including setting research priorities, and support research centres
- Conduct research and systematic reviews to generate knowledge and an evidence base in order to design key interventions in family planning; maternal, perinatal, newborn, child and adolescent health; preventing unsafe abortion; sexually transmitted infections; and gender and violence
- Publish global reports and disseminate results from research and systematic reviews

**AGEING AND HEALTH****Outcome 3.2. Increased proportion of older people who can maintain an independent life**

Outcome indicators	Baseline	Target
Global indicator(s) will be developed as part of a global framework on monitoring ageing and health to be developed by December 2014		

**Output 3.2.1. Countries enabled to develop policies and strategies that foster healthy and active ageing, and improve access to, and coordination of, chronic, long-term and palliative care**

Output indicator	Baseline	Target
Number of national plans that include strategies to promote active and healthy ageing or access to an integrated continuum of care	30/194 (2013)	40/194 (2015)

**Country office deliverables**

- Strengthen country-level capacity to coordinate policy dialogues among stakeholders, broker technical support for meeting the health needs of older persons

**Regional office deliverables**

- Support countries to develop and implement agreed strategies including monitoring regional trends on ageing and health, and documenting and sharing of regional and country experiences
- Strengthen regional partnerships and collaboration to promote policies and strategies that foster healthy and active ageing; support headquarters in global platforms

**Headquarters deliverables**

- Develop world report on ageing and health in collaboration with Member States, and country and regional offices
- Establish global mechanisms to link and support decision-makers to improve access to age-friendly health systems and create age-friendly environments
- Develop evidence based policy guidance on key issues, such as long-term care

**Output 3.2.2. Technical guidance and innovations that identify and address the needs of older people for improved health care**

Output indicator	Baseline	Target
Number of countries that are monitoring and quantifying the diverse health needs of older people as per WHO recommended measures and models	0/194 (2013)	20/194 (2015)

**Country office deliverables**

- Work with partners in countries, with support from the regional office and from headquarters, to consider policy options and adapt strategies on ageing based on country needs, experiences and health system capacity

**Regional office deliverables**

- Strengthen partnerships, interagency collaboration and monitoring/evaluation at regional level and convene groups to share regional experiences, good practices and lessons learnt
- Support country offices in the adoption of models and standards for monitoring and quantifying the diverse health needs of older people and their access to care

**Headquarters deliverables**

- Influence the global research agenda promoting monitoring, innovation and knowledge translation on ageing and health
- Develop guidelines on management of frailty and policy options for workforce development in low- and middle-income countries
- Develop and disseminate measures, models and standards for monitoring and quantifying the diverse health needs of older people and their access to care

**Output 3.2.3. Policy dialogue and technical guidance provided to countries focusing on the health of women beyond the reproductive age**

Output indicator	Baseline	Target
Number of countries that have developed national health-related policies, legislation or plans on the health of women beyond the reproductive age	Not applicable	5 (2015)

**Country office deliverables**

- Convene meetings of partners and conduct policy dialogue on the policy options reflecting country needs and experiences in order to promote the health of women who are beyond the reproductive age
- Support to countries for implementing, monitoring and evaluating the expansion of interventions for women's health across the life-course including beyond the reproductive age

**Regional office deliverables**

- Complement country office capacities to provide technical support and policy advice on promoting the health of women beyond the reproductive age
- Coordinate the provision of regional- and country-specific technical guidance, advocate and support countries in their development and implementation of interventions on the health of women beyond the reproductive age and support the strengthening of related country office capacity

**Headquarters deliverables**

- Develop the policy and research agenda on the health of women beyond reproductive age and evidence-based policy briefs to support regional and country dialogues, adaptation and capacity building
- Support regions with advocacy to generate political commitment, and in policy dialogue on the policy options and related capacity building needs in countries, including the development and use of related tools and methods

**GENDER, EQUITY AND HUMAN RIGHTS MAINSTREAMING****Outcome 3.3. Gender, equity and human rights integrated into the Secretariat's and countries' policies and programmes**

Outcome indicator	Baseline	Target
Evaluation processes are in place to ensure gender, equity and human rights are measured in Secretariat programmes	No	Yes

**Output 3.3.1. Gender, equity and human rights are incorporated in routine strategic and operational planning and monitoring of Secretariat programmes**

Output indicator	Baseline	Target
Percentage of WHO offices and programmes that have integrated gender, equity and human rights into routine strategic and operational planning	Baseline survey to be conducted in 2013	100% (2015)

**Country office deliverables**

- Identify risks and gaps in the mainstreaming of gender, equity and human rights into Secretariat programmes, including the implementation of accountability mechanisms in the country offices
- Adapt technical guidelines, i.e., the health-in-all policies approach, to the country-level context; apply methodologies and tools (i.e. indicators) to implement, monitor and report on the mainstreaming of gender, equity and human rights into Secretariat programmes

**Regional office deliverables**

- Strengthen the evidence base through improved monitoring of the integration of gender, equity and human rights into analysis and actions within WHO's programmes and offices in the regions
- Develop, adapt and implement and monitor capacity building on integrating gender, equity and human rights approaches and support country offices in areas requiring regional office support

**Headquarters deliverables**

- Develop technical guidelines on implementing health-in-all policies approach, methodologies and tools to implement and monitor the integration of gender, equity and human rights approaches into programmes across all levels of WHO

## PROPOSED PROGRAMME BUDGET 2014–2015

- Strengthen global partnerships, dialogue and intersectoral collaboration on gender, equity and human rights mainstreaming
- Develop, strengthen, implement, monitor, and report on Organization-wide policies, systems, and oversight/accountability frameworks for the integration of gender, equity and human rights in programmes across WHO

### Output 3.3.2. Countries' capacity strengthened to integrate and monitor gender, equity and human rights in their health policies

Output indicator	Baseline	Target
Number of countries that are providing key health data disaggregated by two or more social stratifiers	120 (2013)	140 (2015)

#### Country office deliverables

- Convene country-level dialogues and provide technical guidance to countries on integrating and monitoring gender, equity and human rights in national health-related policies, legislation and plans

#### Regional office deliverables

- Advocate for gender, equity and human rights approaches to health and facilitate Member States' participation in those processes
- Provide regional and country-specific technical guidance to support policy dialogues on gender, equity and human rights approaches in health policies, plans and laws

#### Headquarters deliverables

- Implement capacity development in integrating gender, equity and human rights in programmes and functions at headquarters
- Generate and disseminate the body of knowledge on best practices and lessons learnt from regions and countries on integrating gender, equity and human rights approaches in programmes across WHO

## SOCIAL DETERMINANTS OF HEALTH

### Outcome 3.4. Increased intersectoral policy coordination to address the social determinants of health

Outcome indicators	Baseline	Target
Net primary education enrolment rate (MDG target 2A)	90% (2008)	100% (2015)
Number of slum dwellers with significant improvements in their living conditions (MDG target 7D)	Not applicable	100 million (2020)

### Output 3.4.1. Increased country capacity to implement a health-in-all-policies approach, intersectoral action and social participation to address the social determinants of health

Output indicator	Baseline	Target
Number of countries implementing technical guidance on a health-in-all-policies approach and intersectoral action	9/194 (2012)	21/194 (2015)

**Country office deliverables**

- Support coordination mechanisms in country and conduct dialogue on adapting guidelines and policies for implementing a health-in-all-policies approach, intersectoral action, social participation and the application of economic rationales
- Support countries in evaluating national evidence on how other policy sectors impact on health and establish national mechanisms for continued and coordinated action on intersectoral action for health
- Support countries in implementing the five action areas of the Rio Political Declaration on Social Determinants of Health and in implementing other regional agendas on social determinants of health

**Regional office deliverables**

- Convene meetings of regional organizations, sectoral and intersectoral stakeholders, development agencies and other relevant regional institutions in order to undertake joint and coordinated action on the social determinants of health
- Complement country offices capacity to provide technical assistance on the application of best practices, the implementation of the five action areas of the Rio Political Declaration, and the use of agreed indicators to monitor action on the social determinants of health
- Conduct regional aggregation and use of data in support of monitoring national action on the social determinants of health and feed these into the global and regional health information systems

**Headquarters deliverables**

- Develop global guidelines and provide advice on implementing governance for health, including on a health-in-all policies approach, intersectoral action, social participation and the application of economic rationales
- Develop indicators to monitor action on the social determinants of health, and enable disaggregated data collection through an Organization-wide capacity-building package

**Output 3.4.2. Effective guidance to countries to mainstream social determinants of health in all WHO programmes**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Percentage of WHO offices and programmes that have integrated social determinants of health into planning, implementation and monitoring	Baseline survey to be conducted in 2013	100% (2015)

**Country office deliverables**

- Apply approaches, guidelines and tools to integrate social determinants within WHO programmes, policies and strategies

**Regional office deliverables**

- Develop or adapt approaches, tools, guidelines on integrating social determinants of health within WHO programmes, policies and strategies as appropriate to the regional context
- Document and disseminate lessons learnt and good practices on incorporating social determinants of health

**Headquarters deliverables**

- Develop approaches, guidelines and tools to support the integration of social determinants of health within WHO programmes
- Provide expertise to support regional offices in the application of the approaches, guidelines and tools to the integration of the social determinants of health as appropriate to the various contexts
- Collaborate with regional offices and countries to produce global documentation and dissemination of lessons learnt and good practices in incorporating social determinants

**HEALTH AND THE ENVIRONMENT****Outcome 3.5. Reduced environmental threats to health**

<b>Outcome indicators</b>	<b>Baseline</b>	<b>Target</b>
Proportion of the population without access to improved drinking-water sources	11% (2010)	9% (2015)
Proportion of the population without access to improved sanitation	37% (2010)	25% (2015)
Proportion of the population relying primarily on solid fuels for cooking	41% (2010)	38% (2015)

**Output 3.5.1. Country capacity strengthened to assess health risks, develop and implement policies, strategies or regulations for the prevention, mitigation and management of the health impacts of environmental risks**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries with national health monitoring systems in place to assess the health risks from the lack of water and sanitation	31/194 (2013)	45/194 (2015)

**Country office deliverables**

- Strengthen national capacity to assess and manage the health impacts of environment risks including through health impact assessment
- Support the development of national policies and plans on environmental health and sustainable development
- Support the strengthening of national capacity for preparedness and response to environmental emergencies related to climate, water, sanitation, chemicals, air pollution and radiation
- Convene partners and conduct policy dialogue on improving preparedness and mitigation and management of the health impacts of environmental risks and emergencies

**Regional office deliverables**

- Develop regional strategies/action plans on environmental and occupational health and climate change
- Provide additional capacity at country level implementing assessments, developing policies, regulations, and strengthening health systems to manage the health impacts of environment risks
- Advocate for and strengthen partnerships among regional agencies within and outside the health sector

**Headquarters deliverables**

- Develop methodologies, tools and generate evidence to support development of policies, strategies and regulations for prevention, mitigation and management of environmental and occupational risks and climate change, including in sectors of the economy other than health
- Strengthen global cooperation and partnerships to address environmental and occupational health risks
- Complement regional office capacity for technical assistance in highly specialized technical areas

**Output 3.5.2. Norms, standards and guidelines to define environmental and occupational health risks and benefits associated with air quality, chemicals, water and sanitation, radiation, nanotechnologies, and climate change**

Output indicator	Baseline	Target
Number of countries that have developed new or revised existing policies or national standards based on WHO guidelines for environmental and occupational health risks	20/194 (2013)	30/194 (2015)

**Country office deliverables**

- Support countries to use norms and standards in developing policies and plans for preventing and managing the health impacts of environmental and occupational risks

**Regional office deliverables**

- Advocate norms, standards and guidelines on environmental and occupational health risks for regional application, and provide guidance and technical support to countries for implementation

**Headquarters deliverables**

- Develop norms and standards guidelines on environmental and occupational health risks and guidelines for implementing them, taking into account the evidence generated from regions and countries

**Output 3.5.3. Public health issues incorporated in multilateral agreements and conventions on the environment and sustainable development**

Output indicator	Baseline	Target
Degree to which public health issues are recognized in the post-2015 sustainable development agenda	Not applicable	Meets expectations (2015)

**Country office deliverables**

- Convene meetings of partners and conduct policy dialogue to raise the profile of public health issues in the environment and sustainable development national agenda
- Support countries in implementing agreed provisions that have implications for health in regional initiatives and multilateral agreements and conventions on environmental and sustainable development (e.g., Rio+20 United Nations Conference on Sustainable Development)

**Regional office deliverables**

- Advocate for multisectoral cooperation among regional stakeholders
- Promote the health agenda in regional initiatives on environmental and sustainable development

**PROPOSED PROGRAMME BUDGET 2014–2015**
**Headquarters deliverables**

- Convene and lead global forums among other United Nations bodies, international donors, and agencies dealing with public health issues in relation to the environment and sustainable development
- Advocate for the inclusion of public health issues in the establishment and implementation of multilateral agreements, conventions and global initiatives on the environment and sustainable development

**BUDGET BY MAJOR OFFICE AND PROGRAMME AREA (US\$ MILLION)**

Programme area	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Reproductive, maternal, newborn, child and adolescent health	68.9	12.1	14.2	7.0	14.6	12.1	61.0	<b>189.9</b>
* <i>Research in human reproduction</i>	–	–	–	–	–	–	42.9	<b>42.9</b>
Ageing and health	0.7	1.1	0.3	1.5	1.0	0.2	4.7	<b>9.5</b>
Gender, equity and human rights mainstreaming	2.3	2.0	0.5	1.3	1.2	0.2	6.4	<b>13.9</b>
Social determinants of health	7.3	4.2	1.5	7.6	1.2	1.4	7.1	<b>30.3</b>
Health and the environment	12.8	12.8	7.0	22.7	5.1	7.7	33.9	<b>102.0</b>
<b>Subtotal</b>	<b>92.0</b>	<b>32.2</b>	<b>23.5</b>	<b>40.1</b>	<b>23.1</b>	<b>21.6</b>	<b>156.0</b>	<b>388.5</b>



## CATEGORY 4. HEALTH SYSTEMS

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### *Health systems based on primary health care, supporting universal health coverage*

This category covers the work on strengthening of national health policies, strategies and plans; integrated people-centred health services; improvement of access to medicines and health technologies; and strengthening of health systems information and evidence.

#### **NATIONAL HEALTH POLICIES, STRATEGIES AND PLANS**

More than one billion people cannot obtain the health services they need, because those services are either unavailable, unaffordable or of low quality. Every year 100 million people are pushed into poverty because they must pay for necessary health services at the time of treatment. Insufficient funds for health and inefficient use of these result in inadequate staffing, lack of essential medicines, poorly enforced regulation of providers, and a lack of evidence-based priority setting.

In the biennium 2014–2015, the Secretariat will support countries to facilitate a policy dialogue towards universal health coverage, involving all the main players in health system strengthening at national level, as well as many stakeholders outside the health sector. The dialogue will increasingly involve actors from civil society, nongovernmental organizations and the private sector, and must also extend to other sectors in order to ensure that the most important social determinants of health are tackled. National health sector strategic plans, which build on detailed assessments of the various components of health systems (e.g. legislation and regulation, human resources, health technologies, service delivery and health financing), are core instruments for enabling countries to improve the health of their citizens. WHO will work to develop new approaches that will require norms and standards for the training and licensing of health workers, the accreditation of health facilities, and the regulation of private providers and insurers. The Secretariat will focus on collaborating with countries to strengthen the plans and associated accountability mechanisms (such as annual reviews). Health systems in many countries are facing economic and institutional uncertainty. In view of this, and given the need for reform to be based on a better understanding of future circumstances, WHO will work with countries to ensure that strategies developed for achieving universal health coverage are based on the principles of primary health care and health equity.

#### **INTEGRATED, PEOPLE-CENTRED HEALTH SERVICES**

The path to universal health coverage is obstructed by a number of barriers that hinder access to health services. These obstacles are linked to the fragmentation of health care systems and the predominance of hospital-based services that are not well connected with each other, and mainly focused on curative services, with poor continuity of care. At the same time, users are demanding higher quality, and more comprehensive and integrated services that are better adapted to their particular needs and preferences. Health services must thus respond better to people's expectations and focus on the person, and the person's local community, family and individual life-course context.

The growing prominence of chronic noncommunicable conditions, as well as ageing populations, is creating a greater demand for affordable long-term care, high-quality palliative treatment, and better links between medical and social services (as well as between health and other forms of social protection). This new situation also highlights the importance of prevention and promotion in reducing the need for treatment and rehabilitation. Advances in informatics and information technology, such as the use of electronic medical records, have the potential to transform health

care management and promote more people-centred care. Responding to unmet needs in low-resource settings calls for technological innovations that are simple, frugal, safe, effective, affordable, accessible, and acceptable; and that are supported by related service delivery systems. However, authoritative and practical guidance on matching the needs of populations with potential innovations is lacking.

Critical shortages, inadequate skill mix and uneven geographical distribution of the health workforce pose major barriers to achieving better health outcomes. A well-trained and motivated health workforce is essential for people-centred, good-quality services. Also, strategies are needed for reaching populations such as unimmunized children and populations at risk of infection by HIV or tuberculosis, or groups whose health care needs have been relatively overlooked, such as adolescents and the elderly.

Service delivery can further be enhanced by better primary care and hospital services. This can be achieved through better capital planning and service standards for health care facilities, particularly in lower income settings. It is essential for improvements to be made in service quality and patient safety (including reducing rates of hospital infection). Empowering patients and communities as well as engaging staff to improve the quality and safety of health care will be vital in the context of expanding systems for community-based financing and performance incentives.

In the biennium 2014–2015, the Secretariat will work to support countries and communities by developing the norms, tools, and capacity-building approaches that address and integrate the multiple system issues noted above. The Secretariat will also support countries to tackle social determinants-related issues, and to overcome financial barriers to accessing services, such as demand-side financing. The Organization will support countries through the development of tools to collect and analyse equity issues in both national and local contexts. It will document best practices and lessons learnt to support countries in their development of efficient country delivery systems for effective health interventions, ensuring equitable access to quality services for their citizens, with an appropriate mix between prevention, promotion, treatment, rehabilitation and palliative care. In an effort to deal with the problem of fragmentation and lack of people-centredness, WHO will develop a strategy that will support countries to achieve universal health coverage through people-centred and integrated care, within the framework of health systems strengthening.

#### **ACCESS TO MEDICINES AND HEALTH TECHNOLOGIES<sup>1</sup> AND STRENGTHENING REGULATORY CAPACITY**

An estimated 30% of the world's population does not have regular access to essential medicines, and in the poorest areas of Asia and Africa over half of the population lacks access. Those who do have access to medicines face a relatively high cost burden due to out-of-pocket co-payments. It is estimated that poor households devote between 60% and 90% of their health care expenditures to medicines, and medicines consume between 25% and 65% of total public and private spending on health.

Equity in public health depends on access to essential, high-quality and affordable medicines, vaccines, diagnostics and other health technologies. Affordable prices ease health budgets everywhere, but are especially important in developing countries where too many people still have to meet medical expenses out of pocket. Access to affordable health technologies is important for the unfinished agenda of diseases targeted by the Millennium Development Goals. It becomes all the more critical in the face of the growing burden of noncommunicable diseases, since individuals

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<sup>1</sup> As stated in resolution WHA60.29, the term "health technologies" refers to devices, medicines, vaccines, procedures and systems developed to solve a health problem and improve the quality of lives.

may require life-long treatment, and also because access to essential medicines early in the course of a disease can prevent more serious consequences later. Beyond medicines however, there are critical needs for affordable and accessible vaccines, diagnostics, medical and assistive devices, and other health technologies. Improving access to all of these medical products is central to the achievement of universal health coverage, and improving efficiency and reducing wastage is an important component of health financing policy.

There are several elements to this programme area, including rational procurement and pricing policies, and appropriate prescribing that favours greater use of generic over originator brands; promoting research and development for the health technologies needed by low-income countries; strengthening national regulatory authorities and systems; and prequalification that aims to make good-quality priority medicines, diagnostics and vaccines available that benefit those in need; and comprehensive national policies on medical products, based on good governance principles. Special attention will be paid to identifying the main barriers hindering access to medicines and health technologies and the elimination of substandard/spurious/false-labelled/falsified/counterfeit medical products.

In the biennium 2014–2015, WHO will continue to support the implementation of the global strategy and plan of action on public health, innovation and intellectual property. This work will include actions focused on advancing innovation for healthy ageing, including technologies and delivery systems, in order to tackle the needs of the rapidly increasing population group concerned. WHO will build on all these elements, with a focus on countries where local production offers real prospects for increasing access and affordability, and support technology transfer to support this objective. In addition, WHO will support the follow-up work linked to the outcome of the ongoing discussion of the report by the Consultative Expert Working Group on Research and Development: Financing and Coordination.<sup>1</sup>

Another priority for WHO in this area will be the development of tools and guidance to support countries in the prioritization of health technologies through health technology assessment, and in rational procurement and prescription of medical products.

An important missing link in many low-income countries is adequate national regulatory capacity. Thus the development of, and support for, regional or national regulatory authorities will constitute a major priority for WHO's future work in this area, gradually reducing reliance on global prequalification programmes.

#### **HEALTH SYSTEMS, INFORMATION AND EVIDENCE**

Reliable and timely health information and evidence are essential for public health decision-making, resource allocation, monitoring and evaluation. Regular monitoring of health system progress and performance needs to be part of every country's efforts to implement national health strategies in order to achieve universal health coverage. This requires a well-functioning health information system, including birth registration and death registration with a reliable cause of death, the ability to track resources and results, and special attention to equity. However, there is still substantial work to be done in this area. For example, WHO receives reliable cause-of-death statistics from only 31 of its 193 Member States. The lack of civil registration systems means that every year, almost 40%

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<sup>1</sup> See document A66/23.

(48 million) of 128 million births worldwide go unregistered. The situation is even worse for death registration. Globally, two thirds (38 million) of 57 million deaths a year are not registered.<sup>1</sup>

WHO aims to monitor the health situation and trends at global, sub-national and regional levels through observatories, and the Secretariat will support countries in strengthening their own health information and resource tracking systems. In addition, the development of mHealth and eHealth applications has the potential to change the way health services are delivered; however, optimizing the health benefit brought by new information technologies is critically dependent upon the elaboration and implementation of coherent national eHealth strategies. The Secretariat will support countries in developing such eHealth strategies and will promote better standardization and interoperability of information systems.

In the biennium 2014–2015, the Secretariat will support and guide the strengthening of national and local capacity to generate evidence through research in support of the following: health information systems and monitoring and evaluation; and evidence-based, effective and financially sustainable policies, strategies and plans, including the macroeconomic and fiscal dimensions of financing health systems for achieving universal health coverage, and for the transformation and scaling-up of the education and performance of the health workforce. WHO will continue to pursue its core function of monitoring regional and global health situations and trends, bringing together all disease and health system information. The Secretariat will support countries to strengthen the generation, sharing and use of high-quality knowledge resources. WHO will maintain its work on the following activities: developing guidelines and tools, producing multilingual and multi-format information products, enabling sustainable access to up-to-date scientific and technical knowledge by WHO staff and national healthcare professionals, empowering patients through reliable information, managing and supporting knowledge networks, translating evidence into policies and practices and promoting the appropriate use of information and communication technologies.

WHO has a special role to play in the promotion of health research. Ethical considerations and the public perception of the way in which WHO promotes the ethical conduct of research, bioethics or public health interventions are likely to become more prominent in the coming years. The ethical conduct of research and adherence to proper ethical governance of public health practice will be critical for dealing with this matter. In the biennium 2014–2015, WHO will focus on (i) working with countries to establish national health research governance systems and (ii) developing norms and standards for priority ethical issues of global concern.

#### **LINKAGES WITH OTHER PROGRAMMES AND PARTNERS**

The Secretariat will work with countries and communities to strengthen their capacity for inclusive and ethical governance and policy dialogue, facilitating analysis, reviews and engagement with key stakeholders (including external partners and civil society in line with the post-Busan agenda for development effectiveness). The engagement of country governments and donor agencies through the International Health Partnership (IHP+) will reinforce mutual accountability for resources and results, while harmonization of donor involvement in the area of technical support will be promoted through mechanisms such as the Providing for Health (P4H) Social Health Protection Network and the Harmonization for Health in Africa (HHA) network. The transparent engagement of the private sector to promote universal health coverage will be sought while minimizing the risk for conflicts of interest.

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<sup>1</sup> Figures for 2007.

This category contributes to all categories by promoting effective health systems and equitable and affordable access to health services, and good-quality medicines and other health technologies as a cornerstone of integrated people-centred health services.

This work will involve the development of tools and policies to remove health system barriers that have hindered universal health coverage, and the promotion of core services for noncommunicable diseases (Category 2) infant, child, adolescent, adult and older people's health (Category 3), and HIV/AIDS, tuberculosis, malaria and other infectious diseases (Category 1). As health systems are essential in the preparation for, response to, and recovery from health emergencies of all types, there is an integral link with Category 5. This category also has linkages with WHO's cross-cutting work on gender, human rights, equity and the social determinants of health, as it relates both to health in all policies and to ensuring that WHO's programmes are sensitive to the social determinants of health.

**NATIONAL HEALTH POLICIES, STRATEGIES AND PLANS**

**Outcome 4.1. All countries have comprehensive national health policies, strategies and plans updated within the last five years**

<b>Outcome indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries that have a comprehensive national health sector strategy with goals and targets updated within the last 5 years	115/194 (2013)	135/194 (2015)

**Output 4.1.1. Advocacy and policy dialogue to support countries to develop comprehensive national health policies, strategies and plans**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries that conducted reviews of their national health strategy including the financing component during the biennium	0 (2013)	25 (2015)

**Country office deliverables**

- Facilitate the development and implementation of a one-country health plan in line with the IHP+ and/or development effectiveness principles
- Support health officials to engage with other sectors and civil society in policy dialogue to develop and implement national health policies, strategies and plans to promote universal health coverage, taking into consideration social determinants of health and other cross-cutting issues, values and principles
- Advocate for and support high-level national/local policy dialogue for health systems development to support universal health coverage

**Regional office deliverables**

- Facilitate regional platforms that bring together countries and other relevant stakeholders, and promote nationally-owned processes of developing, implementing and monitoring the one-country health plan in line with development effectiveness principles
- Adapt to the regional context global tools for increasing accountability and transparency in the health sector in support of attaining the Millennium Development Goals, addressing noncommunicable diseases, and promoting universal health coverage
- Promote universal health coverage regionally with an emphasis on primary health care, public health approaches, and of whole-of-government/whole-of-society approaches

**Headquarters deliverables**

- Facilitate high-level policy dialogue in line with WHO's global concept and policies on universal health coverage
- Facilitate the alignment of support from various stakeholders in the process of developing, implementing and monitoring one-country health plans, respecting national ownership and remaining in line with agreed principles at the global level
- Develop global tools for increasing accountability and transparency in the health sector, in support of attaining the Millennium Development Goals, addressing noncommunicable diseases and promoting universal health coverage

**Output 4.1.2. Country capacity to develop and implement legislative, regulatory, and financial frameworks strengthened by generation and use of evidence, norms and standards, and robust monitoring and evaluation**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries that have institutionalized tracking of health resources	49/194 (2013)	65/194 (2015)

***Country office deliverables***

- Identify needs and provide support to strengthening country capacity in developing and implementing the legislative and regulatory frameworks required to achieve universal health coverage
- Identify needs for capacity building and information, and experiences in best practices in health financing
- Provide support for strengthening national capacity (i) to monitor and evaluate progress towards universal health coverage, and (ii) to design, prepare for, undertake and report on a joint annual sector review

***Regional office deliverables***

- Provide a platform for generating and sharing regional best practices and lessons learnt on enabling health financing, legislative and regulatory frameworks, and on engagement with other sectors
- Facilitate regional contributions to the annual updates of the global health expenditure databases
- Conduct regional training programmes on health system strengthening for universal health coverage

***Headquarters deliverables***

- Consolidate best practices and lessons learnt on systems and approaches that enable progression towards universal health coverage (e.g. enabling legislation and regulatory frameworks) and support their adaptation and use at regional and country levels
- Develop and support the application of norms and standards for the accreditation and regulation of health facilities and the workforce, and for the regulation of private providers and insurers
- Collate, analyse and disseminate best practices globally on health financing strategies and policies for universal health coverage; set standards and maintain global databases on health expenditures, costs and cost-effectiveness
- Develop tools to improve national conduct of, and alignment of all stakeholders with, annual sector reviews; and analyse their comparative effectiveness and impact

**INTEGRATED PEOPLE-CENTRED HEALTH SERVICES**

**Outcome 4.2. Policies, financing and human resources are in place to increase access to integrated people-centred health services**

<b>Outcome indicators</b>	<b>Baseline</b>	<b>Target</b>
Number of countries that are implementing integrated service strategies	50	65
Proportion of countries facing critical health workforce shortages	30% (2006)	20% (2014)

**Output 4.2.1. Policy options, tools and technical support to countries for equitable people-centred integrated service delivery and strengthening of public health approaches**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries routinely assessing the costs and impact of different service delivery options and the related expenditures	45/194 (2013)	80/194 (2015)

***Country office deliverables***

- Identify capacity strengthening needs, and support countries to adopt and implement the WHO global strategy on integrated people-centred service delivery
- Promote at national and local levels approaches based on public health principles in order to reduce inequalities, prevent disease, protect health and increase well-being

***Regional office deliverables***

- Compile lessons learnt and best practices from countries of the region, and provide platforms for sharing information on successful models of service delivery and financing for universal health coverage
- Convene meetings of relevant stakeholders at regional level to promote public health approaches and develop capacities at all levels of the health system and across sectors and societies, in order to reduce inequalities, prevent disease, protect health and increase well-being
- Promote at regional level approaches based on public health principles to deliver equitable integrated people-centred services

***Headquarters deliverables***

- Develop a WHO global strategy on integrated people-centred service delivery to achieve universal health coverage in a continuum from promotion to palliation
- Collect, synthesize and disseminate successful models of service delivery and financing, targeting different stakeholders (health sector, media, non-health sector and private sector)

**Output 4.2.2. Countries enabled to plan and implement strategies that are in line with WHO's global strategy on human resources for health and the WHO Global Code of Practice on the International Recruitment of Health Personnel**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries that have an investment plan for scaling up and/or improving training and education of health workers in accordance with national health needs	30/57 (2013)	35/57 (2015)

***Country office deliverables***

- Provide support to strengthening country capacity to implement WHO's global strategy on human resources for health and the WHO Global Code of Practice on the International Recruitment of Health Personnel
- Provide support to countries in implementing guidelines for transforming and scaling up the education and accreditation of health personnel

***Regional office deliverables***

- Monitor and evaluate progress at national and regional levels in the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel
- Update and strengthen regional databases and observatories on the health workforce



- Provide expertise to countries where additional capacity is needed in specialized areas of human resource strengthening and quality assurance
- Adapt to the regional context, when appropriate, WHO's guidelines for transforming and scaling up the education and accreditation of health personnel

#### **Headquarters deliverables**

- Upgrade reporting mechanism and instruments to monitor the global implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel
- Develop indicators to monitor and predict health workforce migration flows, and update and maintain global databases and the health workforce atlas
- Update guidelines for transforming and scaling up the education and accreditation of health personnel, including using innovative approaches, such as e-learning materials and other knowledge-sharing platforms

#### **Output 4.2.3. Guidelines, tools and technical support to countries for improved patient safety and quality of services, and for patient empowerment**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries with official engagement in new patient safety initiatives	20 (2013)	40 (2015)

#### **Country office deliverables**

- Identify national capacity-strengthening needs and support countries to increase the quality and safety of health services
- Facilitate the engagement and empowerment of communities and patients through the Patients for Patient Safety network and other patients' initiatives and associations

#### **Regional office deliverables**

- Support the adaptation of policy options and tools to improve medication safety based on the regional situation
- Establish a mechanism for collecting and sharing best practices and models on patient engagement and empowerment
- Provide expertise to countries where additional capacity is needed in specialized areas relating to medication safety and quality assurance of health services

#### **Headquarters deliverables**

- Develop policies, guidelines and innovative tools to support the strengthening of quality and safety of health services, including medication safety as part of the third Global Patient Safety Challenge
- Facilitate the design and implementation of policies and tools
- Support networks for providers (e.g. innovative hospital-to-hospital partnerships) and for the engagement of communities and patients through the Patients for Patient Safety network and other patients' initiatives and associations
- Conduct global consultations to explore self-sufficiency and the non-commercial nature of tissues of human origin and build Member State consensus

**ACCESS TO MEDICINES AND HEALTH TECHNOLOGIES<sup>1</sup> AND STRENGTHENING REGULATORY CAPACITY****Outcome 4.3. Improved access to and rational use of safe, efficacious and quality medicines and health technologies**

<b>Outcome indicator</b>	<b>Baseline</b>	<b>Target</b>
Availability of tracer medicines in the public and private sectors	48% (2011)	80% (2015)

**Output 4.3.1. Countries enabled to develop or update, implement, monitor and evaluate national policies on better access to health technologies; and to strengthen evidence-based selection and rational use of health technologies**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Percentage of countries with official national policies on access, quality and use of medicines and health technologies updated within past five years	80% (2013)	82% (2015)

**Country office deliverables**

- Support the collection of information on access to health technologies without financial hardship (availability, affordability and prices) and on the country's pharmaceutical and/or health technology sector situation and profile
- Provide technical support to revise and implement national medicine policies; national policies for the procurement and management of the supply chain; reimbursement and pricing policies for health technologies based on the country's needs; and national strategies on traditional and complementary medicines
- Identify capacity strengthening needs, particularly in areas such as: regular evidence-based updating of the national list of essential medicines; rational use of health technologies; definition of the content of benefit packages; regulation of promotion of health technologies, prices and availability of medical products; and the collection of national data on consumption of antimicrobials

**Regional office deliverables**

- Establish mechanisms to generate and compile best practices – including those for national medicine policies, and for the management of procurement and supply chains – in order to encourage learning between countries
- Develop or enhance regional observatories with databases, analyses and dissemination platforms for consolidated analyses on the following: access to health technologies without financial hardship; barriers to access; and the situation and profile of the regional pharmaceutical and/or health technology sector
- Adapt WHO's global strategy on traditional and complementary medicine to the regional context, where appropriate
- Adapt global technical guidelines, formularies, treatment guidelines and protocols to regional context (where appropriate) for evidence-based selection and rational use of essential health technologies, and provide expertise to countries to support development of capacity for health technology assessment

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<sup>1</sup> As stated in resolution WHA60.29, the term "health technologies" refers to devices, medicines, vaccines, procedures and systems developed to solve a health problem and improve the quality of lives.

- Support countries to collect and analyse data on access to and rational use of medical products and technologies, including consumption of antimicrobials, and data on antimicrobial resistance
- Adapt WHO norms and guidelines on advertisement and promotion of health technologies to the regional context (where appropriate)

#### **Headquarters deliverables**

- Convene global consultations to share best practices for the implementation and revision of national medicines policies
- Develop the methodology and tools for the assessment of national procurement and supply chain management capacity for health technologies; and make recommendations on best practices for supply, reimbursement and pricing policies for health technologies, including guidance on improving access to controlled medicines, enhance global observatories with databases and analyses of data on access to health technologies without financial hardship, on barriers to access, and on countries' pharmaceutical sector situation and profile
- Update the WHO Model List of Essential Medicines
- Publish WHO's global strategy on traditional and complementary medicine
- Develop technical guidelines, formularies, treatment guidelines and protocols; provide a platform for sharing best practices for the evidence-based selection and rational use of essential health technologies; and support the development of capacity for health technology assessment
- Collect and consolidate information on the global consumption of antimicrobials, and share best practices on policies and approaches to improve their use and contain resistance
- Develop global norms and guidelines to regulate the advertisement of health technologies

#### **Output 4.3.2. Implementation of the global strategy and plan of action on public health, innovation and intellectual property**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries that report data on research and development investments for health	71/194 (2010)	100/194 (2015)

#### **Country office deliverables**

- Collect information on progress and challenges at country level in the implementation of the global strategy and plan of action on public health, innovation and intellectual property; and on research and development for health; and innovation capacity, identify needs and provide support to strengthening the capacity to implement elements the global strategy and plan of action on public health, innovation and intellectual property
- Convene and manage national consultations on various elements of the global strategy and plan of action on public health, innovation and intellectual property

#### **Regional office deliverables**

- Establish, update and maintain regional observatories on research and development for health or a regional web-based platform on health innovation and access to health technologies
- Publish technical reports on regional priorities for pharmaceutical research and development and provide direct support for the establishment of local production where appropriate

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- Convene regional consultations, where appropriate, on various elements of the global strategy and plan of action on public health, innovation and intellectual property
- Provide expertise to countries where additional capacity is needed in implementing the various elements of the global strategy and plan of action on public health, innovation and intellectual property

### *Headquarters deliverables*

- Establish a global observatory on research and development for health, and produce global progress reports on the implementation of research and development for health; and on innovation capacity
- Strengthen the global innovation capacity for research and development for public health through dissemination of policy options on the application and management of intellectual property
- Publish technical reports on global priorities in research and development and on technology transfer to increase access; and provide direct support to establishing local production, where appropriate
- Convene global consultations, where appropriate, to explore and build the consensus among Member States on various elements of the global strategy and plan of action on public health, innovation and intellectual property

### **Output 4.3.3. Strengthening national regulatory authorities facilitated; norms, standards, guidelines for medical products developed; and quality, safety and efficacy of health technologies ensured through prequalification**

Output indicator	Baseline	Target
Number of new medicines and health technologies prequalified	Not applicable	100 (2015)

### *Country office deliverables*

- Identify capacity strengthening needs, and provide support to tackle those needs in implementing WHO technical guidelines, norms and standards for quality assurance and safety of health technologies, including traditional and complementary medicines
- Work with national authorities to implement plans for strengthening their national regulatory authority, identifying capacity-strengthening needs and providing appropriate technical support in response
- Advocate for the strengthening of the national regulatory authority; and raise awareness on substandard/spurious/falsely-labelled/falsified/counterfeit medical products

### *Regional office deliverables*

- Provide expertise to countries in support of: implementing WHO technical guidelines, norms and standards for quality assurance of health technologies, including traditional and complementary medicines; and of the assessment of national regulatory authorities
- Facilitate the progressive convergence and/or harmonization of regulatory practices at regional level, and support global initiatives to develop new models for the prequalification of health technologies
- Provide a regional perspective to the development of global guidelines, tools and curricula to strengthen national regulatory authorities and prequalify health technologies
- Facilitate regional platforms to foster international collaboration and sharing of best practices on strengthening the supply chains, and to raise awareness on substandard/spurious/falsely-labelled/falsified/counterfeit medical products

**Headquarters deliverables**

- Develop and support the application of global technical guidelines, norms and standards (including International Nonproprietary Names) for the quality assurance and safety of health technologies, including for traditional and complementary medicines
- Convene and manage expert committees, including those on the following matters: evaluation of substances subject to international controls; pharmaceutical preparations; biological standardization; medical devices and technologies; and provide timely reports of these meetings
- Develop a consolidated assessment tool for national regulatory authorities, coordinate assessments of national regulatory authorities globally and develop a global approach for facilitating the progressive convergence and/or harmonization of regulatory practices and building of global regulatory networks
- Prequalify health technologies, while developing and piloting new models of prequalification
- Update the global pharmacovigilance guidance to monitor the safety of health technologies and promote strengthening of safety surveillance
- Facilitate global platforms to foster international collaboration and sharing of best practices to address the challenge of substandard/spurious/false-labelled/falsified/counterfeit medical products

**HEALTH SYSTEMS, INFORMATION AND EVIDENCE****Outcome 4.4. All countries have properly functioning civil registration and vital statistics systems**

Outcome indicator	Baseline	Target
Number of countries that report cause of death information using the International Classification of Diseases, 10th revision	108 (2013)	112 (2015)

**Output 4.4.1. Comprehensive monitoring of the global, regional and country health situation, trends and determinants, using global standards, and leadership in the new data generation and analyses of health priorities**

Output indicator	Baseline	Target
Number of countries (among the 75 countries in the Commission on Information and Accountability for Women's and Children's Health report) <sup>1</sup> that have good-quality public analytical reports for informing regular reviews of the health sector strategy	30/75 (2013)	50/75 (2015)

**Country office deliverables**

- Identify capacity-strengthening needs, and support countries in responding to these needs in areas such as: (i) the use of national information and data for analysing and monitoring the national health and health financing situation and trends, and progress towards universal health coverage; and (ii) the adoption of international classification systems such as the International Classification of Diseases
- Collect national information for inclusion into regional and global observatories

<sup>1</sup> Commission on Information and Accountability for Women's and Children's Health. *Keeping promises, measuring results*. Available online at [http://www.who.int/woman\\_child\\_accountability/en/](http://www.who.int/woman_child_accountability/en/) (accessed 12 April 2013).

**Regional office deliverables**

- Consolidate and disseminate regional information and statistics on health and health financing situation and trends, and on equitable access to health services through the regional health observatories and knowledge translation platforms
- Develop tools and guidance for monitoring and reporting on progress towards regional policy framework targets, and support countries to develop corresponding national targets
- Produce WHO regional information products in official languages and versions appropriate to the region
- Provide expertise, where additional capacity is needed, to support monitoring of the country's health situation, trends and determinants, in particular using electronic tools, such as atlases, with disaggregation of data relevant to subnational levels and social determinants of health

**Headquarters deliverables**

- Harmonize definitions of health and health financing indicators globally to improve their quality and comparability; and develop tools, standards and methods to collect, record and analyse and promote use of health information
- Generate and consolidate global information and corresponding global, regional and national statistics through WHO's Global Health Observatory and knowledge translation platforms to support evidence-based policy-making
- Develop tools and guidance to monitor progress towards global targets, and consolidate information to report on progress on these targets
- Develop, revise, license and publish international classification systems (the International Classification of Diseases, the WHO Family of International Classifications and other relevant classification systems and tools)

**Output 4.4.2. Countries enabled to plan, develop and implement an eHealth strategy**

Output indicator	Baseline	Target
Number of countries that have developed an eHealth strategy	80/194 (2013)	100/194 (2015)

**Country office deliverables**

- Identify capacity-strengthening needs, and provide support to deal with these needs, particularly in formulating and implementing a national eHealth strategy

**Regional office deliverables**

- Collect and synthesize lessons learnt and best practices at regional level to facilitate the formulation and implementation of national eHealth strategies
- Collect national information through the global eHealth survey to be incorporated into the Global Observatory for eHealth
- Provide expertise, where additional capacity is needed, to support the development and implementation of a national eHealth strategy

**Headquarters deliverables**

- Identify eHealth standards and provide guidance to standard-setting organizations for their development, including the use of electronic medical records and other related technologies
- Develop global tools and training materials, and consolidate best practices and lessons learnt globally through the Global Observatory for eHealth, in order to facilitate the design and implementation of national eHealth strategies
- Manage global collaborative projects with other United Nations agencies (e.g. ITU) and international standard-setting organizations to maximize public health benefits

**Output 4.4.3. Knowledge management policies, tools, networks, assets and resources developed and fully utilized by WHO and countries to strengthen their capacity to generate, share and apply knowledge**

Output indicator	Baseline	Target
Number of visits to the WHO electronic knowledge assets and resources from low-income and lower-middle-income countries (annual)	20 million (2013)	30 million (2015)

**Country office deliverables**

- Keep national authorities informed about WHO information products and services and facilitate their delivery to appropriate potential users in national institutions
- Identify capacity-strengthening needs and provide technical support for strengthening national capacities to: (i) generate knowledge and (ii) make systematic use of evidence in the formulation of national policies
- Synthesize and disseminate lessons learnt from implementation of innovative policy initiatives or other pilot programmes at the country level
- Identify national expertise for potential incorporation into the global compendium

**Regional office deliverables**

- Support regional platforms of the Evidence Informed Policy Network (EVIPNet) in strengthening national capacity to identify, translate and use evidence for policy
- Produce regional training materials and regional serial and flagship information products and reports, ensuring quality, copyright compliance and dissemination in relevant languages
- Support utilization of regional Index Medicus databases
- Manage regional WHO collaborating centres and advisory committees

**Headquarters deliverables**

- Develop tools and methodologies for strengthening capacity in countries to identify, translate and use evidence for policy – notably through the Evidence Informed Policy Network (EVIPNet); promote countries' access to information and evidence
- Publish and distribute WHO information products (including international guidelines and learning materials, global serial and flagship information products, as well as technical reports) ensuring compliance with WHO's multilingual mandate, and adherence to WHO copyright policy
- Strengthen the quality and evidence-base of WHO guidelines, and compliance with quality standards of WHO information products, through review by the Guidelines Review Committee and the Publishing Policy Coordination Group
- Manage the global network of WHO collaborating centres, advisory and expert committees/panels, and compendium of national expertise; develop and maintain collaborative platforms on health information to strengthen South–South and triangular collaborations (e.g. ePORTUGUÊSe)

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- Consolidate and make available to Member States all WHO institutional information through the Institutional Repository for Information Sharing (IRIS); and promote the use of the Global Index Medicus (a global platform of regional Index Medicus databases)
- Provide access to medical, technical and scientific literature to all low-income countries through the Health InterNetwork Access to Research Initiative (HINARI), and to all WHO staff through the Global Information Full Text (GIFT) project

**Output 4.4.4. Policy options, tools and support provided to define and promote research priorities, and to address priority ethical issues related to public health and to research for health**

Output indicator	Baseline	Target
Number of global and regional Advisory Committees on Health Research convened at least once during the biennium, and whose recommendations have been synthesized, published and disseminated	4 (2013)	7 (2015)

**Country office deliverables**

- Identify capacity-strengthening needs and provide support to countries in responding to these needs, especially in areas such as priority setting and governance for health research, research ethics, and registration of clinical trials

**Regional office deliverables**

- Manage the regional Advisory Committee on Health Research, as well as facilitate priority-setting for health research in the region based on the Committee's recommendations, and the alignment of donors and partners with these priorities
- Maintain and convene meetings of the WHO regional research ethics review committee
- Provide expertise, where additional capacity is needed, in support of national capacity for health research

**Headquarters deliverables**

- Manage meetings of the global Advisory Committee on Health Research and build on its recommendations to facilitate the development of tools for priority-setting and the consolidation of a global health research agenda
- Produce normative guidance and tools to develop clinical trial registries, and further develop WHO's international clinical trials registry platform
- Facilitate global platforms for discussion of priority ethical issues related to health, and formulate relevant ethical norms and standards

**BUDGET BY MAJOR OFFICE AND PROGRAMME AREA (US\$ MILLION)**

Programme area	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
National health policies, strategies and plans	15.2	14.5	12.6	17.6	11.1	15.4	39.3	125.7
Integrated people-centered health services	30.0	6.0	22.3	11.7	15.4	23.9	42.2	151.5
Access to medicines and health technologies and strengthening regulatory capacity	11.6	5.7	4.7	7.0	7.3	8.9	100.3	145.5
Health systems information and evidence	14.5	4.5	5.3	8.5	9.2	6.0	60.4	108.4
<b>Subtotal</b>	<b>71.3</b>	<b>30.7</b>	<b>44.9</b>	<b>44.8</b>	<b>43.0</b>	<b>54.2</b>	<b>242.2</b>	<b>531.1</b>



## **CATEGORY 5. PREPAREDNESS, SURVEILLANCE AND RESPONSE**

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***Reducing mortality, morbidity and societal disruption resulting from epidemics, natural disasters, conflicts and environmental and food-related emergencies, through prevention, preparedness, response and recovery activities that build resilience and use a multisectoral approach.***

This category focuses on strengthening countries' capacities in prevention, preparedness, response and recovery for all types of hazards, risks and emergencies that pose a threat to human health. It includes those hazards and emergencies covered by the requirements of the International Health Regulations (2005) such as the following: established, emerging or re-emerging human and zoonotic diseases with the potential to cause outbreaks, epidemics or pandemics; food-safety-related events; and antimicrobial drug resistance. This category also covers the work in polio eradication and emergency risk management, building country and community resilience to disasters of all types.

During the period 2001–2010, an average of more than 700 natural and technological emergencies occurred globally every year, affecting approximately 270 million people and causing over 130 000 deaths annually. Approximately 25% of these emergencies, and 44% of these deaths, occurred in less developed countries that have limited capacities to prepare for and respond effectively to emergencies. Communicable diseases are the most often reported. Outbreak of even limited cases can spark high levels of concern and activity, and large-scale emergencies that can cause widespread death and suffering create panic and severe stress for the public. For example, in Africa over the past six years, WHO verified 168 epidemic disease outbreaks in 34 countries, caused by 16 different diseases. In all types of emergencies, the poorest and most vulnerable people are affected disproportionately. The resulting economic costs are very large, averaging over US\$ 100 billion per year. The appropriate and timely management of these risks requires effective national and international capacity strengthening and intersectoral collaboration, the promotion of equity, the protection of human rights, and the advancement of gender equality.

Previous approaches to emergency risk management have generally been limited, involving fragmented, narrowly focused or isolated efforts. WHO is adopting a holistic perspective and a coordinated multi-hazard approach that covers essential elements including enhanced prevention, emergency risk reduction, preparedness, surveillance, response and early recovery across Member States and the international health community. For optimal impact, this approach must be integrated into comprehensive national plans for emergency risk management that involve all sectors and contribute to improved health outcomes. New tools can substantially reduce the impact of many disasters.

### **ALERT AND RESPONSE CAPACITIES**

The top priority is to ensure that all countries have the core capacities needed to fulfil their responsibilities under the International Health Regulations (2005) before the deadline in 2016. These cover: national legislation, policy and financing; coordination and national focal point communications; surveillance; response; preparedness; risk communication; human resources; and laboratory capacity-building. The Secretariat will provide support to countries for their national efforts and report on progress. At the same time, WHO will continue to develop, maintain and exercise the policy and technical guidance, information management and communication systems and the operational systems needed at global, regional and country levels to detect, verify, assess and coordinate the response to important hazards and risks and important sub-acute and acute public health events when they arise.

#### EPIDEMIC-PRONE AND PANDEMIC-PRONE DISEASES

The focus is shared between multiple priority actions. The first priority will be to support (i) the implementation of relevant international frameworks and agreements, such as the Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits and the WHO Global Action Plan for Influenza Vaccines, and (ii) established mechanisms for emerging, re-emerging and established epidemic-prone conditions. These mechanisms include the following: the International Coordinating Group mechanism for the operation of global vaccine stockpiles in crises and their use for the control of epidemic diseases such as cholera, hepatitis and meningitis; and the WHO global influenza surveillance and response system for developing international recommendations for influenza vaccine, and stockpiles. Other priority actions will include the development of key information and guidance in core documents and reports to be disseminated on the Internet and through the publication of the *Bulletin of the World Health Organization* and *Weekly epidemiological record*. Support for preparedness will include building essential diagnostic capacities and securing selected supplies through networks and stockpile mechanisms and strengthening access to global and WHO expertise and technical support.

Other priorities include closing major knowledge gaps by promoting and facilitating research such as modelling and translational and operational research; developing strategies to combat antimicrobial resistance more effectively; and ensuring the availability of important tools and products.

#### EMERGENCY RISK AND CRISIS MANAGEMENT

Every year an increasing number of emergency events are recorded, affecting approximately 270 million people. Such events have significant effects on human health, health infrastructure and the delivery of health care services. Most countries experience a major emergency every five years. In addition, many countries suffer from protracted emergencies, which lead to poor health of individuals and the crippling of health systems in the long term.

Good health outcomes are at the heart of emergency risk management. The Secretariat will provide support to countries for implementing multi-hazard emergency risk management, using a multisectoral approach, in accordance with a new emergency and disaster risk management framework for health. Although national authorities, not outside bodies, are responsible for emergency risk management including emergency response, it is the role of WHO and other parts of the United Nations system to help them to build the required capacities to deal with the broad scope of emergency work.

In responding to crises, the Secretariat's support to countries will continue to be defined by WHO's Emergency Response Framework.<sup>1</sup> Accordingly, the Secretariat will implement a rigorous programme of institutional readiness. Its work in this area is in line with the United Nations Inter-Agency Standing Committee's transformative agenda, the cluster approach and the global platform for disaster risk reduction.

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<sup>1</sup> *Emergency response framework*. Geneva, World Health Organization, 2013.

## **FOOD SAFETY**

Unsafe food causes many acute and life-long diseases, ranging from diarrhoeal diseases to various forms of cancer. WHO estimates that foodborne and waterborne diarrhoeal diseases taken together kill about 2.2 million people annually, 1.9 million of them children.

The principles of detection, assessment, prevention and management apply equally to foodborne public health risks. A key aspect of prevention in the area of food safety is the establishment of internationally harmonized recommendations and standards. Similarly, preparedness is based on evidence-based risk management options to control major hazards throughout the food chain. Future work will pay particular attention to the links between agriculture and veterinary and public health.

## **POLIO ERADICATION**

Polio is a crippling and potentially fatal infectious disease. There is no cure, but there are safe and effective vaccines. The strategy to eradicate polio is therefore based on preventing infection by immunizing every child until transmission stops and the world is polio-free. The completion of the eradication of polio has been declared a programmatic emergency for global public health.<sup>1</sup> The immediate objective is the complete eradication of wild poliovirus. Thereafter, internationally agreed surveillance, containment and outbreak response protocols are needed for the endgame period of polio eradication; regional consensus is required on the phased cessation of the use of oral polio vaccine from routine immunization programmes; and international consensus must be achieved on the goal and process for securing the public health legacy of polio eradication.

## **OUTBREAK AND CRISIS RESPONSE**

At global, regional and national levels, WHO continues to play a critical operational role in outbreak and crisis response, and this role will not diminish in the foreseeable future. Humanitarian and public health emergencies are acute external events that are unpredictable and call for an urgent, and sometimes massive, response by WHO. The Organization's success in supporting national and international response efforts is dependent on several components. Of these, the ability to perform the following actions is particularly significant: coordinate action among many stakeholders; provide access to global technical assistance, knowledge and guidance; provide surge capacity (mobilizing expert staff and materials rapidly); provide information generally unavailable from other sources; and provide services directly often under the mandate of the International Health Regulations (2005) when relevant. Some emergencies can require support for a wide range of specific issues, including public health and clinical infection control; public risk communication; water, sanitation and hygiene; nutrition; communicable and noncommunicable diseases; maternal and newborn health; mental health; health technologies; logistics; surveillance and health information services; and restoration of the health infrastructure and recovery of health systems.

## **LINKAGES WITH OTHER PROGRAMMES AND PARTNERS**

This category is strongly linked to all the other categories of work. The capacities required for risk reduction, the International Health Regulations (2005), and disaster preparedness, response and recovery are fundamental components of health systems and services. In particular, this category has strong links with category 1, for the reduction of the burden of communicable diseases, the surveillance and control of which is a major aspect of WHO's responsibilities under the International

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<sup>1</sup> See resolution WHA65.5.

Health Regulations (2005) and in the context of humanitarian emergencies (including provision of expert guidance on the management of pneumonia, diarrhoeal disease, malaria, tuberculosis and HIV infection in such settings). The management of noncommunicable diseases, injuries, mental health, environmental health, nutrition, and maternal and reproductive health is central to WHO's work in this category. The principles of human rights, ethics, equity, gender mainstreaming, sustainable development and accountability inform all of the Organization's emergency work.

The Secretariat will take a multifaceted approach. Current activities that are part of existing multilateral, international and regional frameworks and mechanisms will be fully implemented, particularly those of the International Health Regulations (2005), the Pandemic Influenza Preparedness Framework, the Global Action Plan for Influenza Vaccines, the Hyogo Framework for Action 2005–2015, the United Nations Inter-Agency Standing Committee's transformative agenda, the Codex Alimentarius Commission, chemical conventions, global and regional platforms for disaster risk reduction, the International Food Safety Authorities Network, the tripartite WHO, FAO and OIE One Health initiative, the International Association for Conflict Management, and the Global Polio Eradication Initiative. Major networks, such as the Global Outbreak Alert and Response Network, the Global Influenza Surveillance and Response System, the Inter-Agency Standing Committee's Global Health Cluster and regional response teams will be maintained and strengthened.

The Secretariat will use partnerships to provide support to countries in enhancing their emergency risk management capacities. WHO will strengthen its interaction with other organizations in the United Nations system and multilateral, bilateral and regional agencies that are active on such issues as disposal of hazardous chemicals, ionizing and non-ionizing radiation, water and food safety, health rights, trauma care and psychosocial support. WHO will continue to be a leading partner in the Global Polio Eradication Initiative in order to ensure that the objectives of the polio eradication and endgame strategy are achieved and that the polio endgame is initiated.

**ALERT AND RESPONSE CAPACITIES**

**Outcome 5.1. All countries have the minimum core capacities required by the International Health Regulations (2005) for all-hazard alert and response**

<b>Outcome indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries meeting and sustaining International Health Regulations (2005) core capacities	80 (2013)	195 (2016)

**Output 5.1.1. Countries enabled to develop core capacities required under International Health Regulations (2005)**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Proportion of countries supported that have met and sustained International Health Regulations (2005) core capacities within the biennium	50% (2013)	100% (2015)

**Country office deliverables**

- Support further development and implementation of the national plan for implementation of the International Health Regulations (2005) in countries that have requested an extension
- Facilitate national dialogue across different disciplines in particular in relation to animal health, food, chemical and radio nuclear safety and points of entry
- Coordinate with National IHR Focal Point to review, analyse and use national information and ensure adequate reporting on implementation of the International Health Regulations (2005)

**Regional office deliverables**

- Implement regional strategies to support capacity strengthening for the International Health Regulations (2005) at the country level
- Develop and/or adapt regional, subregional and (when required) country-specific tools, guidelines and training materials
- Advocate for, raise awareness of and increase political commitment to the core capacity requirements for the International Health Regulations (2005), including through meetings of regional stakeholders
- Produce a regional report (including publication of data) and share regional information with Member States

**Headquarters deliverables**

- Formulate policies, norms and standards, and guidelines for the development of specific capacities
- Provide advocacy on global health matters related to core capacity requirements for the International Health Regulations (2005) and convene meetings of international technical partners to facilitate global dialogue across different sectors and disciplines on issues related to animal health, food, chemical and radio nuclear safety, and points of entry
- Publish a global report on the implementation status of the International Health Regulations (2005)

**Output 5.1.2. WHO has the capacity to provide evidence-based and timely policy guidance, risk assessment, information management and communications for all acute public health emergencies**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Proportion of WHO offices fully meeting standards for event-based surveillance and risk assessment	60% (2013)	100% (2015)

**Country office deliverables**

- Use a common WHO event-based surveillance and risk assessment system and procedures for all identified events
- Develop capacities or ensure mechanisms are in place for adequate information management, risk assessment and risk communication for events of potential international concern
- Identify national institutions that can join the Global Outbreak Alert and Response Network and facilitate opportunities for national institutions that are part of the Network to contribute to alert and response

**Regional office deliverables**

- Use, and contribute to further development of, a common WHO event-based surveillance and risk assessment system with common procedures for all identified events
- Ensure mechanisms are in place for adequate information management, risk assessment and risk communication for events of potential international concern
- Coordinate international response and provide surge capacity to countries
- Support further development of the Global Outbreak Alert and Response Network adapted to regional specificities

**Headquarters deliverables**

- Maintain and further develop a common WHO event-based surveillance and risk assessment system with common procedures for all identified events
- Support the regional offices to ensure that capacities are in place or mechanism identified for coordinating international response and providing surge capacity to countries
- Maintain the secretariat of the Global Outbreak Alert and Response Network, ensure its further development, including the management of meetings of the Network's Steering Committee

**EPIDEMIC-PRONE AND PANDEMIC-PRONE DISEASES****Outcome 5.2. Increased capacity of countries to build resilience and adequate preparedness to mount a rapid, predictable and effective response to major epidemics and pandemics**

<b>Outcome indicator</b>	<b>Baseline</b>	<b>Target</b>
Percentage of countries with a national strategy in place that covers resilience and preparedness for major epidemics and pandemics	40% (2011)	50% (2015)

**Output 5.2.1. Countries are enabled to develop and implement operational plans, in line with WHO recommendations on strengthening national resilience and preparedness covering pandemic influenza and epidemic and emerging diseases**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries that have developed or updated since the end of the 2009 influenza pandemic their operational plans on strengthening national resilience and preparedness for pandemic influenza and epidemic and emerging diseases	10/194 (2013)	40/194 (2015)

***Country office deliverables***

- Support countries in implementing national plans to prevent and control outbreaks, epidemic diseases, including antimicrobial resistance
- Contribute to setting norms and standards on epidemic and pandemic diseases and advocate for intersectoral collaborations

***Regional office deliverables***

- Provide regional data and inputs to development, regional adaptation and implementation of global strategies for epidemic diseases including the implementation of the Pandemic Influenza Preparedness Framework and the WHO global strategy for containment of antimicrobial resistance
- Inform regional Member States about best practices and relevant norms and standards for the control of epidemic diseases; foster the implementation of vaccine or treatment recommendations for epidemic and pandemic diseases, through regional Technical Advisory Groups, where these exist
- Support and backstop country offices for national capacity strengthening in all aspects related to the prevention and control of epidemic diseases
- Facilitate collaboration with regional intergovernmental organizations and other regional actors

***Headquarters deliverables***

- Coordinate implementation of the Pandemic Influenza Preparedness Framework in line with the International Health Regulations (2005) and the WHO Global Action Plan for Influenza Vaccines
- Lead development of global strategies, policies, norms, standards and research agendas for numerous epidemic and pandemic infectious diseases
- Coordinate management of global stockpiles and technical experts networks for preparedness and response to epidemic diseases
- Advocate for commitment to tackling emerging or re-emerging global threats, such as hepatitis and antimicrobial resistance, and foster innovation in responding to known epidemic diseases (e.g. use of oral cholera vaccine)

**Output 5.2.2. Expert guidance and systems support in place for disease control, prevention, treatment, surveillance, risk assessment and risk communications**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries with routine and event based surveillance reporting based on international standards for epidemic diseases	100/194 (2013)	120/194 (2015)

**Country office deliverables**

- Provide and adapt global and regional good practices for epidemic preparedness and response
- Support national research initiatives to address the threat posed by antimicrobial resistance
- Support countries in implementing international standards for epidemic diseases; routine and event based surveillance; early warning; and risk assessment
- Contribute to the dialogue with national health authorities and health actors when assessing risks during epidemics

**Regional office deliverables**

- Promote cross-border exchange of information on epidemic and pandemic diseases of common interest to countries
- Provide regional data and situation analyses on major epidemic diseases and antimicrobial resistance to contribute to the development of the public health research agenda
- Provide technical support for the development of regional systems to collect baseline information on epidemic and pandemic diseases and ensure connectivity between national and global platforms
- Support countries in generating evidence on best practices and implementation of international standards for routine and event-based surveillance of epidemic diseases, as well as risk assessment

**Headquarters deliverables**

- Shape the research agenda on major epidemic and pandemic diseases and global threats such as antimicrobial resistance, based on a consolidation of existing knowledge and identification of critical knowledge gaps
- Update standards, tools, information technology platforms and methodology for the risk assessment and surveillance of epidemic and pandemic diseases (event-based, early warning and routine surveillance)
- Provide global technical coordination and expertise to regions where additional capacity is needed for risk assessment of, and response to, emerging and re-emerging pathogens
- Integrate an “antimicrobial resistance perspective” into WHO’s clinical guidelines for diseases and in the regulations for antimicrobial use in humans, animals and food production

**EMERGENCY RISK AND CRISIS MANAGEMENT****Outcome 5.3. Countries have the capacity to manage public health risks associated with emergencies**

<b>Outcome indicator</b>	<b>Baseline</b>	<b>Target</b>
Percentage of countries with minimum capacities to manage public health risks associated with emergencies	Not applicable	80% (2019)

**Output 5.3.1. Global Health Cluster and country health clusters reformed in line with the United Nations Inter-Agency Standing Committee’s transformative agenda**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Percentage of health clusters that meet the minimum requirements for a satisfactory performance	40% (2013)	70% (2015)



**Country office deliverables**

- Assess health cluster performance every six months against the protocols of the United Nations Inter-Agency Standing Committee's transformative agenda, using the cluster performance monitoring tool, and take remedial measures where necessary
- Generate country-level information on the health situation, including health service coverage and/or utilization, every six months, in targeted health cluster countries

**Regional office deliverables**

- Ensure the application of the cluster performance monitoring tool and the monitoring of health service coverage and/or utilization, track, and report on, results and remedial actions
- Produce the annual reports on cluster performance and health service coverage and/or utilization

**Headquarters deliverables**

- Establish a Global Health Cluster unit and renew partnerships, strategy, structure, systems and outputs for the Global Health Cluster in line with the protocols of the United Nations Inter-Agency Standing Committee's transformative agenda
- Publish the annual global reports on country health cluster performance and on health service coverage and/or utilization

**Output 5.3.2. Health established as a central component of global multi-sectoral frameworks for emergency and disaster risk management; national capacities strengthened for all-hazard emergency and disaster risk management for health**

Output indicator	Baseline	Target
Percentage of countries conducting an capacity assessment for all-hazard emergency and disaster risk management for health	40% (2013)	80% (2015)

**Country office deliverables**

- Integrate all-hazard emergency and disaster risk management for health into new WHO country cooperation strategies, the United Nations Development Assistance Framework and national health strategies
- Support the conduct of risk and capacity assessments to identify priority actions for all-hazard emergency and disaster risk management for health
- Support countries to apply the WHO survey tool to document the status of all-hazard emergency and disaster risk management for health at country level

**Regional office deliverables**

- Provide technical support for the integration of all-hazard emergency and disaster risk management for health into WHO country cooperation strategies, the United Nations Development Assistance Framework and national health strategies
- Strengthen the capacity of WHO country office staff and regional partners in all-hazard emergency and disaster risk management for health
- Ensure the application of the WHO survey tool on the status of all-hazard emergency and disaster risk management for health at country level; and validate, consolidate, analyse and disseminate the survey results, every biennium

**Headquarters deliverables**

- Establish a global framework to be used for national all-hazard emergency and disaster risk management for health, including related tools, a training curriculum, hazard specific guidance, and a support network of specialists
- Develop a survey tool to document the status of all-hazard emergency and disaster risk management for health at country level; and publish the global report with inputs from regional offices

**Output 5.3.3. Organizational readiness successfully realized for full implementation of WHO's Emergency Response Framework**

Output indicator	Baseline	Target
Percentage of WHO offices that fully comply with WHO's readiness checklist	20% (2013)	80% (2015)

**Country office deliverables**

- Apply readiness checklist to the WHO country offices, report on results and take remedial measures where necessary

**Regional office deliverables**

- Ensure the application of the readiness checklist; track the results and remedial actions; report annually on the readiness of WHO country offices and regional offices as per checklist
- Adapt regional standard operating procedures for emergencies as required, including regional administrative procedures for rapid deployment
- Maintain quarterly regional on-call surge teams; conduct surge team training

**Headquarters deliverables**

- Finalize organizational readiness procedures and checklist; track and report on readiness of WHO headquarters as per checklist; and publish annual global report, including a trend analysis
- Finalize surge mechanism and components for WHO and health cluster functions, in line with the Emergency Response Framework and the transformative agenda
- Maintain and update the Emergency Response Framework; develop a tool for tracking implementation of the Emergency Response Framework; maintain and update organizational standard operating procedures for emergencies

**Output 5.3.4. Health sector strategy and plan developed, implemented and reported on in all targeted protracted-emergency countries by an in-country network of qualified and trained WHO emergency staff**

Output indicator	Baseline	Target
Percentage of protracted-emergency countries that meet the performance standards	25% (2013)	70% (2015)

**Country office deliverables**

- Maintain dedicated emergency staff, including for health cluster and/or health sector coordination; and strengthen national health sector coordination mechanisms
- Apply the Emergency Response Framework and the standard operating procedures; and track performance against performance standards
- Provide technical support for the transition to recovery and development

**Regional office deliverables**

- Apply the Organizational plan for recruitment, development, and retention of high-performing emergency staff, including for the health cluster and/or health sector and for administrative actions; and provide relevant training to build technical, coordination and managerial capacities
- Ensure application of the tool for tracking implementation of the Emergency Response Framework; consolidate annual regional report on implementation of the Emergency Response Framework in protracted emergencies
- Conduct country-level evaluations of the performance of WHO and the health cluster jointly with cluster partners in protracted emergencies, in at least two countries globally each year

**Headquarters deliverables**

- Develop with regional offices an organizational plan for recruitment, development, and retention of high-performing emergency staff, including for health cluster and/or health sector and administrative functions
- Publish an annual global report on implementation of the Emergency Response Framework in protracted emergencies, including a trend analysis

**FOOD SAFETY****Outcome 5.4. All countries are adequately prepared to prevent and mitigate risks to food safety**

Outcome indicator	Baseline	Target
Number of countries that have adequate mechanisms in place for preventing or mitigating the risks to food safety	116/194 (2013)	136/194 (2015)

**Output 5.4.1. Support the work of the Codex Alimentarius Commission to develop, and for countries to implement, food safety standards, guidelines and recommendations**

Output indicator	Baseline	Target
Percentage of high priority requests for international guidance, standards or recommendations on food hazards successfully dealt with	80% (2013)	90% (2015)

**Country office deliverables**

- Facilitate applications to Codex Trust Fund and promote the importance of work of the Codex Alimentarius Commission at the national level

**Regional office deliverables**

- Promote the work of the Codex Alimentarius Commission at the regional level and support the development of regional food-safety strategies and priorities with the involvement of regional Codex coordinating committees where appropriate
- Facilitate systematic collection, analysis and interpretation of regional data to guide risk analysis and support policy decisions

**Headquarters deliverables**

- Develop and formulate international norms, standards and recommendations through the Codex Alimentarius Commission
- Convene international expert meetings to perform risk assessments on priority food hazards

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**Output 5.4.2. Multisectoral collaboration to reduce foodborne public health risks, including those arising at the animal–human interface**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries with mechanism for multisectoral collaboration on reducing foodborne public health risks	97/194 (2013)	116/194 (2015)

**Country office deliverables**

- Facilitate cross-sectoral collaboration at national level in support of the development of national policies, strategies and plans for food safety, and in order to address and contain antimicrobial resistance
- Facilitate interaction with national contact points for International Food Safety Authorities Network (INFOSAN) and the International Health Regulations (2005), and support the development of national standard operating procedures
- Provide support to countries in developing and implementing risk communication and health promotion strategies on food safety and the prevention of zoonoses along the farm-to-table continuum

**Regional office deliverables**

- Coordinate regional collaboration with the agriculture sector and the animal and human health sectors, including cross-sectoral monitoring and risk assessment of emerging food-related zoonotic diseases and the food safety aspects of antimicrobial resistance
- Develop regional strategies for enhancing and strengthening International Food Safety Authorities Network (INFOSAN), including training for regional members
- Adapt to the regional context risk communication tools for foodborne public health risks together with key related health promotion messages

**Headquarters deliverables**

- Act as the secretariat to tripartite collaboration with the agriculture sector and the animal and human health sectors including cross-sectoral monitoring and risk assessment of emerging food related zoonotic diseases and the food safety aspects of antimicrobial resistance
- Act as the secretariat to the International Food Safety Authorities Network (INFOSAN) to increase preparedness and ensure a rapid international response to food safety emergencies and outbreaks of foodborne disease
- Develop risk communication tools and key health promotion messages in relation to foodborne public health risks

**Output 5.4.3. Adequate national capacity to establish and maintain risk-based regulatory frameworks to prevent, monitor, assess and manage foodborne and zoonotic diseases and hazards**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries with a food safety system that has an appropriate legal framework and enforcement structure	156/194 (2013)	170/194 (2019)

**Country office deliverables**

- Support countries in establishing and maintaining a risk-based framework to target and prevent foodborne diseases
- Provide technical support for strengthening alert and response systems for food safety and zoonotic emergencies, including those relating to the requirements of the International Health Regulations (2005)
- Support national authorities in adapting or adopting guidelines, methods and tools for collecting, analysing and interpreting data related to specific hazards along the food chain

**Regional office deliverables**

- Support country offices to identify capacity-strengthening needs in areas that include the following: microbiological, chemical and zoonotic risks; effective participation in the Codex Alimentarius Commission; food safety and zoonotic emergency response and surveillance
- Provide surge capacity to country offices during food safety and zoonotic emergencies
- Provide regional guidance in the review of food safety laws, inspection techniques and/or services, laboratory capacity and other food safety system components, in support of the development and updating of risk-based, integrated food safety systems

**Headquarters deliverables**

- Develop guidelines, methods and tools for the establishment of risk-based food safety systems, and for collecting, analysing and interpreting data related to specific hazards along the food chain
- Publish biennial reports of global estimates of the burden of foodborne and zoonotic diseases caused by agents of microbial, parasitic and chemical origin

**POLIO ERADICATION****Outcome 5.5. No cases of paralysis due to wild or type-2 vaccine-related poliovirus globally**

<b>Outcome indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of countries reporting cases of paralysis due to any wild poliovirus or type-2 vaccine-related poliovirus in the preceding 12 months	8 (2012)	0 (2019)

**Output 5.5.1. Direct support to raise population immunity against polio to the required threshold levels in affected and high-risk areas**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of polio-infected and high-risk countries supported to conduct polio vaccination campaigns and surveillance	72/72 (2013)	72/72 (2015)

**Country office deliverables**

- Provide direct in-country support for polio vaccination campaigns and surveillance in all polio-outbreak, polio-affected and high-risk countries
- Prepare weekly reports of case-based data on acute flaccid paralysis, polio cases, and supplementary oral poliovirus vaccination activities

**Regional office deliverables**

- Conduct quarterly regional risk assessment reports to identify and address gaps in population immunity and surveillance sensitivity for poliovirus
- Consolidate country reports into weekly and monthly regional bulletins, and provide analysis and country-specific feedback
- Support polio outbreak response, surveillance reviews and programme assessments

**Headquarters deliverables**

- Develop and update with regional offices, every six months, operational plans of action for the Global Polio Eradication Initiative, consolidate regional reports into weekly and monthly global bulletins
- Coordinate a quarterly global risk assessment for areas requiring supplementary immunization to inform the re-allocation of financial and human resources

**Output 5.5.2. International consensus established on the cessation of the use of oral polio vaccine type 2 in routine immunization programmes globally**

Output indicator	Baseline	Target
Number of countries (those using oral polio vaccine) where there is an agreed timeline for cessation of use of oral polio vaccine type 2 in routine immunization	0 (2013)	130 (2015)

**Country office deliverables**

- Provide guidance on the national plan for withdrawal of oral polio vaccine type 2 and introduction of inactivated polio vaccine use in routine immunization
- Coordinate with regulatory authorities the licensure of appropriate inactivated polio vaccine and oral polio vaccine products

**Regional office deliverables**

- Develop regional guidelines on synchronized withdrawal oral polio vaccine type 2 and introduction of inactivated polio vaccine
- Provide specialized technical assistance to country offices on the development of plans for cessation of immunization with oral polio vaccine type 2 and introduction of inactivated polio vaccine

**Headquarters deliverables**

- Coordinate programme of work on the six prerequisites for global withdrawal of oral polio vaccine type 2, in consultation with the Strategic Advisory Group of Experts on immunization
- Ensure licensure and availability of sufficient bivalent oral polio vaccine and affordable inactivated polio vaccine options, including Sabin-strain inactivated polio vaccine, for withdrawal of oral polio vaccine type 2

**Output 5.5.3. Processes established for long-term poliovirus risk management, including containment of all residual polioviruses, and the certification of polio eradication globally**

Output indicator	Baseline	Target
Number of fully functional certification processes for polio eradication at global and regional levels	4 (2013)	7 (2015)

**Country office deliverables**

- Support national committees to prepare reports for review by the Regional Certification Commission
- Support national authorities in the development, implementation and monitoring of the national poliovirus containment and emergency response plan in line with the global containment guidelines and action plan

**Regional office deliverables**

- Convene the Regional Certification Commission and serve as its secretariat
- Coordinate implementation of regional poliovirus containment processes, adapted from the global containment guidelines

**Headquarters deliverables**

- Convene the Global Certification Commission and serve as its secretariat
- Update the global containment guidelines and action plan including standard operating procedures for the global poliomyelitis laboratory network; develop protocols for the era following withdrawal of oral polio vaccine

**Output 5.5.4. Establishment of the polio legacy plan**

Output indicator	Baseline	Target
Plan for the polio legacy established	No (2013)	Yes (2015)

**Country office deliverables**

- Develop an inventory of the human resources and material assets of the polio eradication programme
- Document important lessons learnt in the country, including the role of partnership and donor engagement
- Facilitate national dialogue on the polio legacy

**Regional office deliverables**

- Document important country and regional or intercountry lessons learnt
- Consolidate the inventory of assets of the Global Polio Eradication Initiative in the region
- Develop regional consensus on priorities for the legacy of the polio eradication programme

**Headquarters deliverables**

- Consolidate the inventory of human and material assets of the polio eradication programme
- Consolidate, document, and disseminate lessons learnt in polio eradication
- Coordinate global legacy planning with regions and core stakeholders in the Global Polio Eradication Initiative

**OUTBREAK AND CRISIS RESPONSE****Outcome 5.6. All countries adequately respond to threats and emergencies with public health consequences**

<b>Outcome indicator</b>	<b>Baseline</b>	<b>Target</b>
Percentage of countries that demonstrated an adequate response to an emergency from any hazard with a coordinated initial assessment and a health sector response plan within five days of onset	Not applicable	100%

**Output 5.6.1. Implementation of the WHO's Emergency Response Framework in acute emergencies with public health consequences**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Percentage of emergencies from any hazard with public health consequences, including any emerging epidemic threats, where WHO's Emergency Response Framework has been fully implemented	0% (2013)	80% (2015)

**Country office deliverables**

- Apply the Emergency Response Framework in all graded emergencies, including adherence to its performance standards and implementation of its emergency response procedures
- Provide information management, risk assessment and risk communication during acute outbreaks and crisis; apply the tool for tracking performance against Emergency Response Framework performance standards, and take remedial actions as required
- Lead the health cluster in humanitarian emergencies, outbreaks and crises, as required, and apply standard operating procedures

**Regional office deliverables**

- Implement emergency response procedures for the regional office, including the provision of increased human, material and financial support, and the deployment of surge support as required by Emergency Response Framework surge policy
- Ensure the application of the tool for tracking performance against the Emergency Response Framework in all graded emergencies; support and track remedial actions; and report annually
- Conduct evaluations with partners for all Grade 3 (and selected Grade 2) emergencies; provide a platform for sharing best practices across countries

**Headquarters deliverables**

- Implement emergency response procedures for headquarters; including global surge support through the Global Outbreak Alert and Response Network and other partner networks and agreements
- Perform global monitoring and support risk assessment, communication, technical response and resource mobilization during major acute events
- Consolidate and disseminate an annual global report on implementation of the Emergency Response Framework in graded emergencies



## PROPOSED PROGRAMME BUDGET 2014–2015

## BUDGET BY MAJOR OFFICE AND PROGRAMME AREA(US\$ MILLION)

Programme area	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Alert and response capacities	8.4	6.3	6.0	7.5	5.0	15.1	49.7	<b>98.0</b>
Epidemic- and pandemic-prone diseases	4.8	3.8	3.8	1.4	3.5	8.0	43.2	<b>68.5</b>
Emergency risk and crisis management	37.7	3.2	6.0	3.4	7.3	4.0	26.4	<b>88.0</b>
Food safety	4.6	2.9	0.8	1.4	1.4	2.3	19.1	<b>32.5</b>
<b>Subtotal</b>	<b>55.5</b>	<b>16.2</b>	<b>16.6</b>	<b>13.7</b>	<b>17.2</b>	<b>29.4</b>	<b>138.4</b>	<b>287.0</b>

Programme area	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Polio eradication	408.2	3.5	69.6	4.0	140.1	1.9	73.1	<b>700.4</b>
Outbreak and crisis response	39.3	7.6	5.2	5.0	151.2	5.0	14.2	<b>227.5</b>
<b>Subtotal</b>	<b>447.5</b>	<b>11.1</b>	<b>74.8</b>	<b>9.0</b>	<b>291.3</b>	<b>6.9</b>	<b>87.3</b>	<b>927.9</b>

## **CATEGORY 6. CORPORATE SERVICES/ENABLING FUNCTIONS**

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This category includes both work on strengthening WHO's leadership and governance, and activities to foster improved transparency, accountability and risk management within the Organization. It also covers the work on enhancing strategic planning, resource coordination and reporting, management and administration and strategic communications.

For the biennium 2014–2015, the focus will be on organizational effectiveness to ensure that the work of the Secretariat is organized in ways that meet the changing health needs of Member States. The Organization's governance will be strengthened to make it more efficient and effective; the implementation of a control and accountability framework will be a priority for all offices, with risk management and accountability reinforced by the establishment of a dedicated unit at headquarters and by enhanced compliance and control activities in regional and country offices. This effort will require the strengthening of the management and administration of country offices; bearing this in mind, careful consideration will be given to ensuring that services further improve and that reform activities are implemented as a priority.

### **LEADERSHIP AND GOVERNANCE**

The work in this category aims to support greater coherence in global health. To achieve this, WHO will need to continue to play a leading role in enabling many different actors to work towards a common health agenda. In exercising the Organization's leadership role, WHO acts as a convener for a wide range of negotiations and discussions between Member States and other stakeholders on public health issues. This convening role is performed at country level in relation to the coordination of health partners, at regional level in relation to cross-border and other issues relevant to groups of countries or to a region as a whole, and at headquarters in relation to the increasing number of global issues requiring intergovernmental negotiations and agreement.

The continuing reform effort will strengthen health governance both from the perspective of WHO's governing bodies and the role that WHO plays in coordination with other health actors, as well as WHO's broader role in governance for health. WHO's role in global health governance is expressed not just at headquarters, but increasingly at regional and country levels, in the health sector as well as influencing action in other sectors and in interactions with a wide range of stakeholders. These include the following: United Nations funds, programmes and specialized agencies; other intergovernmental and parliamentary bodies; regional political and economic integration organizations; development banks and other providers of development assistance; philanthropic foundations; a wide range of partnerships, with interests in global health, including those hosted by WHO; and non-State actors.

The work in this category aims to strengthen the oversight by the governing bodies, achieve greater alignment of agendas with the general programme of work and the programme budget, and promote better harmonization and stronger linkages between the regional committees and the global governing bodies.

Achieving greater organizational effectiveness will entail stronger leadership and stewardship of the Organization at all levels. In particular, WHO's leadership at country level will allow the Organization both to respond to country needs and priorities, and to support national authorities in setting the broader health agenda with other partners. The country cooperation strategies provide the basis for this work. A key priority is to strengthen WHO's in-country leadership capacity through staff

development, and by ensuring that the right staff are in place and that they have the appropriate skills and competencies.

#### **TRANSPARENCY, ACCOUNTABILITY AND RISK MANAGEMENT**

Managerial accountability, transparency and risk management are key aspects of the reform agenda. Towards this end, a series of measures are being introduced to ensure that WHO is an Organization that is accountable and that effectively manages risk.

Evaluation is one aspect of improving the accountability of WHO. WHO's work in fostering a culture and use of evaluation entails providing a consolidated institutional framework for evaluation at the three levels of the Organization, and facilitates conformity with best practice and with the norms and standards of the United National Evaluation Group. In May 2012, the Executive Board at its 131st session approved the evaluation policy for WHO.<sup>1</sup> Beyond this, a strengthened culture of evaluation in WHO requires evaluation to become an integral component of operational planning, along with putting in place a robust assessment of WHO's performance against the programme budget. A coordinated approach and ownership of the evaluation function will be promoted at all levels of the Organization. Independent evaluation will be facilitated, in line with the Organization-wide evaluation policy and will be supported by tools, such as clear guidelines on evaluation.

In addition, the Secretariat's internal audit and oversight services will be strengthened and a new ethics function will be established to focus on standards of ethical behaviour by staff and to ensure the highest standards of business practice (particularly in relation to conflicts of interest and financial disclosure). The office performing the ethics function will also work closely with a strengthened internal justice system and will oversee the implementation of a new information disclosure policy.

Managing risks is an important area of focus. WHO is constantly exposed to risks of various types, including risks related to the following: its technical and public health work; financing; the Secretariat's procurement activities on behalf of Member States; the systems and structures needed for the Organization to function; the political and governance context and the Organization's reputation. An effective and comprehensive management of risk is at the heart of management reform in WHO. WHO is establishing a risk management framework that will identify, categorize, assess, prioritize, mitigate and monitor risks across the Organization and that will regularly update an Organization-wide risk register consisting of risk registers at the different levels. This will enable WHO's senior management to practise informed and timely decision-making.

In order to ensure the effective working of the risk management system as well as the compliance and control activities at all levels of the Organization, a Compliance and Risk Unit will be established. This will be supported by the Independent Expert Oversight Advisory Committee, which provides the link between internal oversight and WHO's governing bodies – through the Executive Board, and its subcommittee, the Programme, Budget and Administration Committee.

#### **STRATEGIC PLANNING, RESOURCE COORDINATION AND REPORTING**

This component is concerned with financing and the alignment of resources with the priorities and health needs of the Member States in a results-based management framework. It encompasses strategic planning, operational planning, budget management, performance assessment, resource mobilization, and reporting at all three organizational levels. A key feature of this work is sequenced

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<sup>1</sup> Decision EB131(1).

planning to enable country needs to be better reflected in the development of the programme budget, coupled with a realistic programme budget that highlights the results delivered at all levels of the Organization.

An additional feature is the use of predictable financing to support the implementation of the programme budget, with funding allocated to allow each level of the Organization to fulfill its roles and responsibilities. Success in this effort will call for well-coordinated planning and resource mobilization, efficient coordination and management and robust monitoring of performance at all levels.

#### **MANAGEMENT AND ADMINISTRATION**

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

The focus on human resources is also in line with the overall management reform, which includes the following key elements: (a) flexible workforce; (b) enhanced staff learning and development; (c) improved performance assessment; (d) a mobile workforce; (e) administration of justice. This ensures that WHO has human resources policies and systems in place that allow the Organization to respond rapidly to changing circumstances and public health needs.

Further efforts will be needed to strengthen administrative capacity in country offices to address audit observations about policy compliance and data quality issues at the country level.

These efforts will be combined with the work currently ongoing to continue improving effectiveness and awareness of internal control measures, in activities associated with human resources, travel, finance and procurement, where standard operating procedures have been made available.

Based on the conclusion of external studies conducted on management and administration costs in WHO, more attention will be given to cost efficiency measures, including benchmarking, and a more sustainable financing model that would ensure full cost recovery.

Information technology and operations support are key enabling functions for the Organization. The former provides the Organization with the computing and network infrastructure and with a portfolio of corporate systems and applications. The latter represents the backbone of WHO through the logistics support, procurement, infrastructure maintenance and security services for staff and for the Organization's property.

#### **STRATEGIC COMMUNICATIONS**

Strategic communications represents two interlinked objectives for communications. WHO has a crucial role in providing the public with timely and accurate health information, including during emergencies. In addition, WHO needs to communicate its work better, including its impact, to increase its visibility.

Health is an issue of public and political concern worldwide. The increasingly complex institutional landscape, the emergence of new players influencing health decision-making, 24-hour media coverage and the influx of social media platforms, and a growing demand from donors, politicians and the public for the impact of WHO's work to be clearly demonstrated, mean that rapid, effective and well-coordinated communication across all levels of the Organization is essential. In addition, WHO will create a communications surge capacity to support Member States with communications during emergencies; WHO will take a more proactive approach working with media and staff to better explain its role and impact on people's health. Finally, the Organization will regularly measure stakeholder perceptions and adjust the communication strategy accordingly. This can be achieved by the development of a global communications strategy that is coordinated across all levels of the Organization.

Furthermore, WHO will enhance its capacity to provide health information using innovative communications to reach a broader audience.

**LEADERSHIP AND GOVERNANCE**

**Outcome 6.1. Greater coherence in global health, with WHO taking the lead in enabling the many different actors to play an active and effective role in contributing to the health of all people**

<b>Outcome indicators</b>	<b>Baseline</b>	<b>Target</b>
Level of satisfaction of stakeholders with WHO's leading role in global health issues	High (based on composite rating from the Stakeholder Survey (November 2012))	At least high (Stakeholder survey 2015)

**Output 6.1.1. Effective WHO leadership and management in place**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Proportion of country cooperation strategies that are up to date and aligned with national health policies strategies and plans	88% (2013)	95% (2015)

**Country office deliverables**

- Establish effective leadership and coordination of WHO's work at the country level
- Ensure priority setting of WHO's technical cooperation within country through the development and implementation of a country cooperation strategy
- Support countries in their preparation for regional and global governing body meetings and processes

**Regional office deliverables**

- Establish effective leadership and coordination of WHO's work at the regional level
- Support the assessment and strengthening of performance of country offices
- Convene meetings with regional partners on important matters of policy, strategic dialogue and advocacy
- Facilitate cooperation across countries, including South–South cooperation and triangular cooperation, exchange of expertise, lessons learnt and best practices

**Headquarters deliverables**

- Convene meetings with stakeholders for strategic dialogue and advocacy on important global health issues and promote coherent collaboration
- Demonstrate effective leadership and stewardship of WHO's work, including the management and coordination of work across the three levels of the Organization
- Support the strengthening of country offices by improved selection and induction of heads of WHO Offices in countries, territories and areas
- Coordinate the strengthening of WHO's technical cooperation, including the development of guidelines on the enhancement of the country cooperation strategy process
- Facilitate cooperation across regions, exchange of expertise, lessons learnt and best practices, including South–South and triangular cooperation and interaction

**Output 6.1.2. Effective engagement with other stakeholders in building a common health agenda that responds to Member States' priorities**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Percentage of countries where WHO is perceived as providing the main support to government/partner coordination for health	80%	85%

***Country office deliverables***

- Support countries to establish effective mechanisms for engaging with other sectors, civil society and other non-state actors on a common health agenda
- Coordinate WHO's engagement with the United Nations at country level, including active participation in the United Nations Country Teams and engagement in developing the United Nations Development Assistance Framework

***Regional office deliverables***

- Facilitate effective working relations and mechanisms for increasing engagement with the non-health sector, including non-health ministries, parliaments, government agencies and other non-state actors
- Engage with regional partnerships, technical partners, donors, governing bodies of other agencies (including the United Nations) to advocate for health priorities specific to countries and the region as a whole

***Headquarters deliverables***

- Maintain and strengthen effective WHO cooperation, policy and systems to support the management of WHO-hosted partnerships
- Facilitate the definition by the Health Assembly of the principles, policies and operational procedures for engagement with non-state actors
- Engage with global partnerships, global technical partners networks, donors, governing bodies of other agencies (including the United Nations) to raise the profile of health priorities specific to countries, regions and globally

**Output 6.1.3. WHO governance strengthened with effective oversight of the sessions of the governing bodies, and efficient, aligned agendas**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Extent of the alignment of the governing bodies' agendas with the general programme of work and the programme budget, and their harmonization	Not applicable	Progressive improvement

***Country office deliverables***

- Support Member States in their preparation for regional and global governing body meetings and processes, and follow-up implementation of governing body decisions and resolutions

***Regional office deliverables***

- Support countries in preparing for effective engagement in the work of the governing bodies, including the provision of relevant and timely briefings
- Manage and administer regional committees and subcommittees in all relevant official languages

**PROPOSED PROGRAMME BUDGET 2014–2015****Headquarters deliverables**

- Manage and administer the Health Assembly, the Executive Board and committees, and related working groups, in all relevant official languages
- Strengthen support to countries for improved preparation and participation in the work of the governing bodies, including improving electronic access to governing body meetings and mission briefings
- Facilitate the negotiation and implementation of reforms to strengthen the role of the governing bodies, their oversight, harmonization, alignment and strategic decision-making

**Output 6.1.4. Integration of WHO reform into the work of the Organization**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Percentage of outputs in the WHO implementation plan being completed or on track	25% (2013)	100% (2015)

**Country office deliverables**

- Implement WHO reform activities that contribute to achieving the outputs of the reform work, particularly those that are relevant to strengthening WHO's performance at country level

**Regional office deliverables**

- Implement WHO reform activities that are relevant to strengthening WHO performance at regional level; support WHO reform activities that strengthen country-level performance
- Contribute to overall monitoring of the implementation of the reform agenda, including change management

**Headquarters deliverables**

- Implement and monitor the reform agenda, including change management
- Conduct specific time-limited reform projects in relation to areas still under discussion

**TRANSPARENCY, ACCOUNTABILITY AND RISK MANAGEMENT****Outcome 6.2. WHO operates in an accountable and transparent manner and has well-functioning risk-management and evaluation frameworks**

<b>Outcome indicator</b>	<b>Baseline</b>	<b>Target</b>
Proportion of corporate risks with response plans approved and implemented	Not applicable	100% (2015)

**Output 6.2.1. Accountability ensured through strengthened corporate risk management and evaluation at all levels of the Organization**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Organization-wide risk management framework implemented	No (2013)	Yes (2015)

**Country office deliverables**

- Maintain an effective and efficient internal compliance mechanism, including a comprehensive risk management framework in the country office



**Regional office deliverables**

- Maintain an effective and efficient internal compliance mechanism, including a comprehensive risk management framework in the regional office

**Headquarters deliverables**

- Maintain an effective and efficient internal compliance mechanism, including a comprehensive risk management framework at corporate level
- Strengthen capacity and implement internal audit and oversight
- Support external audit and other compliance mechanisms, including the Independent Expert Oversight Advisory Committee and the United Nations Joint Inspection Unit

**Output 6.2.2. Implementation of WHO's evaluation policy across the Organization**

Output indicator	Baseline	Target
WHO programmes regularly evaluated according to established policy, with follow-up actions initiated within 6 months from the date of the final recommendations	Not applicable	Yes (2015)

**Country office deliverables**

- Conduct country office evaluation in line with WHO's policy on evaluation and methodologies

**Regional office deliverables**

- Implement evaluation, document and share results of evaluations at regional level; support countries to conduct evaluation in line with WHO's policy on evaluation and methodologies

**Headquarters deliverables**

- Coordinate implementation of the evaluation policy of the Organization
- Conduct systematic evaluation of WHO's programmes in accordance with the evaluation policy of the Organization
- Monitor usage of evaluation findings and recommendations to improve programme planning and strengthen capacity through lessons learnt

**Output 6.2.3. Ethical behaviour, decent conduct and fairness promoted across the Organization**

Output indicator	Baseline	Target
Proportion of the complaints and/or allegations reported that are assessed within 6 months of registration	Currently being determined	100% (2015)

**Country office deliverables**

- Support the activities of the Board of Appeal, Ombudsperson and the Staff Association's work on the internal justice system in the country office

**Regional office deliverables**

- Support the activities of the Regional Board of Appeal, Ombudsperson, and the related Staff Association's work on the internal justice system in the regional office

**PROPOSED PROGRAMME BUDGET 2014–2015****Headquarters deliverables**

- Support the activities of the Board of Appeals, Ombudsperson, and the related Staff Association's work on internal justice system at global level
- Ensure timely assessment and initiation of investigations of alleged staff misconduct and harassment

**STRATEGIC PLANNING, RESOURCE COORDINATION AND REPORTING****Outcome 6.3. Financing and resource allocation aligned with priorities and health needs of the Member States in a results-based management framework**

<b>Outcome indicator</b>	<b>Baseline</b>	<b>Target</b>
Alignment of income and expenditure with approved programme budget by category and major office	Not fully aligned	100% aligned

**Output 6.3.1. Results-based management framework in place including an accountability system for WHO's corporate performance assessment**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Organizational performance measured through a consolidated assessment of delivery of planned outputs	Not applicable	Yes

**Country office deliverables**

- Define the country priority needs, strategies and resource requirements in relation to the development of the programme budget
- Develop and manage operational plans that include staff and non-staff resources based on the agreed programming framework and budget allocations
- Monitor and assess the implementation of plans, including tracking of performance indicators and financial vulnerabilities, and initiate actions to address related issues

**Regional office deliverables**

- Support the strengthening and coordination of strategic and operational planning for the region, ensuring alignment of regional and country plans with agreed priorities, as well as the planning of human resources and budget and resource allocations and their alignment with the approved plans and agreed priorities
- Coordinate the monitoring and assessment of regional and country outcomes, outputs and plans, including tracking of performance indicators and provision of related performance, budget and implementation analyses and reporting, ensure follow-up of actions taken to deal with related issues
- Develop and prepare regional input to the global programme of work and the programme budget and prepare related overviews and analyses for regional governing bodies

**Headquarters deliverables**

- Develop policy, guidance, systems and tools for the implementation and communication of WHO's results-based management
- Coordinate global strategic and operational planning, ensuring alignment of human resource plans and budget allocations with agreed priorities
- Coordinate the monitoring and assessment of plans, including tracking of performance indicators and financial performance, and ensure follow up on actions taken to deal with related issues

**Output 6.3.2. Alignment of WHO's financing with agreed priorities facilitated through strengthened resource mobilization, coordination and management**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Percentage of programme budget by category and major office funded at the beginning of biennium	55% (2013)	At least 70% (2015)

***Country office deliverables***

- Coordinate resource mobilization efforts and engage with donors at country level
- Coordinate the allocation of resources to country plans in alignment with agreed priorities
- Ensure the timely and accurate reporting of grants and agreements

***Regional office deliverables***

- Coordinate resource mobilization efforts and engage with donors at the regional level
- Coordinate the allocation of resources to regional and country plans in alignment with agreed priorities
- Ensure the timely and accurate reporting of grants and agreements

***Headquarters deliverables***

- Develop and support the implementation of resource mobilization policy and management, and the administration of donor partner agreements
- Coordinate global resource mobilization efforts, engage with donors and develop income projections
- Strengthen corporate resource mobilization communications (internal and external)
- Oversee the allocation of resources to plans to ensure alignment with agreed priorities

**MANAGEMENT AND ADMINISTRATION**

**Outcome 6.4. Effective and efficient management administration established across the Organization**

<b>Outcome indicator</b>	<b>Baseline</b>	<b>Target</b>
The level of performance of WHO management and administration	Adequate	Strong (2015)

**Output 6.4.1. Sound financial practices managed through an adequate control framework, accurate accounting, expenditure tracking and the timely recording of income**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
An unqualified audit opinion	Yes (2013)	Yes (2015)

***Country office deliverables***

- Implement the control framework and ensure compliance with WHO's administrative policies and regulations at the country level
- Manage expenditure tracking and reporting at the country level in a timely manner
- Manage Imprest and local payments at the country level in accordance with established policies and procedures

**PROPOSED PROGRAMME BUDGET 2014–2015*****Regional office deliverables***

- Implement the control framework and ensure compliance with WHO's administrative policies and regulations at the regional level
- Manage accounts, compliance and control, expenditure tracking, financial reporting at the regional level to ensure accuracy
- Manage local payments at the regional level

***Headquarters deliverables***

- Implement the control framework and ensure compliance with WHO's administrative policies and regulations at all levels, including Global Service Centre activities
- Set financial policies for the Organization in line with best practices
- Manage accounts, expenditure tracking and reporting, income and awards for the Organization
- Administer the pension, staff health insurance, entitlements and travel for the Organization
- Manage a fully functional corporate treasury for the Organization

***Global Service Centre deliverables***

- Manage accounts, process expenditures, perform reporting for the Organization
- Process and verify accounts payable, payroll, pension, entitlements and travel for the Organization
- Record income and awards for the Organization

**Output 6.4.2. Effective and efficient human resources management in place to recruit and support a motivated, experienced and competent workforce in an environment conducive to learning and excellence**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Percentage of recruitment processes completed within 180 days	65% (2013)	90% (2015)

***Country office deliverables***

- Conduct effective human resource plan to align staff resources with the relevant priorities
- Adhere to human resource policies of the Organization, including on rotation and mobility and reassignment of staff, gender balance, health-promoting workplace policies, staff development and learning and advise on benefits and entitlements
- Monitor staffing, ensuring adequate, qualified and motivated workforce in the country office
- Implement staff development and learning plans to ensure appropriate, competent, motivated and accountable staff for the country office

***Regional office deliverables***

- Facilitate human resource planning based on needs and priorities for the region and monitor the implementation of the human resource plan
- Implement human resource policies, including on recruitment and sourcing, rotation and mobility and reassignment, including policies to achieve gender balance in the Organization

- Monitor the staffing of the regional and country offices, ensure timely creation of positions, help ensure availability of a qualified and motivated workforce to meet the priorities of the Organization at the regional level; ensure implementation of mechanisms for more effective staff performance management and for promoting greater staff accountability
- Promote welfare of staff by advising on benefits and entitlement, staff development and learning, implement health-promoting occupational policies at regional level

#### **Headquarters deliverables**

- Support human resource planning based on the needs and the priorities of the Organization; monitor the implementation of the plans globally
- Set policies for recruitment and sourcing, rotation and mobility, and reassignment to achieve greater workforce flexibility and diversity goals, including gender balance; implement policies on, and conduct, recruitment and sourcing, rotation and mobility, and reassignment; implement measures for adequate flexibility for hiring and separation according to policy
- Work with regions and countries to further enhance performance management and strengthen staff accountability
- Monitor the staffing at headquarters, ensure timely creation of positions, help ensure the availability of a qualified and motivated workforce to meet the priorities of the Organization; promote the welfare of staff by setting policies, advising on and implementing benefits and entitlements, staff development and learning, and health promoting workplace practices

#### **Global Service Centre deliverables**

- Manage effective and efficient issuance and maintenance of staff contracts
- Administer and process entitlements
- Manage staff data, including registration of staff personal and human resources-supporting documents in the Record Management System

#### **Output 6.4.3. Efficient and effective computing infrastructure, network and communications services, corporate and health-related systems and applications, and end-user support and training service provided**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of IT infrastructure and services delivered according to common accepted standards	6 IT infrastructure and services (2013)	10 IT infrastructure and services (2015)

#### **Country office deliverables**

- Manage and administer information and communication technology, including support in the country office

#### **Regional office deliverables**

- Oversee regional governance of information and communication technology
- Manage continuity of information technology service, develop and implement ICT regional strategy, policies and governance for information and communication technology
- Manage and administer information and communication technology support for areas including networks, applications, hosting environment, event support, emergency support, and training in information and communication technology at the regional level

**PROPOSED PROGRAMME BUDGET 2014–2015****Headquarters deliverables**

- Manage, in the area of information and communication technology: global/headquarters governance; global policy, strategy and coordination; global business continuity capability development; and global applications and hosting
- Manage global technology road maps, including those for networks, telephony and desktops; design, build and manage global private network
- Manage, in the area of information and communication technology: support for headquarters staff in areas including networks, applications and hosting management; emergency response support; and training
- Administer the Global Management System, manage hosting and service levels and the global staff support help desk
- Design, build and manage common services/solutions including Synergy, e-mail and security

**Output 6.4.4. Provision of operational and logistics support, procurement, infrastructure maintenance and asset management, and of a secure environment for WHO's staff and property (in compliance with United Nations Minimum Operating Security Standards (MOSS) and Minimum Operating Residential Security Standards (MORS))**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Percentage of WHO facilities worldwide that are MOSS/MORS compliant	85% (2013)	95% (2015)

**Country office deliverables**

- Manage and administer building and maintenance
- Manage procurement of goods and services
- Manage transport and meeting services
- Administer asset and inventory, control and reporting, records and archives
- Coordinate with the United Nations on ensuring security of WHO personnel at country level and other shared costs at the country level

**Regional office deliverables**

- Manage and administer building and maintenance
- Manage procurement of goods and services
- Manage transport and meeting services
- Administer asset and inventory, control and reporting, records and archives
- Coordinate with the United Nations on ensuring security of WHO personnel and other shared costs at the regional level

**Headquarters deliverables**

- Manage and administer maintenance of building and premises
- Manage procurement of goods and services
- Manage transport and conference services
- Administer asset and inventory, control and reporting, records and archives
- Coordinate with the United Nations on ensuring security of WHO personnel and other shared costs

**Global Service Centre deliverables**

- Develop procurement policy and strategy; manage and administer their implementation
- Manage global contracts
- Manage and administer procurement
- Administer goods and shipping purchase order and service contracts purchase order processing

**STRATEGIC COMMUNICATIONS****Outcome 6.5. Improved public and stakeholders' understanding of the work of WHO**

<b>Outcome indicator</b>	<b>Baseline</b>	<b>Target</b>
Percentage of Member States and other stakeholder representatives evaluating WHO's performance as excellent or good	77% (2013)	85% (2015)

**Output 6.5.1. Improved communication by WHO staff leading to a better understanding of the Organization's action and impact**

<b>Output indicator</b>	<b>Baseline</b>	<b>Target</b>
Number of WHO offices that have completed the communications capacity building programme and assessed to be effective communicators of WHO's work	0 (2013)	40 (2015)

**Country office deliverables**

- Implement WHO's communications strategy at the country level
- Implement the standard operating procedures for communication during emergencies

**Regional office deliverables**

- Implement the standard operating procedures for communication during emergencies and provide surge capacity to country offices where it is needed
- Create strategic networks and partnership with communications, media and other relevant practitioners at regional level, and link them with country offices to support communication needs

**Headquarters deliverables**

- Develop the global communication strategy in collaboration with focal points at headquarters and in regional offices, covering both internal and scientific communications
- Develop the standard operating procedures for communicating during emergencies and provide surge capacity to regions where it is needed
- Support regional offices in strengthening capacity for health information, including communicating WHO's work to a broader audience, promoting the incorporation of communication components into key planning processes and monitoring
- Create strategic networks and partnerships with health communicators, media and other relevant practitioners at the global level

## PROPOSED PROGRAMME BUDGET 2014–2015

**Output 6.5.2. Development and efficient maintenance of innovative communication platforms**

Output indicator	Baseline	Target
Percentage of stakeholders who say WHO communicates public health information in timely and accessible ways	66% (2013)	75% (2015)

**Country office deliverables**

- Strengthen strategic communications, media relations and marketing of WHO's identity at the country level
- Launch public health campaigns, manage media relations, news releases at the country level

**Regional office deliverables**

- Strengthen strategic communication, media relations and marketing of WHO's identity for the region as a whole, including the appropriate and effective use of social media
- Increase the visibility of WHO's work through advocacy, managing media relations, news releases, public health campaigns, and other communication and advocacy platforms at the regional level
- Work in collaboration with communications focal points at headquarters to develop and implement modernized media outreach and education

**Headquarters deliverables**

- Set communication policies (e.g. social media, web) and strategy to strengthen strategic communications and use of these media platforms to improve WHO's visibility and image
- Improve capacity of WHO staff overall in contributing to communication activities that promote the visibility of WHO's work through training and facilitating access to information (i.e. training and access to internal web platform, Intranet, corporate social media channels)
- Improve media outreach and education to ensure that journalists report accurately on WHO's work; develop and disseminate materials for public health campaigns

**BUDGET BY MAJOR OFFICE AND PROGRAMME AREA(US\$ MILLION)**

Programme area	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Total
Leadership and governance	47.5	17.7	14.3	25.3	22.8	17.1	83.0 <sup>a</sup>	<b>227.7</b>
Transparency, accountability and risk management	7.3	4.6	1.0	1.1	1.4	0.1	34.9	<b>50.4</b>
Strategic planning, resource coordination and reporting	5.2	0.6	5.7	3.4	2.8	4.0	12.8	<b>34.5</b>
Management and administration	88.7	22.4	35.6	30.5	50.7	26.8	218.6	<b>473.3</b>
Strategic communications	5.3	3.1	0.6	2.8	2.9	3.3	19.1	<b>37.1</b>
<b>Subtotal</b>	<b>154.0</b>	<b>48.4</b>	<b>57.2</b>	<b>63.1</b>	<b>80.6</b>	<b>51.3</b>	<b>368.4</b>	<b>823.0</b>
Less post occupancy charge	23.5	3.8	6.2	9.1	8.6	7.0	80.8	<b>139.0</b>
<b>Total</b>	<b>130.5</b>	<b>44.6</b>	<b>51.0</b>	<b>54.0</b>	<b>72.0</b>	<b>44.3</b>	<b>287.6</b>	<b>684.0</b>

<sup>a</sup> Includes US\$ 5.2 million as a contribution towards UN Resident Coordinator System funding at country level.





## ANNEX. PROPOSED PROGRAMME BUDGET 2014–2015:

Categories and programme areas	Africa			The Americas			South-East Asia		
	Country Offices	Regional Offices	Total	Country Offices	Regional Offices	Total	Country Offices	Regional Offices	Total
<b>1. Communicable diseases</b>									
HIV/AIDS	30.3	15.6	45.9	2.6	1.4	4.0	8.8	5.4	14.2
Tuberculosis	13.1	3.8	16.9	0.7	0.4	1.1	25.6	4.8	30.4
Malaria	16.3	5.0	21.3	0.3	0.2	0.5	8.8	4.6	13.4
Neglected tropical diseases	13.4	6.0	19.4	3.0	1.6	4.6	5.3	3.3	8.6
* <i>Tropical disease research</i>	–	–	–	–	–	–	–	–	–
Vaccine-preventable diseases	124.0	39.2	163.2	6.0	3.3	9.3	29.6	11.2	40.8
<b>Subtotal</b>	<b>197.1</b>	<b>69.6</b>	<b>266.7</b>	<b>12.6</b>	<b>6.9</b>	<b>19.5</b>	<b>78.1</b>	<b>29.3</b>	<b>107.4</b>
<b>2. Noncommunicable diseases</b>									
Noncommunicable diseases	28.8	19.2	48.0	8.6	4.6	13.2	9.5	6.4	15.9
Mental health and substance abuse	0.7	1.6	2.3	1.7	0.9	2.6	1.0	0.4	1.4
Violence and injuries	0.9	0.5	1.4	1.4	0.8	2.2	0.7	0.2	0.9
Disabilities and rehabilitation	0.1	0.8	0.9	0.6	0.3	0.9	0.3	0.3	0.6
Nutrition	2.7	1.2	3.9	1.8	1.0	2.8	1.8	1.2	3.0
<b>Subtotal</b>	<b>33.2</b>	<b>23.3</b>	<b>56.5</b>	<b>14.1</b>	<b>7.6</b>	<b>21.7</b>	<b>13.3</b>	<b>8.5</b>	<b>21.8</b>
<b>3. Promoting health through the life-course</b>									
Reproductive, maternal, newborn, child and adolescent health	48.9	20.0	68.9	7.9	4.2	12.1	9.8	4.4	14.2
* <i>Research in human reproduction</i>	–	–	–	–	–	–	–	–	–
Ageing and health	0.1	0.6	0.7	0.7	0.4	1.1	0.1	0.2	0.3
Gender, equity and human rights mainstreaming	0.7	1.6	2.3	1.3	0.7	2.0	0.1	0.4	0.5
Social determinants of health	4.4	2.9	7.3	2.7	1.5	4.2	0.9	0.6	1.5
Health and the environment	6.8	6.0	12.8	8.3	4.5	12.8	3.9	3.1	7.0
<b>Subtotal</b>	<b>60.9</b>	<b>31.1</b>	<b>92.0</b>	<b>20.9</b>	<b>11.3</b>	<b>32.2</b>	<b>14.8</b>	<b>8.7</b>	<b>23.5</b>
<b>4. Health systems</b>									
National health policies, strategies and plans	9.1	6.1	15.2	9.5	5.0	14.5	8.3	4.3	12.6
Integrated people-centered health services	16.5	13.5	30.0	3.9	2.1	6.0	15.8	6.5	22.3
Access to medicines and health technologies and strengthening regulatory capacity	6.7	4.9	11.6	3.7	2.0	5.7	3.9	0.8	4.7
Health systems information and evidence	7.2	7.3	14.5	2.9	1.6	4.5	3.4	1.9	5.3
<b>Subtotal</b>	<b>39.5</b>	<b>31.8</b>	<b>71.3</b>	<b>20.0</b>	<b>10.7</b>	<b>30.7</b>	<b>31.4</b>	<b>13.5</b>	<b>44.9</b>
<b>5. Preparedness, surveillance and response</b>									
Alert and response capacities	4.3	4.1	8.4	4.0	2.3	6.3	1.3	4.7	6.0
Epidemic- and pandemic-prone diseases	2.5	2.3	4.8	2.5	1.3	3.8	2.7	1.1	3.8
Emergency risk and crisis management	30.0	7.7	37.7	2.1	1.1	3.2	4.3	1.7	6.0
Food safety	1.4	3.2	4.6	1.9	1.0	2.9	0.5	0.3	0.8
<b>Subtotal</b>	<b>38.2</b>	<b>17.3</b>	<b>55.5</b>	<b>10.5</b>	<b>5.7</b>	<b>16.2</b>	<b>8.8</b>	<b>7.8</b>	<b>16.6</b>
<b>6. Corporate services/enabling functions</b>									
Leadership and governance	33.0	14.5	47.5	12.5	5.2	17.7	12.4	1.9	14.3
Transparency, accountability and risk management	–	7.3	7.3	3.0	1.6	4.6	–	1.0	1.0
Strategic planning, resource coordination and reporting	–	5.2	5.2	–	0.6	0.6	–	5.7	5.7
Management and administration	30.6	34.6	65.2	11.6	7.0	18.6	15.5	13.9	29.4
Strategic communications	–	5.3	5.3	2.0	1.1	3.1	0.1	0.5	0.6
<b>Subtotal</b>	<b>63.6</b>	<b>66.9</b>	<b>130.5</b>	<b>29.1</b>	<b>15.5</b>	<b>44.6</b>	<b>28.0</b>	<b>23.0</b>	<b>51.0</b>
<b>Emergencies</b>									
Polio eradication	379.8	28.4	408.2	2.3	1.2	3.5	67.1	2.5	69.6
Outbreak and crisis response	31.6	7.7	39.3	4.9	2.7	7.6	5.1	0.1	5.2
<b>Subtotal</b>	<b>411.4</b>	<b>36.1</b>	<b>447.5</b>	<b>7.2</b>	<b>3.9</b>	<b>11.1</b>	<b>72.2</b>	<b>2.6</b>	<b>74.8</b>
<b>Total</b>	<b>843.9</b>	<b>276.1</b>	<b>1 120.0</b>	<b>114.4</b>	<b>61.6</b>	<b>176.0</b>	<b>246.6</b>	<b>93.4</b>	<b>340.0</b>

## BREAKDOWN BY MAJOR OFFICE AND CATEGORY

Country Offices	Europe		Eastern Mediterranean			Western Pacific			Headquarters	Total
	Regional Offices	Total	Country Offices	Regional Offices	Total	Country Offices	Regional Offices	Total		
2.5	3.3	5.8	6.7	2.9	9.6	7.4	2.7	10.1	41.9	131.5
5.2	5.8	11.0	17.8	3.1	20.9	9.6	4.8	14.4	36.2	130.9
0.2	0.9	1.1	11.7	2.1	13.8	8.2	4.4	12.6	28.9	91.6
0.1	0.3	0.4	4.4	1.9	6.3	4.7	3.6	8.3	43.7	91.3
–	–	–	–	–	–	–	–	–	48.7	48.7
2.2	10.1	12.3	31.5	7.8	39.3	15.0	11.1	26.1	55.8	346.8
<b>10.2</b>	<b>20.4</b>	<b>30.6</b>	<b>72.1</b>	<b>17.8</b>	<b>89.9</b>	<b>44.9</b>	<b>26.6</b>	<b>71.5</b>	<b>255.2</b>	<b>840.8</b>
1.7	14.7	16.4	8.2	8.1	16.3	15.7	12.5	28.2	54.1	192.1
3.0	4.2	7.2	1.4	1.4	2.8	1.9	2.4	4.3	18.6	39.2
3.5	3.2	6.7	0.5	0.5	1.0	3.5	0.7	4.2	14.7	31.1
0.5	–	0.5	0.2	0.2	0.4	0.2	2.1	2.3	9.9	15.5
0.3	1.7	2.0	1.8	1.2	3.0	2.0	1.1	3.1	22.2	40.0
<b>9.0</b>	<b>23.8</b>	<b>32.8</b>	<b>12.1</b>	<b>11.4</b>	<b>23.5</b>	<b>23.3</b>	<b>18.8</b>	<b>42.1</b>	<b>119.5</b>	<b>317.9</b>
1.5	5.5	7.0	10.2	4.4	14.6	9.0	3.1	12.1	61.0	189.9
–	–	–	–	–	–	–	–	–	42.9	42.9
0.1	1.4	1.5	0.6	0.4	1.0	0.1	0.1	0.2	4.7	9.5
0.2	1.1	1.3	0.8	0.4	1.2	0.1	0.1	0.2	6.4	13.9
1.1	6.5	7.6	0.6	0.6	1.2	0.3	1.1	1.4	7.1	30.3
2.1	20.6	22.7	3.3	1.8	5.1	5.7	2.0	7.7	33.9	102.0
<b>5.0</b>	<b>35.1</b>	<b>40.1</b>	<b>15.5</b>	<b>7.6</b>	<b>23.1</b>	<b>15.2</b>	<b>6.4</b>	<b>21.6</b>	<b>156.0</b>	<b>388.5</b>
3.5	14.1	17.6	7.2	3.9	11.1	10.6	4.8	15.4	39.3	125.7
3.4	8.3	11.7	10.8	4.6	15.4	18.3	5.6	23.9	42.2	151.5
0.7	6.3	7.0	4.4	2.9	7.3	5.2	3.7	8.9	100.3	145.5
0.4	8.1	8.5	6.0	3.2	9.2	1.9	4.1	6.0	60.4	108.4
<b>8.0</b>	<b>36.8</b>	<b>44.8</b>	<b>28.4</b>	<b>14.6</b>	<b>43.0</b>	<b>36.0</b>	<b>18.2</b>	<b>54.2</b>	<b>242.2</b>	<b>531.1</b>
2.6	4.9	7.5	3.0	2.0	5.0	9.8	5.3	15.1	49.7	98.0
0.2	1.2	1.4	2.1	1.4	3.5	4.3	3.7	8.0	43.2	68.5
1.2	2.2	3.4	4.5	2.8	7.3	2.7	1.3	4.0	26.4	88.0
0.6	0.8	1.4	0.7	0.7	1.4	1.1	1.2	2.3	19.1	32.5
<b>4.6</b>	<b>9.1</b>	<b>13.7</b>	<b>10.3</b>	<b>6.9</b>	<b>17.2</b>	<b>17.9</b>	<b>11.5</b>	<b>29.4</b>	<b>138.4</b>	<b>287.0</b>
12.9	12.4	25.3	14.8	8.0	22.8	9.8	7.3	17.1	83.0	227.7
–	1.1	1.1	–	1.4	1.4	–	0.1	0.1	34.9	50.4
–	3.4	3.4	0.1	2.7	2.8	–	4.0	4.0	12.8	34.5
5.8	15.6	21.4	27.0	15.1	42.1	11.2	8.6	19.8	137.8	334.3
–	2.8	2.8	1.0	1.9	2.9	–	3.3	3.3	19.1	37.1
<b>18.7</b>	<b>35.3</b>	<b>54.0</b>	<b>42.9</b>	<b>29.1</b>	<b>72.0</b>	<b>21.0</b>	<b>23.3</b>	<b>44.3</b>	<b>287.6</b>	<b>684.0</b>
1.1	2.9	4.0	135.8	4.3	140.1	1.0	0.9	1.9	73.1	700.4
3.7	1.3	5.0	143.6	7.6	151.2	4.9	0.1	5.0	14.2	227.5
<b>4.8</b>	<b>4.2</b>	<b>9.0</b>	<b>279.4</b>	<b>11.9</b>	<b>291.3</b>	<b>5.9</b>	<b>1.0</b>	<b>6.9</b>	<b>87.3</b>	<b>927.9</b>
<b>60.3</b>	<b>164.7</b>	<b>225.0</b>	<b>460.7</b>	<b>99.3</b>	<b>560.0</b>	<b>164.2</b>	<b>105.8</b>	<b>270.0</b>	<b>1 286.2</b>	<b>3 977.2</b>

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