

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

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

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

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

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

**DRAFT TWELFTH WHO GENERAL PROGRAMME OF WORK
*draft for discussion by the Executive Board in January 2013***

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...

OVERVIEW

1. This draft of the twelfth general programme of work has been influenced by the views expressed by Member States during the regional committees of 2012, as well as by further work on the part of the Secretariat, particularly in relation to strategic priorities. A final draft incorporating additional guidance from the Programme, Budget and Administration Committee and from the Executive Board will be submitted to the Sixty-sixth World Health Assembly for its consideration in May 2013.
2. The purpose of the twelfth general programme of work is to provide a high-level strategic vision for the work of WHO for the six-year period beginning January 2014.
3. Chapter 1 provides an analysis of the changing political, economic and institutional context in which WHO is working, outlining how these changes impact on people's health and countries' health systems. Chapter 2 then examines the implications of this analysis for the work of WHO, highlighting the need for both continuity and change. In so doing, it shows the link between changing context and the programmatic, governance and management elements of WHO reform.
4. At the heart of reform is the need for WHO to set clear priorities. Chapter 2 also reviews how a step-wise process of priority setting has resulted in a set of eight high-level strategic priorities for the period of this programme of work. Within the broad range of work for which WHO is responsible, the priorities provide the focus through which to judge the Organization's overall performance. Eight strategic priorities are discussed in Chapter 3, six of which relate to programmatic issues, and the remaining two relate to governance and management.
5. The six-year programme of work does not attempt to describe the totality of WHO's work, but rather focuses on high-level strategic priorities. This two-year programme budget provides a comprehensive account of the work for that biennium. The programme budget also provides the more detailed results framework that is needed in order to ensure accountability across the whole of the Organization. Chapter 4 briefly discusses the structure of the results chain and the links between the general programme of work and the programme budget from this perspective.¹
6. Member States requested that the new programme of work reflect key elements of the former Medium-term strategic plan. This has been achieved as follows. Firstly, the present document combines the high-level strategic vision of its predecessor with a focus on how the environment in which WHO works shapes the Organization's own focus and priorities. Secondly, reducing the duration of the programme of work from 10 to 6 years ensures close alignment with the planning and budgeting cycle. Thirdly, the present general programme of work identifies a selected number of high-level results, linked to the strategic priorities, against which WHO's overall performance can be judged. Lastly, it signals (also in Chapter 4) changes in the way that financial resources will be deployed in order to achieve these results, and outlines broad resource shifts between categories of work over the six-year period.

¹ Further work is required to strengthen the results chain in the general programme of work, including clearer linkages between and articulation of the impact goals, outcomes, and outcome indicators, as well as the development of a framework and systems for monitoring and evaluation.

CHAPTER 1

SETTING THE SCENE

New political, economic, social and environmental realities

7. The twelfth general programme of work has been formulated in light of the lessons learnt during the period of the Eleventh General Programme of Work, 2006–2015. The Eleventh General Programme of Work 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.

8. 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.

9. 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 fragile recovery.

10. At the start of the second decade of this century, around three quarters of the world's absolute poor live in middle-income countries. Moreover, many of these countries are becoming less dependent on (and 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 States, the private sector and civil society.

11. 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 United Nation's work in other, less poor, countries will be financed.

12. 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.

13. 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.

14. This brief sketch suggests both challenges and opportunities, with 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. While migration between countries can offer benefits to both the countries from which migrants leave and to those to which they migrate, this is by no means guaranteed and many migrants are exposed to increased health risks in their search for economic opportunity.
- 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 rise to outrage and uprising.
- The global environment is equally under pressure. Key planetary boundaries, such as loss of biodiversity, have been surpassed; and others soon will be. In many parts of the world, climate change will 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 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 level, 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 relation to tackling challenges such as child and maternal mortality, and HIV, tuberculosis and malaria. But the most complex problems still require well-managed multilateral negotiations in an organization with universal membership to reach a fair and equitable deal for all.

An evolving agenda for global health

15. New political, economic, social and environmental realities are reflected in the agenda for global health – not just in epidemiological and demographic terms, but also in the role and functioning of the institutions at national, regional and global level that have responsibility for delivering better health outcomes. As ever there is good news and bad news, there are successes and new challenges.

Successes and continuing challenges

16. The last decade has seen health take on an increasingly prominent role politically, reflected in the emergence of a number of international agreements and initiatives.

- The **Millennium Development Goals** (MDGs) include some of the most serious challenges to population health. Their simple format – a set of concise goals, targets, and indicators with defined time lines is intuitively attractive and readily understandable. A decade after the adoption of the Millennium Development Goals, substantial progress has been made in reducing child and maternal mortality, improving nutrition and reducing morbidity and mortality due to HIV infection, tuberculosis and malaria.
- By the end of 2012, 100 million people will have been protected by a new affordable vaccine against meningitis A in Africa. **New vaccines** are being rolled out in countries worldwide – now with the potential to prevent adult diseases such as cervical and liver cancer.
- **Legal instruments** negotiated by WHO's Member States such as the International Health Regulations (2005) help to protect populations from any new or emerging threat of international concern to public health. The Pandemic Influenza Preparedness (PIP) Framework will improve the sharing of influenza viruses with pandemic potential, and ensure more predictable, efficient, and equitable access, for countries in need, to life saving vaccines and medicines during future pandemics. A global code of practice on health worker recruitment will play a part in reducing the shortages and maldistribution of health workers.

17. As a response to these successes, domestic and international spending has increased in the health and development sectors. In 2010 **total health spending** reached US\$ 6.45 trillion. Although this figure is influenced by the weakness of the United States dollar in recent years, it is still 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 had a higher profile. **Development assistance for health** has undergone a similar increase from US\$ 10.52 billion in 2000 to US\$ 26.8 billion 10 years later.

18. In addition to those listed above, there are many other examples of success that could be cited, however, much still remains to be done. The health goals will not be reached in many countries and thus there is an extensive agenda of unfinished business in relation to the Millennium Development Goals. It is also a critical challenge to secure the place of health in the next generation of **global goals post-2015**. Much of the progress in combating AIDS and rolling out vaccines has depended on separate, vertically-managed programmes. There remains a need to integrate services, make them more user-friendly and ensure that people are not impoverished by out-of-pocket payments. The world has new drugs, vaccines and diagnostics, but many of the health problems of low-income countries and poor populations require affordable innovation and better access to medical products. Likewise, agreement on legal instruments such as the International Health Regulations (2005) is a critical step, but while many countries lack the necessary capacities to put them into practice, the

task is far from over. The International Food Safety Authorities Network (INFOSAN) faces similar challenges with regard to threats deriving from the global trade in foodstuffs.

The particular challenge of noncommunicable diseases

19. 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. What has changed is the recognition – not just by health professionals but by ministers of finance, 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.

20. Meeting the challenge of noncommunicable diseases and particularly addressing their determinants through multisectoral responses, requires that the **role of the ministries of health** must change: from a primary preoccupation with the provision and financing of health services, to becoming a broker and interlocutor with other parts of government. Similarly, ministries need the capacity to steer, regulate and negotiate with a wide range of partners in an increasingly complex environment.

21. 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 – that focus on prevention, early detection of disease and the promotion of healthy lifestyles – will be needed to sustain **universal 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 result in greater exclusion of those without financial means to access care.

Access to health services towards universal health coverage

22. Universal health coverage means ensuring access to effective health services (prevention, promotion, treatment and rehabilitation) and essential medicines and medical products and technologies that people need, without risk of their financial ruin in having to pay for these services out of pocket. Thus the goal of achieving universal health coverage has two interrelated components: coverage with needed health services (prevention, promotion, treatment and rehabilitation); and coverage with financial risk protection, for everyone. Although this cannot be achieved overnight, action is needed to move more rapidly towards it or to maintain the gains made.

23. Universal health coverage is conceived not as a minimum set of services but as an active process by which countries gradually increase access to curative and preventive services as well as protecting increasing numbers of people from catastrophic financial consequences when they fall ill. Universal health coverage is a dynamic process concerned with 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 are covered.

24. Moving towards universal coverage requires a strong, efficient health system that can deliver quality services on a broad range of country health priorities. This requires health financing systems that raise sufficient funds for health, access to essential medicines, good governance and health information, people-centred services, and a well-trained, motivated workforce, for example. Access to needed services improves or maintains health, allowing people to earn incomes, and children to

learn, providing them with a means to escape from poverty. Moreover, access to services when needed and financial protection provide security to populations where health services that might be needed are available, are of good quality, and affordable. At the same time, financial risk protection prevents people from being pushed into poverty because of out-of-pocket payments for health. Universal health coverage not only maintains and improves health, but is also a critical component of sustainable development and poverty reduction, and a practical expression of the concern for health equity and the right to health.

Health security and humanitarian action

25. 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.

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

27. 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.

28. The need for better coordination will remain a governance challenge for development cooperation in health, in the face of the fragmentation that results from a growing number of partnerships, alliances, financing channels and sources of technical support. Other more fundamental changes can also be expected. Financial pressures in many traditional donor countries will bring increasing concerns for fiduciary accountability and avoidance of risk. Sustained growth in many other economies may decrease their eligibility for external finance but also raise questions about how best to address the health needs of large, poor populations within their borders. Powerful emerging countries will become more influential as donors, particularly as financiers of major infrastructure projects. 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.¹

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

CHAPTER 2

THE ROLE OF WHO

29. 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. It thereby links the analysis of context with the main components of WHO reform.

Continuity: enduring principles, values and approaches

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

Box 1. Constitution of the World Health Organization: principles

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

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

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

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

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

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

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

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

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

31. 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.

32. 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.

- 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 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 WHO's core function of monitoring health trends and determinants at global, regional and country level.
- The review of health governance issues points to the need for negotiated solutions to shared international health problems, particularly in instances of interaction between health and other sectoral interests (such as trade, migration, security and intellectual property). In addition, the capacity to convene and facilitate the negotiation of binding international instruments distinguishes WHO from most other health actors. A commitment to multilateralism remains a core element of WHO's work.
- WHO will continue to be a normative agency that produces a range of guidelines, norms and standards that benefit countries collectively.
- WHO will also 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.
- 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.
- 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.¹

WHO reform: a strategic response to a changing environment

33. As Chapter 1 has shown, the twenty-first century has witnessed a series of commitments, opportunities, innovations, successes, setbacks and surprises 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.

¹ The core functions are: providing leadership; shaping the research agenda; setting norms and standards; articulating policy options; providing technical support and building capacity; and monitoring and health trends.

Finance aligned with priorities

34. 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, constrained financial reality rather than just managerially to a short-term crisis. Sustainable and predictable financing aligned to a carefully defined set of priorities, agreed by Member States, is therefore central to the vision of a reformed WHO. The process of priority setting which has identified the set of high-level strategic priorities is discussed in more detail in the final section of this chapter.

Effective health governance

35. 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. 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.

36. In the overall vision for a reformed WHO, health governance is a critical function at all levels of WHO: at headquarters through the work of the governing bodies and interactions with other global players; 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 as a strategic priority in Chapter 3.

Pursuit of organizational excellence

37. 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.

38. In structural terms, the objective is to improve support to countries, through strengthened, more autonomous, 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 on one hand, and a clear division of labour with accountability for resources and results on the other.

39. By the time the twelfth 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 pursuit of continuous improvements in organizational performance remains a strategic priority for the period of the programme of work, as discussed in the final section of Chapter 3.

Priority setting for the general programme of work

40. In early 2012, a meeting of Member States on priority setting agreed the criteria and categories for priority setting and programmes in WHO for the period 2014–2019 to be covered by the twelfth general programme of work. The five categories (plus an additional category for corporate services and enabling functions) will provide the main organizing structure for successive programme budgets.

41. The categories and criteria agreed by Member States are set out in Tables 1 and 2.

Table 1: Categories for 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 medical products; 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.

Table 2: 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.

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 ongoing assessment of performance;
- (d) potential to work with other sectors, organizations, and stakeholders to have a significant impact on health.

42. The priorities that emerge from examining the criteria provided in the context of the categories of work represent the most important contributions that WHO will make to global health over the period of the general programme of work. Their additional significance is that they are linked to a set of high-level results at outcome and impact level against which WHO can be held accountable.

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.

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.

Addressing the challenge of noncommunicable diseases and mental health.

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.

43. These six priorities collectively contribute to the programmatic objective of WHO's reform: *"Improved health outcomes, with WHO meeting the expectations of its Member States and partners in addressing agreed global health priorities, focused on the actions and areas where the Organization has a unique function or comparative advantage, and financed in a way that facilitates this focus".*¹

44. The other two reform objectives are strategic priorities in their own right:

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.

¹ See document EBSS/2/2, paragraph 3.

CHAPTER 3

Strategic priorities

45. This chapter reviews each of the eight strategic 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.

Health-related Millennium Development Goals: unfinished and future challenges

46. 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.

47. 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.

48. The unfinished Millennium Development Goal agenda is a strategic priority for WHO for several reasons. As the debate on the next generation of goals begins, it is clear from the first round of 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.

49. 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.¹

50. Thirdly, the Millennium Development Goal agenda brings 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.

¹ 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).

51. 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. To reduce **maternal and newborn mortality**, interventions in the 24 hours around delivery (management of labour, oxytocin after delivery, resuscitation of the newborn and early initiation of breast feeding) are specific priorities.

52. 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

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

54. The growing burden of noncommunicable diseases 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 spent now on cost-effective interventions can prevent US\$ 47 trillion-worth of future damage to the world's economies by 2030. In short, action can show how better health can make a significant contribution to poverty reduction and economic development.

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

56. WHO will focus primarily over the next six years on combating the four major noncommunicable diseases¹ and their major risk factors.² 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.

57. 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.

58. 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.

59. 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.

60. It is possible to identify policy levers in relation to all 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 priority for WHO. Success will require coordinated, multisectoral action at global, regional, national and local levels.

61. 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.

62. 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.

¹ Cardiovascular disease, cancers, chronic lung diseases, diabetes.

² Tobacco use, unhealthy diet, physical inactivity, and harmful use of alcohol.

Advancing universal health coverage

63. Universal health coverage is a new strategic priority for WHO. It combines two fundamental components: access to the services (promotion, prevention, treatment and rehabilitation) as well as the living conditions needed to achieve good health, with financial protection that prevents ill health leading to poverty. It thus provides a powerful unifying concept to guide health and development in coming years.

64. Universal health coverage in this sense is instrumental in helping people enjoy the highest attainable level of health. At the same time, it is valued for its own sake. People sleep well at night knowing that good quality health care services are available when they are needed and that they are affordable. The outcome of the United Nations Conference on Sustainable Development (Rio +20)¹ 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 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.

¹ *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 multi-sectoral action to address urgently the health needs of the world's population.*

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.

Implementing the provisions of the International Health Regulations (2005)

71. The world's defence against shocks arising from the microbial world (and increasingly the interface between humans and animals – the source of 75% of new diseases) 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) provides 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.

72. The International Health Regulations (2005) 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.

73. 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.

74. 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

75. 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.

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

77. 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.

78. 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.

79. 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 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.

80. 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

81. 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, and the World Conference on Social Determinants of Health held in Rio, October 2011.¹

82. 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. 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.

83. 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 (final draft) that address social and other determinants will be highlighted to demonstrate the range that they cover.

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

84. 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*.¹ This latter perspective is well illustrated by the whole of society approach to noncommunicable disease mentioned in the previous paragraph 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:² *“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 outcome”*.³

Strengthening WHO’s governance role

85. WHO has a range of governance roles in health at country, regional and headquarters levels. It is therefore a strategic priority to strengthen and, where necessary, build the requisite capacity to fulfil these roles effectively, in line with the objectives of WHO’s reform agenda.

86. Several areas relevant to WHO’s governance role have been touched on in earlier sections of the general programme of work: in relation to noncommunicable diseases, national health policies and universal health coverage; and the International Health Regulations. The previous section on social determinants also distinguished governance of health, which is primarily a coordinating, directing and internal coherence function, from governance in other sectors in the interests of health, which is an advocacy function. WHO needs to be adept at both.

87. In addition, the analysis in Chapter 1 suggests that while 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.

88. The proposed reforms in governance therefore cover two closely linked areas: the internal governance of WHO by Member States and the role of WHO in health governance and governance for health in other arenas. The fundamental objectives for the internal governance reforms are to foster a more strategic and disciplined approach to priority setting, to enhance the oversight of the programmatic and financial aspects of the Organization, and to improve the efficiency and inclusivity of intergovernmental consensus building, by strengthening the methods of work of the governing bodies. The main objective of reforming WHO’s role in health governance more broadly is to increase the effectiveness of engagement with the other stakeholders that influence global health policy, to strengthen the negotiation capacity of health actors and to capitalize more effectively on WHO’s leadership position in order to enhance coherence among the many actors involved in global health.

¹ In the general programme of work the term “health governance and governance for health” is used in preference to “global health governance” or “global governance for health” in order to stress the point that governance is not just a global issue but is of equal importance at country, regional and subregional level.

² Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand.

³ The Oslo Ministerial Declaration (2007).

Governance of WHO

89. In brief, the internal governance agenda will focus initially on the work of the governing bodies: the World Health Assembly, the Executive Board and the regional committees. For the Board, this will mean strengthening its executive and oversight roles; increasing its 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 governance functions, through briefing of new members as well as even higher quality and more timely documents.

90. 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. The general programme of work foresees that this demand is unlikely to decrease. WHO, as a consequence, will put in place the requisite capacities to manage these processes effectively.

91. A further element of governance reform concerns WHO's relationship and engagement, beyond the purely technical and working level, with a range of other stakeholders including nongovernmental organizations, civil society organizations, partnerships, and private sector entities. In relation to partnerships this includes the governance of partnerships hosted by WHO, as well as WHO's governance role as a member of independent partnerships. Principles governing these relationships have been agreed;¹ the next step will be to use these as the basis to guide practical working arrangements in each case. In particular, the aim will be to forge stronger links between WHO's governing bodies and the governing mechanisms of its principal partners.

92. Lastly, while the World Health Assembly provides a forum primarily for ministers of health, there are fewer opportunities to bring ministers of health together with ministers of finance, foreign affairs, development or other sectoral groups. Looking to the future, as health becomes a more multisectoral issue, broader governmental involvement in WHO's governance is a logical step.

Strengthening WHO's role in health governance

93. The role of ministries of health in all countries is evolving from a primary preoccupation with the provision and financing of health services, to becoming a broker and interlocutor with other parts of government. Ministries need the capacity to steer, regulate and negotiate with a wide range of partners in an increasingly complex environment. In all countries, managing relationships with ministries of finance, planning and the economy is essential if health concerns are to be given due prominence.

¹ The four principles are: (1) retention of the intergovernmental nature of WHO's decision-making remains paramount; (2) the development of norms, standards, policies and strategies, which lies at the heart of WHO's work, must continue to be based on the systematic use of evidence and protected from influence by any form of vested interest; (3) neither increasing engagement nor promoting coherence are ends in themselves: any new initiative must have clear benefits and add value in terms of enriching policy or increasing national capacity; (4) building on existing mechanisms should take precedence over creating new forums, meetings or structures, with a clear analysis provided of how any additional costs can lead to better outcomes.

94. At country level, WHO's primary governance role will be to support national authorities, build capacity where it is required, facilitate the development of national policies and strategies around which domestic and external financiers can align; ensure that health is well-positioned and coordinated in the work of the United Nations Country Team; and where national governments are disabled by conflict or disaster, play an effective role as coordinator of the health cluster in emergencies.

95. Regional and subregional integration is a growing trend, and one that can ensure that regional issues are more influential in global debates. Many of the regional organizations are new. In many cases, health issues are not necessarily high on their agendas; to redress this, health issues need an effective advocate and powerful voice. WHO's regional offices will play a vital role in fulfilling this function. This will include building networks of relationships with regional development banks, regional and subregional political and economic bodies, the regional coordination mechanisms of the United Nations and the United Nations Development Group. It will also mean forging links and synergies between these institutions and WHO's regional committees.

96. At a global level, 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.

Building governance capacity

97. Common to all aspects of the governance priority agenda is the need to build capacity across the Organization to manage this agenda more effectively. Specifically, this will mean 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. It will also require the deployment of a range of different tools to strengthen staff skills and systems. Mandatory training in health diplomacy is already in place for WHO Representatives, will be progressively extended across other parts of the Organization and encouraged amongst Member States.

Reforming management policies, systems, and practices

98. 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

99. 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.

100. 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.

Enhancing performance in countries

101. 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.¹

102. 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.

103. 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

104. 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.

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

105. 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.

106. 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

107. 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 (IEOAC) which, in addition, provides the link between internal oversight services and WHO's governing bodies, through the Executive Board, and its subcommittee, the Programme, Budget and Administration Committee. Lastly, this 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.

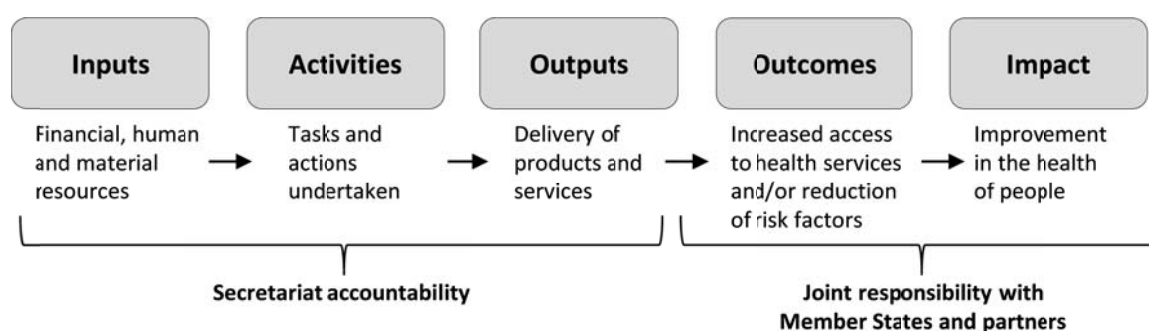
CHAPTER 4

RESULTS AND RESOURCES

108 This chapter sets out how WHO's performance can be judged over the period of the twelfth general programme of work and defines the resource envelope required to deliver overall results.

Results chain

109. Before looking at the impact and outcomes of WHO's work it is useful to briefly review the results chain as a whole in order to explain the relationship between what appears in the general programme of work and what will be found in successive programme budgets. The two documents in combination set out a complete chain of results that links outputs, outcomes and impact, as summarized in the following diagram.



110. Each programme budget will contain a limited number of **outputs** that define what the Secretariat will be accountable for delivering during the biennium concerned. The programme budget also provides details of the resources needed to perform the activities that deliver the outputs in each programme area. Outputs are measured through the delivery of a set of key products and services at each level of the Organization. During operational planning the activities required for each output are developed and then monitored throughout implementation.

111. At the next level in the chain, outputs combine to contribute to **outcomes** that represent the collective or individual changes in countries to which the work of the Secretariat contributes. Progress towards each outcome is measured in terms of changes in policy, institutional capacity, access to health services, or reduction of risk factors. Each programme budget will include a complete set of outcomes that span all programme areas.

112. At the highest level of the results chain, outcomes contribute to **impacts**; the sustainable changes in the health of populations to which the Secretariat, countries and other partners contribute. 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 does not relate only to outcomes under child health. It depends equally on work in health systems, nutrition and access to medical products.

Measuring performance

113. The performance of the Organization against the programme budget is assessed against two key questions: did the Secretariat use the resources allocated to deliver the outputs defined in each programme budget; and, as a result, has there been measurable progress in relation to the agreed outcomes in each biennium?

114. The overall performance of the Organization for the period of the general programme of work for 2014–2019) will be measured against a selected set of impacts and outcomes.

115. Achievements at impact and outcome level clearly depend on collaboration with countries and other partners. In this regard, the draft 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. They do not reflect everything that WHO does, but in terms of WHO's contribution to global health, they are the results that matter most.

116. The impacts and selected outcomes set out below are linked to the strategic priorities in the general programme of work.¹ To reflect the synergy between priorities, performance will be measured against a set of overall impacts. This approach also allows for the fact that priorities such as access to medical products or the implementation of the International Health Regulations (2005) should, strictly speaking, be judged in terms of outcomes, as they do not in and of themselves impact on health status. Nevertheless, in combination with other priorities they are essential to achieving changes in health, and thus to the overall impact of WHO's work. The outcomes selected also signal areas of emphasis within the strategic priorities. For example, progress in addressing shortages of health workers and establishing vital registration systems are highlighted as being essential to progress in extending universal health coverage.

Impact goals

117. The work of WHO will contribute to increases in healthy life expectancy and reduction in health inequities. It will do so by working with countries and other partners to achieve progress in relation to seven impact goals. For the time being, internationally agreed targets have been used where they are available. Specific targets for all the seven goals will be developed for the final draft of the general programme of work.

- Reduce under-five child mortality
Reduction by 2/3 by 2015 compared with the 1990 baseline
- Reduce maternal mortality
Reduction by 75% by 2015 compared with the 1990 baseline

¹ Selected because of their close link with one or more of the strategic priorities for the whole six-year period, the outcomes in the general programme of work represent a subset of the outcomes found in each programme budget. In contrast, each programme budget will include a complete set of outcomes and outputs for the biennium and thus a comprehensive framework for regular performance assessment and accountability throughout the period of the general programme of work.

- Reduce the 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; 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
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 and dracunculiasis
Eradication of polio completed by the end of 2014 and eradication of dracunculiasis completed by 2015
- Prevention of death and disability arising from disasters and outbreaks
(Indicator to be developed)
- Reduction in health inequities *(Indicator to be developed)*

Outcomes

- Increase the number of people living with HIV on antiretroviral treatment
*Outcome indicator:
Number of people living with HIV on antiretroviral treatment. Baseline: 8 million (2011), target: 15 million (2015)*
- Increase the number of tuberculosis patients successfully treated
*Outcome indicator:
Cumulative number of tuberculosis patients successfully treated in programmes that have adopted the WHO-recommended strategy since 1995. Baseline: 48 million (2011), target: 70 million (2015)*
- Increase the number of confirmed malaria cases receiving first-line antimalarial treatment
*Outcome indicator:
Percentage of confirmed malaria cases receiving first-line antimalarial treatment according to national policy. Baseline: to be developed, target: 100%*
- Increase and sustain the global average coverage with three doses of diphtheria, tetanus and pertussis (DTP) vaccines
*Outcome indicator:
Global average coverage with three doses of DTP vaccines. Baseline: 85%, target: >90%*
- Increase access to interventions for improving the health of women, newborn infants, children and adolescents as measured by:
Outcome indicators:
 - *Percentage of babies exclusively breastfed for six months. Baseline: 39%, target: 40% (2015)*
 - *Percentage of mothers and babies receiving postnatal care within two days of childbirth. Baseline: 50%, target: 60% (2015)*
 - *Percentage of pregnant women receiving skilled attendance at birth. Baseline: 55%, target: 60% (2015)*
 - *Adolescent birth rates (per 1000 girls aged 15–19 years). Baseline: 52 per 1000 girls, target: 51 per 1000 girls (2015)*

- *Percentage of children with suspected pneumonia receiving antibiotics. Baseline: 29%, target: 35% (2015)*
- *Unmet need for modern family planning methods in targeted countries. Baseline: 19% (2012), target: to be developed*
- Increase the number of people with access to interventions to prevent and manage the four major noncommunicable diseases and their risk factors as measured by:
 - *Outcome indicators:*
 - *Age-standardized prevalence of current tobacco use among persons aged 18+ years. Baseline: 22% (2010), target: 15% (2025)*
 - *Age-standardized prevalence of insufficiently physically active persons aged 18+ years (defined as less than 150 minutes of moderate-intensity activity per week, or equivalent). Baseline: 31% (2010), target: 28% (2025)*
 - *Total (recorded and unrecorded) alcohol per capita (15+ years old) consumption within a calendar year in litres of pure alcohol. Baseline: 6 litres (2010), target: 5 litres (2025)*
 - *Age-standardized mean population intake of salt (sodium chloride) per day in persons aged 18+ years. Baseline: 10 grams (2010), target: 7 grams (2025)*
 - Reduce the treatment and services gap for mental disorders
 - Outcome indicator:*
Treatment and services gap for mental disorders. Baseline: to be developed, target: 20% reduction by 2020
 - Reduce early childhood nutritional risk factors as measured by:
 - Outcome indicators:*
 - *Proportion of stunted children below five years of age. Baseline: 24%, target: 19%*
 - *Proportion of overweight children below five years of age. Baseline: 6.7%, target: 6.7%*
 - *Proportion of women of reproductive age (15–49 years) with anaemia. Baseline: 27%, target: 19%*
 - Increase intersectoral policy coordination to address the social determinants of health
 - Outcome indicator:*
Number of countries reporting data based on the set of indicators for monitoring social determinants of health. Baseline: to be developed, target: to be developed
 - All countries have comprehensive national health policies, strategies and plans
 - Outcome indicators:*
 - *Proportion of countries in which the share of out-of-pocket payment in total health expenditure is less than 15%. Baseline: 19%, target: 25%*
 - *Proportion of countries that have a national health sector strategy that conduct a regular review and evaluation of its implementation, based on a commonly agreed performance assessment of their health system. Baseline: 65%, target: 90%*
 - *Proportion of countries facing critical health workforce shortages. Baseline: 30%, target: 20%*
 - All countries have properly functioning civil registration and vital statistics systems
 - Outcome indicator:*
Proportion of countries with properly functioning civil registration and vital statistics systems. Baseline: 42%, target: 62%

- Improved access to and rational use of safe, efficacious and quality medicines, medical products and technologies:
Outcome indicator:
Availability of generic medicines in the public and private sectors. Baseline: to be developed, target: 80%
- All countries have the minimum core capacities required by the International Health Regulations (2005) for all-hazards alert and response
Outcome indicator:
Number of countries meeting and sustaining International Health Regulations (2005) core capacities (as defined in Annex 1 of the International Health Regulations (2005)). Baseline: 80, target: 190
- Countries have an all-hazards health emergency risk-management programme integrated into their national health plan and national disaster management plan
Outcome indicator:
Number of countries conducting or updating a multi-hazard risk assessment at least every two years. Baseline: 127, target: 180

WHO governance and management

118. Strengthening WHO's governance and management are strategic priorities in their own right. Reform of governance has two different elements: the internal governance systems of WHO by Member States at global and regional level, and the role of WHO in the governance of health at country, regional and global level. The two measures of success reflect this distinction. Both will, by necessity, be measured by independent assessments.

A streamlined and effective system of governance in WHO that provides strategic oversight and that enhances synergy across the Organization.

A more coordinated approach to a well-defined multi-sectoral global health agenda, reflected in better alignment of financial and technical support to country health policies and strategies.

119. Reform of management will result in an organization that pursues excellence; one that is effective, efficient, responsive, objective, transparent and accountable. Out of the many components of organizational change and reform, two are of particular importance for the future of WHO, namely financing and accountability. Measures of success therefore focus on these two elements.

WHO has a financing model which ensures that a programme budget agreed by Member States is fully financed with predictable and transparent resources; which allows sufficient flexibility to meet changing needs; and which diversifies funding sources to reduce vulnerability.

WHO has systems in place to ensure full accountability at all levels of the Organization for resources and results, and which ensure transparency and facilitate the assessment and mitigation of all organizational risks.

Financial resources

120. Having established clear priorities and set out what WHO will achieve over the period of the general programme of work, the final section outlines what will be needed in order to deliver these results.

A new financing model¹

121. 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.

122. Several constraints need to be overcome if these two objectives are to be realized. Firstly, the misalignment between WHO's programme budget and the funds available to finance it that results in part from a reliance on highly specified voluntary contributions. Second, the unpredictability that is a feature of much voluntary funding. Third, the vulnerability that arises from dependence on a very narrow donor base. Fourth, the lack of transparency and heavy transaction costs associated with current approaches to resource mobilization and management. Lastly, the limited availability of unspecified funding needed to bridge funding gaps and to respond to changing circumstances.

123. A new financing approach 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

124. 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 approach 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.

125. 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. Progress in financing all parts of the budget is made available in as transparent a way as possible,

¹ Text in this section will be amended in the final version in order to reflect the views of the Executive Board in January 2013.

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 gaps then become targets for focused resource allocation.

Trends in financing 2014–2019

126. 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.

127. 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 the right balance is achieved between resources for staff and activities over the six-year period.

Resource shifts within a stable budget

128. 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.**

129. 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.**

130. 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.**

131. 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.**

132. 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.**

133. 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's 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.**

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