Draft twelfth general programme of work

OVERVIEW

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

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

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

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

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

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[1] As required under Article 28 of the WHO Constitution.

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

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

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

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

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

CHAPTER 1

SETTING THE SCENE

New political, economic, social and environmental realities

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

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

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

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

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

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

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

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

- A continuing economic downturn in some developed countries with consequent decreases in public spending puts the social contract between people and their governments under ever-increasing pressure. Reductions in public spending risk creating a vicious cycle with a negative impact on basic services, low health and educational attainment, and high youth unemployment. At the opposite end of the age spectrum, those retiring from work may face the spectre of impoverishment and ill health in old age.

- By 2050, 70% of the world's population will live in cities. Rapid unplanned urbanization is a reality, particularly in low- and middle-income countries. Urbanization brings opportunities for health, not least from well-resourced city administrations, but equally it brings risks of exclusion and inequity. Migration between countries can offer benefits to both the countries from which migrants leave and those to which they migrate; however, this is by no means guaranteed and many migrants are exposed to increased health risks in their search for economic opportunity.

- The demographic dividend that accrues from a larger, young working population has boosted economic growth in many parts of the world. For many countries this presents a vital opportunity, but one that will be lost in the absence of efforts to increase youth employment. Chronic unemployment combined with a lack of economic and political rights and any form of social protection can give lead to outrage and uprising.

- The global environment is equally under pressure. Key planetary thresholds, such as loss of biodiversity, have been crossed; and others soon will be. In many parts of the world, climate change will jeopardize the fundamental requirements for health, including clean urban air, safe and sufficient drinking-water, a secure and nutritious food supply, protection from extreme weather events and adequate shelter. Most people and governments accept the scientific case for sustainable development. They also recognize that health contributes to its achievement, benefits from robust environmental policies and offers one of the most effective ways of measuring progress. Nevertheless, at global and national levels, progress in the creation of institutions and policies that are better able to ensure a more coherent approach to social, environmental and economic policy has been disappointingly slow.

- In the face of these challenges, countries with different national interests seek solutions to shared problems. Global groupings (such as the G20) with more limited or like-minded membership offer a means of making more rapid progress on specific issues, but lack the legitimacy conferred by fully multilateral processes. Similarly in health, issue-based alliances, coalitions and partnerships have been influential in making more rapid progress in tackling challenges such as child and maternal mortality, and HIV/AIDS, tuberculosis and malaria. But the most complex problems still require well-managed multilateral negotiations in an organization with universal membership in order to reach a fair and equitable deal for all.

The evolving agenda for global health

Current health and demographic trends

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

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

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

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

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

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

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

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

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

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

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

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

More complex health challenges

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

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

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

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

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

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

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

More effective health security and humanitarian action

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

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

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

New challenges in health governance

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

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

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

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

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

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

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[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."*

Growing pressures on multilateral organizations

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

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

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

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

CHAPTER 2

WHO: UNIQUE VALUES, FUNCTIONS AND COMPARATIVE ADVANTAGE

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

Continuity: enduring principles and values

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

Box 1. Constitution of the World Health Organization: principles

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

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

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

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

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

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

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

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

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

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

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

- The combination of WHO's intergovernmental foundation and its regionalized structure confers a unique legitimacy in engaging and supporting countries. In particular, the review of health governance issues in Chapter 1 highlights to the need for negotiated solutions to shared international health problems, particularly in instances of interaction between health and other sectoral interests (such as trade, migration, security and intellectual property). In addition, the capacity to convene and facilitate the negotiation of binding and non-binding international instruments distinguishes WHO from other health actors. A commitment to multilateralism remains a core element of WHO's work.

- Represented in some 150 countries, territories and areas by a WHO Office, the Organization is uniquely positioned to remain as a provider of technical support to individual Member States, facilitating increasing links within and between countries in the interests of South–South and triangular cooperation. WHO will continue to provide humanitarian assistance, ensuring that care for peoples' health is central to disaster relief efforts.

- In line with the principle of equity and social justice, WHO will continue to give emphasis where needs are greatest. Although WHO's work will continue to be relevant to all Member States, the Organization sees health as being central to poverty reduction. The analysis in Chapter 1 points to the fact that the greatest absolute number of poor people are now citizens of middle-income and emerging economies. The focus is therefore not only on countries, but on poor populations within countries.

- WHO is committed to the mainstreaming of gender, equity and human rights and will establish an accountability mechanism to monitor the effectiveness of the mainstreaming process. WHO is committed to operationalizing the United Nations System-wide Action Plan (UN SWAP) to further the goals of gender equality and women's empowerment within the policies and programmes of the United Nations system.

- In its normative and standard setting work, which benefits Member States collectively, WHO is and will remain a science and evidence-based Organization with a focus on public health. The environment in which WHO operates is becoming ever more complex and politicized; however WHO's legitimacy and technical authority lies in its rigorous adherence to the systematic use of evidence as the basis for all policies. This also underpins the Organization's core function of monitoring health trends and determinants at global, regional and country level. As a public health agency, WHO continues to be concerned not only with the purely medical aspects of illness, but with the determinants of ill-health and the promotion of health as a positive outcome of policies in other sectors.

Core functions and division of labour

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

1. Providing leadership on matters critical to health and engaging in partnerships where joint action is needed;

2. Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;

3. Setting norms and standards, and promoting and monitoring their implementation;

4. Articulating ethical and evidence-based policy options;

5. Providing technical support, catalysing change, and building sustainable institutional capacity;

6. Monitoring the health situation and assessing health trends.

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

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

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

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[1] The six categories are those agreed by Member States in 2012. Their programmatic content is discussed in more detail in Chapter 5.

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

WHO reform: a strategic response to a changing environment

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

Finance aligned with priorities

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

Effective health governance

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

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

Pursuit of organizational excellence

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

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

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

CHAPTER 3

PRIORITY SETTING

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

- The current health situation including: demographic and epidemiological trends and changes, urgent, emerging and neglected health issues; taking into account the burden of disease at the global, regional and/or country levels.

- Needs of individual countries for WHO support as articulated, where available, through the country cooperation strategy, as well as national health and development plans.

- Internationally agreed instruments that involve or impact health such as declarations and agreements, as well as resolutions, decisions and other documents adopted by WHO's governing bodies at the global and regional levels.

- The existence of evidence-based, cost-effective interventions and the potential for using knowledge, science and technology for improving health

- The comparative advantage of WHO, including:

    (a)   capacity to develop evidence in response to current and emerging health issues;

    (b)   ability to contribute to capacity building;

    (c)   capacity to respond to changing needs based on an on-going assessment of performance;

    (d)   potential to work with other sectors, organizations, and stakeholders to have a significant impact on health.

Leadership priorities

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

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

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

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

Box 2

Leadership priorities 2014–2019

> **Advancing universal health coverage:** enabling countries to sustain or expand access to essential health services and financial protection and promoting universal health coverage as a unifying concept in global health.
>
> **Health-related Millennium Development Goals** – addressing unfinished and future challenges: accelerating the achievement of the current health-related Goals up to and beyond 2015. This priority includes completing the eradication of polio and selected neglected tropical diseases.
>
> **Addressing the challenge of noncommunicable diseases** and mental health, violence and injuries and disabilities.
>
> Implementing the provisions of the **International Health Regulations**: ensuring that all countries can meet the capacity requirements specified in the International Health Regulations (2005).
>
> Increasing access to essential, high-quality and affordable **medical products** (medicines, vaccines, diagnostics and other health technologies).
>
> Addressing the **social, economic and environmental determinants** of health as a means of reducing health inequities within and between countries.

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

Advancing universal health coverage

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

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

64.   Ensuring that all people can take advantage of comprehensive and high quality health services through universal health coverage and access is a means to achieve better health outcomes. It is also a desirable goal that people value in its own right – the assurance that they have access to a health system that prevents and treats illness effectively and affordably within people's homes, in their communities, and with referral to clinics and hospitals when required. Such a goal would seek to ensure that 100 million people do not fall into poverty each year due to the cost of health services they need (as they do today). Universal health coverage is important in reducing poverty, and promoting a stable and secure society. The outcome statement of the United Nations Conference on Sustainable Development (Rio+20)[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 leadership priority for the next six years universal health coverage gives practical expression to WHO's concern for equity and social justice and helps to reinforce the links between health, social protection and economic policy. In practical terms WHO will focus on responding to the groundswell of demand from countries in all parts of the world that seek practical advice on how to take this agenda forward in their own national circumstances. Universal health coverage will also provide a clear focus for WHO's work on health system strengthening.

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

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[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 multisectoral action to address urgently the health needs of the world's population." See United Nations General Assembly resolution 66/288, Annex, paragraph 139.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[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).

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

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

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

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

84.   WHO will focus primarily over the next six years on combating the four major noncommunicable diseases[1] 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.

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

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

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

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

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

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

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

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

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

Implementing the provisions of the International Health Regulations (2005)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[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.

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

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

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[1] Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand.

2 The Oslo Ministerial Declaration (2007).

CHAPTER 4

GOVERNANCE AND MANAGEMENT

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

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

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

WHO's role in global health governance

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

- there are a growing number of health-related issues in which agreement requires a careful negotiation in order to balance technical and political interests;

- the wider range of actors that are involved in global health challenges the coordinating and directing authority of WHO;

- and there is a growing interest in ensuring that governance in other sectors and policy arenas avoids compromising health and ideally has a positive impact on it.

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

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

Governing body reform

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

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

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

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

Hosted partnerships

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

Non-State actors

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

Strengthening WHO's role in governance for health

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

Positioning and promoting health

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

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

120.   *Health and sustainable development*: Preparations for the Rio+20 Conference in June 2102 illustrated a related aspect of WHO's governance work: effective synergy on advancing health interests between the Secretariat, Member States and other stakeholders. The first draft of the Rio +20 outcome document made only passing reference to health. The WHO Secretariat at headquarters and at regional level therefore worked with Member States in Geneva and New York, as well as with nongovernmental organization groups to develop a convincing position on the role of health, which was eventually taken up by negotiators in Rio. The final text includes virtually all of WHO's health concerns.[1] In the follow-up to Rio+20 health provides an important link between the process of developing sustainable development goals and the post-2015 agenda. In addition, work with other sectors such as sustainable energy, water and sanitation, climate change and adaptation, food security and nutrition is showing the value of health indicators as a means of measuring progress across the three pillars of sustainable development.

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

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

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

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

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

Health governance and WHO's leadership priorities

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

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[1] Fidler, D. *The Challenges of Global Health Governance*, Council on Foreign Relations, May 2010.

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

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

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

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

Building governance capacity

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

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

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

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

Reforming management policies, systems, and practices

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

Organizational alignment: headquarters, regional, subregional and country offices

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

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

Enhancing performance in countries

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

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

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

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

Strategic communications and knowledge management

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

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

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

Accountability, risk management and transparency

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

CHAPTER 5

ORGANIZING WORK, MEASURING RESULTS AND MONITORING PERFORMANCE

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

Organization: categories of work and programme areas

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

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

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

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

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

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

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

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

146. The derivation of the technical programme areas reflects an iterative process of priority setting, which has taken place at different levels. As described in Chapter 3, the criteria, collectively, were used to arrive at WHO's leadership priorities. In addition, applying the priority-setting criteria to the five categories of work, with particular emphasis on the needs of individual countries and the current health situation, informed the development of the programmatic framework that is outlined in the proposed programme budget. Thus application of these criteria for priority setting within each category narrowed down what WHO will do out of all the things it could do.
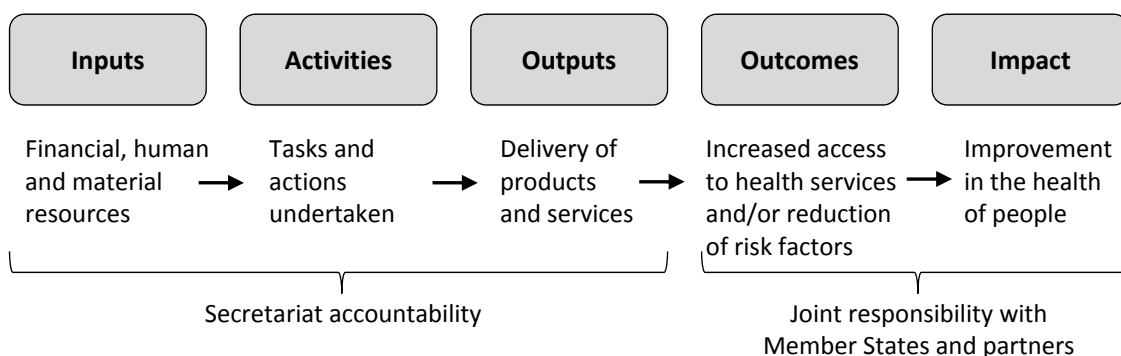
147. Finally, the application of the criteria, with their particular emphasis on the existence of evidence-based interventions, internationally agreed instruments, and WHO's comparative advantage, has shaped the formulation of WHO's focus and direction in each of the programme areas. The outputs described in the proposed programme budget are the expression of that focus and direction. The aim will be to maintain consistency in the way work is organized in order to support comparisons across the three bienniums of the programme of work.

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

Results chain

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

Figure. The results chain framework

Inputs	Activities	Outputs	Outcomes	Impact
Financial, human and material resources	Tasks and actions undertaken	Delivery of products and services	Increased access to health services and/or reduction of risk factors	Improvement in the health of people

Secretariat accountability — Joint responsibility with Member States and partners

Outputs

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

Outcomes

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

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

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

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

Impacts

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

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

WHO's results – creating change

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

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

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

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

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

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

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

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

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

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

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

163.   In late 2012 and early 2103, the importance of another aspect of normative work has come into focus: the development of a monitoring framework, defining indicators and setting voluntary global targets for the control and prevention of noncommunicable diseases. This was not a purely technical exercise as many other political and commercial interests were involved. A simple test of the framework's success would be to select countries and assess in a reasonable time frame whether they adopt or measure the agreed indicators. However, a theory of change would suggest a further dimension: that the added-value of WHO in this process is strongly evidenced by the fact that the world now can collectively monitor progress against a social, economic and political threat that faces all countries in a way that would not otherwise have been possible.

Measuring performance: a framework for monitoring and evaluation

Monitoring performance using the results chain

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

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

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

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

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

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

Assessing progress against leadership and reform priorities

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

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

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

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

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

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

Accountability framework: monitoring and evaluation

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

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

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

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

CHAPTER 6

FINANCIAL RESOURCES

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

A new financing model

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

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

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

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

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

Trends in financing 2014–2019

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

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

Resource shifts within a stable budget

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

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

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

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

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

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

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

ANNEX

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

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

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

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

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

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