WORLD HEALTH ORGANIZATION

Draft Eleventh General Programme of Work, 2006-2015 (revised)

As decided by the Executive Board at its 117th session in January 2006, the Programme, Budget and Administration Committee will hold an extraordinary meeting to consider the revised draft eleventh general programme of work, 2006-2015, in order to validate, on behalf of the Executive Board, the changes made reflecting the input provided at the meetings of the Board and its Committee, and in consultations held in November 2005 and January 2006.

Foreword by Dr LEE Jong-wook, Director-General

Defining our General Programme of Work gives us a welcome opportunity to step back from immediate tasks and take a broad look at the health of the world. It requires us to prepare for the future, predict the impact of current trends, outline a common vision, set goals and name the steps that will take us to specified health objectives.

A realistic view of the future requires an informed understanding of the past. WHO and its Member States and partners have made an extensive review of past successes and failures through a wide-ranging process of consultation and debate to draw up this programme for our future.

This Eleventh General Programme of Work covers a 10-year period from 2006 to 2015, coinciding with the time-frame for achieving the Millennium Development Goals. It reviews and restates our understanding of the determinants of health and the measures required to improve the health of populations, communities, families and individuals. It recognizes health as a shared resource and a shared responsibility. It outlines the priority problems, and says how the world must tackle them.

Each of the 192 Member States of WHO has a unique health profile. Although the diversity is extreme, there are common issues. Factors such as stable economies, strong health systems and supportive social environments are associated everywhere with well-being and security. There are still far too many areas where, in spite of great potential, such improvements are not happening. Instead we see wasted opportunity, instability and exclusion from the benefits of progress.

Although trends in some major determinants of health are relatively predictable, such as demographic changes, many are not. Natural disasters – whether climatic, seismic or infectious – illustrate how quickly situations can change and how precarious health can be. We have to plan for this unpredictability. As the next 10 years unfold, it will be essential to respond flexibly to immediate challenges, keeping activities in line with the long-term perspectives described in the following pages, and remaining accountable to them.

The engagement of new partnerships for health has increased during the last years. This is a positive development as it reflects a greater political and financial commitment. However this more complex health architecture also provides some very clear challenges and new expectations for WHO. WHO is also taking a proactive role in terms of UN collaboration, with a specific focus on what happens in countries and the overall management reforms.

This document outlines a strategic framework and direction for the work of WHO, both Member States and the Secretariat, and a platform for dialogue with our partners in global health. I invite all those reading it to consider its implications for their own activities, and how they and WHO can best work together. This is an opportunity for a renewal of commitment to attaining the highest possible standard of health for all.

Table of Contents

Text boxes/Annexes:

1. **The Millennium Development Goals & Indicators**

2. **Summary of the scenarios work**

3. **Health Data: Short description of trends and illustrations of current situation**

4. **Glossary of Terms (from resolutions eg health equity, universal coverage)**

5. **Description of Country Cooperation Strategy**

6. **WHO Results chain: from GPW to Operational Plans**
   TO ADD

7. **Key topics for future World Health Assemblies (Commission reports, WHRs, UN events)**

8. **WHO health-related targets up until 2015 (as committed to in WHA Resolutions)**

Executive Summary

The 11th General Programme of Work (2006-2015) starts with an assessment of the health challenges and gaps now facing the world, and then outlines a global health agenda for responding to them. Having described the many responsibilities involved for the international community as a whole, the document defines the role of the World Health Organization within this effort, and the broad directions for its future work. A more detailed account of WHO's tasks will be given in the Medium Term Strategic Plan for 2008-2013 and linked Programme Budgets.

Over the last 20 years, life expectancy continued to increase but health inequalities increased as well. New diseases are adding to the urgency of controlling epidemics. Few developing countries are on track to fully reach the Millennium Development Goals. The proportion of elderly people in the world's population is increasing, with corresponding increases in health care needs. Large numbers of young people in developing countries lack the information, services and support they need for a healthy life.

The unpredictable nature and increasing numbers of emergencies means that all national health authorities have to be prepared for such events. Many of them lack the resources needed for this, however, and skilled health workers are migrating to the wealthier societies. The cost of care impoverishes patients in many parts of the world. The rapid increase in organizations involved in health work has the potential to alleviate the burden of excessive demand on national health systems, but they also add to the management burden.

Several areas of unrealized potential for improving people's health are apparent from this overview of current challenges. Opportunities to promote social justice are often overlooked in policy-making. The many sectors, actors and partners involved in health work could multiply their successes by improving their coordination. Much of the knowledge needed to solve major problems exists but is not put into practice. Lastly, where the necessary knowledge does not yet exist, much more can be done to pursue it.

Action in many sectors is needed at all levels – individual, community, national, regional and global. The agenda outlined here – for all the stakeholders, not just WHO – highlights seven priority areas. The first three are investing in health to reduce poverty; building individual and global health security; and promoting universal coverage, gender equality, and health-related human rights. These set the direction for the other four, which are to tackle the determinants of health; strengthen health systems and equitable access to them; harness knowledge, science and technology; and strengthen governance, leadership and accountability.

WHO has several comparative advantages among the many entities involved in international health work. These include its impartiality , its capacity to engage diverse groups in dialogue, its leadership in health, its normative functions, its global and regional networks of expertise, and its presence in countries.

The core functions of WHO are as follows: *providing leadership* on matters critical to health and engaging in partnerships where joint action is needed; *shaping the research agenda* for health and stimulating the generation, translation and dissemination of valuable knowledge; *setting norms and standards*, and promoting and monitoring their implementation; *indicating policy options* that are ethical and evidence-based; *providing technical support*, catalysing

change, and building sustainable institutional capacity; and *monitoring the health situation* and assessing health trends.

Future opportunities for WHO entail using its comparative advantages and carrying out its core functions to take forward the global health agenda. To do this it will need to make the case strongly for realistic investment in health, act swiftly and effectively in times of crisis, firmly uphold the values of justice in health work, lead by example in promoting gender equity, promote the rapid scaling up of approaches that work, build cross-sectoral alliances, and harmonize the global health architecture.

The WHO secretariat faces challenges in financing the organization to enable it to fulfil these obligations, get results in countries, and continually improve the quality of its work. Work will continue towards increasing the level of common management systems across WHO. WHO is committed to building a highly competent workforce and to strengthening its scientific and technical advisory functions.

To carry out this General Programme of Work, WHO will define its future priorities with Member States through the Medium Term Strategic Plan and the Programme Budgets agreed with the Governing Bodies. It will strengthen its engagement with international partners, to mobilize more resources for health. It will engage fully in the dialogue to improve the UN and set up mechanisms for engaging a wider range of stakeholders in the policy dialogue around the global health agenda. Progress in carrying out that agenda and WHO's central role in it will be monitored by the international community.

A INTRODUCTION

1. The world has changed radically since 1946, when the WHO Constitution was adopted. Spectacular scientific advances have led to major advances in health care in which millions more lives are protected than ever before and life expectancy has increased globally by 20 years. Yet, whilst there has been progress in many areas, many public health problems, both old and new, remain to be resolved.

2. WHO as a specialized agency of the UN, is accountable to its Member States and works closely with other entities of the UN system. Its Constitution requires that the Executive Board submit a General Programme of Work for the World Health Assembly to consider. The purpose of the Eleventh of these (2006-2015) is different from the previous one in that it examines current problems, the challenges they imply, and the ways in which the international community, not just WHO, must respond to them over the next decade. It defines a global health agenda for the world and the actions needed to carry it out. The document also acknowledges that many of the challenges we will face are unforeseeable, and governments and the global community must be able to respond in a flexible manner as demands appear. It later describes the responsibilities of WHO as the world's health agency, and sets the broad directions for its future work. The more specific priorities will be set out in the WHO Medium Term Strategic Plan 2008-2013 where they are defined as strategic objectives, and in the two-yearly Programme Budget, in terms of expected results.

3. The document also reflects the values and principles of the WHO Constitution, the Declaration of Alma-Ata, and the United Nations Millennium Declaration, interpreting them in the global context. Many of the issues highlighted here are not new. The difficulty lies in promoting joint action within and outside the conventional health sector, securing the commitment of many partners to resolving those issues. Therein lies the challenge of shaping the evolving role of WHO as the directing and coordinating authority in international health work.

B HEALTH IN A CHANGING GLOBAL ENVIRONMENT

Health as a defining value of the twenty-first century

4. Health is increasingly seen as a key aspect of human security. Actual or potential health emergencies are objects of intense public attention and debate. Violence contributes significantly to preventable morbidity and mortality. Diseases linked to poverty accelerate societal breakdown. Wider concerns about security include the dependence of health on safe food and water, financial security, and protection from the effects of climate change.

5. Health occupies a prominent place in debates on the priorities for development. This is well reflected in national poverty reduction strategies and national development plans. Countries, at all levels of development, are realizing the need for sustained, equitable increases in health investment if they are to become or remain stable and prosperous nations.

6. The Constitution of WHO states that: "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". Health is a key aspect of human rights and social justice and constitutes the core values and principles for the United Nations and WHO. Health-related human rights are endorsed in a large number of international and regional human rights instruments. These are closely related to, and dependent on, the realization of other human rights such as those to food, housing, work and education. Every country in the world is now party to at least one international treaty that recognizes health-related human rights, and the importance of opposing inequalities and discrimination.

7. Global efforts to improve health are inseparable from medical science, but social, economic, environmental and political factors also determine health opportunities and outcomes. For health action to be effective, it must be guided by a broad perspective, and taken in collaboration with a variety of agencies and institutions.

The current health situation

8. Over the last 20 years, life expectancy at age 15 has increased by between two and three years in most countries. This improvement is due to social and economic development, the wider provision of safe water and sanitation facilities, and the expansion of national health services. Nevertheless, there are widening health inequalities between and within countries, between rich and poor, between men and women, and between different ethnic groups. More than a billion of the world's poorest people are not benefiting from the major advances in health care.

9. There have been sharp contrasts in health trends across the regions of WHO. For example, the countries of the former Soviet Union experienced health reversals in the early 1990s, while in Africa earlier gains in child health have been reversed over the last 15 years in about 15 countries. These reversals reflect a combination of infectious diseases, in particular HIV/AIDS, collapsing health services and deteriorating social and economic conditions.

10. The illness, disability and death caused by the infectious diseases have a massive social and economic impact. New diseases, such as avian influenza and SARS, are appearing, adding to the urgency of controlling epidemics.

11. The target year for achieving the improvements set out in the Millennium Development Goals is 2015, but the trends for goals relating to health are not encouraging. The majority of poor countries are unlikely to meet them. Few developing countries are currently on track to meet the target for reducing child mortality, despite this being largely due to common conditions for which knowledge and effective interventions exist. The proportion of neonatal deaths is increasing. Although the maternal mortality ratio has declined in countries with lower levels of mortality, those with high maternal mortality rates are experiencing stagnation or even higher death rates. Data on health interventions are more encouraging, however: progress towards the targets for tuberculosis control is on course; and measles immunization coverage is on the rise in many countries, leading to a dramatic reduction in mortality. The proportion of women assisted by a skilled medical attendant during delivery has increased substantially in some regions, especially in Asia.

12. Poverty remains a major problem, and the upheavals coming with globalization and rapid economic development are not having the desired effect on major sections of the global community. Trends in the world's population show that it is still increasing although the rate of growth has slowed, with nearly all growth now occurring in developing countries. Mid-range population estimates suggest a global population of approximately nine billion by 2050, compared with the present six billion.

13. This demographic trend will include a significant increase in the proportion of elderly people in the world. This, together with environmental conditions which support unhealthy behaviours, has led to a rise in several chronic diseases and a consequent surge in demand for expensive long-term tertiary care. For developing countries where communicable diseases remain common, this means a double burden of disease. As more children survive into adulthood, there will also be a larger numbers of young people. Their lives will be at risk, however, if they do not have the information, life skills, health services and support they need to ensure a healthy adolescence. Without these, they are exposed to tobacco-related diseases, substance abuse, sexually transmitted infections, unwanted pregnancy, and other health problems related to behaviour. About half of the world's population now lives in urban areas. In developing countries, 43% of the urban

population lives in slums, and in the least developed countries, 78% of urban residents are slum-dwellers, with 30% of families headed by women.

14. Crises, whether from natural or human causes, are a prominent feature of twenty-first century life. Each year, one in five countries experiences a crisis, characterized by high levels of suffering and death. The unpredictable nature and increasing numbers of conflicts and emergencies make it necessary for all national authorities to be prepared for such events.

15. Many public sector health systems have similar problems across the globe: insufficient staff with the right skills, low pay and motivation, difficulties in managing complex services with inadequate financial resources, and rising expectations. In many developing countries, there is insufficient and unequal access to essential public health services. Many governments have ambitious plans for building new primary and secondary care facilities, and for increasing operating budgets and providing incentives for staff to work in underserved areas. Trends in national health expenditure usually do not usually match these plans, however.

16. Development assistance for health is estimated to have risen by 26% from US$ 6.4 billion in 1997 to US$ 8.1 billion in 2002. Much of the increase was due to new funds committed to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Although considerable resources have been mobilized, in particular for the HIV/AIDS pandemic, many other areas have received inadequate attention. There is still a massive shortfall in the overall resources required to meet the Millennium Development Goals and deal with other growing health problems such as weak health systems, chronic diseases, and related areas of research.

17. Shortages of skilled health workers are increased by the migration of health workers to wealthier societies offering better conditions of service. This trend is likely to continue in the medium to long term. It will lead in some situations to shortages of clinical specialists, and will add to the burden of care borne by some communities and homes, particularly by women and girls, thereby increasing inequities.

18. As technology advances, many wealthy countries and countries in transition continue to increase spending on health in response to growing expectations. Non-state providers are increasing in many countries, and targeting the wealthier sectors of the population. Individuals and households not covered by pre-payment schemes with pooling of risks face high out-of-pocket payments which cause or increase impoverishment. Most countries in the world face major difficulties in extending or sustaining social protection or other mechanisms to protect individuals from expenditure on medical care and ensure their independent ability to pay.

Health actors and partners: a changing world

19. The last ten years have seen a dramatic increase in the number of international partnerships in health. These partnerships are highly diverse in nature, scope and size. Many target a single disease such as AIDS, malaria or tuberculosis. Others support health interventions such as immunization, or components of the health system, such as monitoring. Many of these partnerships focus on improving access to existing technologies. Some concentrate on research and development for new products. The large amount of resources brought in by new partners, in addition to increases in grants and loans from bilateral and multilateral bodies, is changing the way health is funded in many countries. New mechanisms have been devised to better support national development objectives, such as poverty reduction strategies, and sector-wide approaches.

20. Global health partnerships offer the potential to combine the different strengths of public and private organizations, along with civil society groups, in tackling health problems. They provide ways to scale up responses to global health needs and step in where the market fails to mobilize the necessary research and development. Partnerships can activate awareness, money, expertise

and a wider range of participants. They also give rise to further challenges, however, such as duplication of effort between initiatives, high transaction costs to government and donors, unclear accountability, and lack of alignment with country systems. Although some shaking down can be expected, the number of partnerships is likely to grow. They will achieve many of their aims if they obtain long-term, predictable funding and focus on building country capacities.

21. Demands on the UN as a whole are increasing, as are requests for it to reform and show more clearly how it adds value. This is as much a challenge for WHO as it is for its partner UN agencies. Of particular importance are relations at country level, where health is central to development and many changes are taking place as international agencies align their work with national health policies and programmes, and attempt to harmonize their efforts so as to reduce the overall management burden.

22. Important changes are occurring globally as well. The ratification in 2005 of the Framework Convention on Tobacco Control and the adoption of the revised International Health Regulations were landmark events for WHO. They provide international instruments that tackle some of the causes and effects of disease and propose unified international action. They are examples of a new kind of synergistic responsibility. A similar approach has been taken with recent Commissions covering Macroeconomics and Health; Intellectual Property, Innovation and Public Health; and the Social Determinants of Health.

23. Individuals united in a particular cause, such as patient or civil society groups, are forming powerful lobbies and raising public awareness of issues such as access to treatment for HIV/AIDS, and international development assistance. Current communication and information technologies give consumers an unprecedented degree of informed freedom of choice. An increasing number of nongovernmental, faith-based and private sector organizations are delivering care and complement the efforts of national health systems.

24. Academic, industrial, government and nongovernmental research continue to shape the directions and use of knowledge acquisition. Industry, trade and finance are a powerful driver of research and development and a massive force in producing and distributing goods, and in making decisions on health policy. Public-private partnerships in the area of research are increasingly important.

International declarations and agreements

25. The global health agenda is shaped by agreements adopted by world leaders. In September 2000, the United Nations Millennium Declaration committed states to a global partnership to reduce poverty, improve health and education, and promote peace, human rights, gender equality and environmental sustainability. Rich and poor countries alike are committed to achieving the Millennium Development Goals. The United Nations Special Session on HIV/AIDS gave prominence to an infectious disease that was seen as a threat to global security.

26. Health-related human rights have been codified in numerous international and regional treaties. Far-reaching commitments have been made in several United Nations world conferences, focusing on segments of the population that often experience discrimination, such as women, children, older people, those with disabilities, indigenous minorities, or those living with HIV/AIDS. Of particular importance still is the outcome of the United Nations International Conference on Population and Development (Cairo, 1994) and the Conference on Women (Beijing, 1995), which covered women's rights, reproductive health, and the elimination of violence against women and girls.

27. Health features prominently in many recent international agreements, including the World Trade Organization Declaration on Trade-Related Aspects of Intellectual Property Rights (the

TRIPS Agreement and Public Health, Doha, 2001), the Monterrey Consensus of the International Conference on Financing for Development (Monterrey, 2002) and the products of the World Summit on Sustainable Development (Johannesburg, 2002).

28. The 2005 UN General Assembly World Summit made a number of commitments to the fight against poverty, debt relief and development. It called for increased investment to improve health systems, to increase HIV prevention, treatment and care, to control malaria and tuberculosis, to ensure universal access to reproductive health services and to support the full implementation of the revised International Health Regulations (2005), including the Global Outbreak Alert and Response Network of WHO.

29. In 2004 the Mexico Ministerial Summit on Health Research discussed an agenda for future research, and the Bangkok Charter for Health Promotion in 2005 reaffirmed the importance of tackling the determinants of health and the negative health effects of globalization.

The challenges to health: closing the gaps in the international response.

30. The analysis above of the present situation reveals several areas of unrealized potential for improving people's health. These appear not only in responding to known and anticipated disease threats but in dealing with other factors that negatively influence health. The missing elements can be broadly summarized as gaps in social justice, gaps in responsibility, gaps in implementation, and gaps in knowledge.

Gaps in social justice

31. Major gaps in addressing problems of equity, health-related human rights and gender equality exist in policy-making. Those treated inequitably in many countries include indigenous people, ethnic minorities, people in poor communities, people living with HIV/AIDS, people with disabilities, and migrants. Discrimination has a definite impact on health. For example, in many settings, being born female still means having fewer opportunities than males for work and living conditions conducive to good health.

32. Health policies and programmes frequently perpetuate gender stereotypes and do not take account of women's lack of autonomy regarding their health. Women's health is also affected by gender bias in the health system, health information and health research, and by inadequate and inappropriate medical services.

33. In many countries, including some with highly developed economies, there are more than 20 years' difference in life expectancy between people belonging to the most privileged social classes and those without access to essential social services. Access to HIV treatment exemplifies these inequalities.

Gaps in responsibility

34. The increasing number of sectors, actors and partners involved in health work has led to gaps in accountability and lack of synergy in the coordination of actions to improve health. People's health suffers or benefits not just from their domestic environment and personal choices, but from decisions made at national level and outside their own countries.

35. For example, environmental changes resulting from growing economies and international trade have a direct bearing on infectious diseases in different parts of the globe. International conflict and national crises may lead to human rights violations and disruption of social services. Global economic forces and the migration of populations are influencing the modern nation state and its ability to sustain a welfare policy. Antimicrobial resistance, which has undermined many

disease control efforts, requires action in the realms of international research and development, patent law, intellectual property rights and international trade and finance. Some noncommunicable diseases are inseparable from market forces and lifestyles. Whilst our understanding of these determinants is growing, it is not always clear who is responsible for taking them into account, and how.

36. A better understanding of what will improve people's health implies that there is a need for cross-sectoral action and action in sectors beyond the control of the health sector. Substantial improvements in key health outcomes could be achieved by capitalizing on these potential synergies.

37. In addition, the global health infrastructure is characterized by a wide range of global, national and local organizations. Coherence of action within and between these entities is rarely achieved, and mechanisms for intersectoral dialogue are in many cases weak. Again, it is not always clear who is responsible for leading these actions. Ministries of health would be the natural coordinators, but they frequently do not have the capacity to fully engage fully enough in such matters.

Gaps in implementation

38. Many groups and communities still do not have access to essential public health interventions even when these are known to be cost-effective. This is largely due to inadequate allocation of resources to health and disproportionate allocation to curative and high-tech services in urban settings. Also, the funds that are committed often do not benefit those who need them most, and remain underutilized. Equitable health systems need financing mechanisms which remove the barriers to health care, especially those confronting disadvantaged groups.

39. Gaps in implementation include, in some cases, too much emphasis on pilot projects and islands of excellence, with inadequate plans for scale up. A significant proportion of today's global death and disease burden from environmental risks, for example, could be avoided by using relatively inexpensive solutions known to be effective. Similarly, death rates from cardiovascular disease have been reduced through cost-effective prevention and treatment strategies in some rich countries, but this knowledge remains mostly unused in poorer ones. Many effective interventions depend on essential medicines, yet today almost two billion people have no dependable access to them. There also remain vast areas of unmet needs for contraception and other reproductive health commodities. Many other examples could be quoted, and this list will get larger as more technology becomes available, for instance with new vaccines requiring more expenditure by government and international partners.

40. International assistance is often not sufficiently aligned with national priorities and systems, and not harmonized across agencies, leading to inefficiency and overlap in implementation. All donors need to endorse and support the high level dialogue on aid effectiveness if knowledge and money are not to be wasted.

Gaps in knowledge

41. Lastly, there are gaps in what is known about how to tackle some of the major health challenges. Research is sometimes not focused on areas of greatest need. Even where there is agreement on old or new research priorities, such as tackling neglected infectious diseases and the needs of an ageing population, the best way of discovering, producing and financing these public goods for health is seldom clear. Where effective interventions are available, knowledge on how to scale up their availability is inadequate.

42. Governments and public health institutions are not always aware of the need for evidence-based decisions for better health policies and strategies. For example, sex-disaggregated data are rarely collected or used for decision-making, yet such information is known to be indispensable for effective and gender-sensitive services. Access to information through modern and appropriate communication channels is still highly erratic in poor parts of the world and contributes to widening gaps in knowledge, for example hygiene and dietary practices, physical activity, road safety and injury prevention, and tobacco and substance abuse.

43. Health workers, teachers and community and family members in many cases lack the knowledge that is indispensable for health. Curriculum development to enhance schoolchildren learning on health-promoting practices can lead to whole communities benefiting, yet opportunities of this kind are widely neglected.

44. These challenges and gaps are not new, but it is clearer now than ever before that only joint action both within and outside the conventional health sector can respond to them adequately. The gaps examined above provide a starting point for defining an agenda for future action.

C A GLOBAL HEALTH AGENDA

45. The analysis of the past and our understanding of the key challenges and gaps in the response, show that future progress, with less health inequality, requires strong political will, integrated policies and broad participation. Any significant progress towards the health-related Millennium Development Goals will require action in many sectors and at all levels – individual, community, national, regional and global.

46. The global health agenda outlined here is for all the stakeholders, not just WHO. It highlights seven priority areas. The first refer to three broad areas closely related to health: investing in health to reduce poverty; building individual and global health security; and promoting universal coverage, gender equality, and health-related human rights. The other four focus on more specific tasks: tackle the determinants of health; strengthen health systems and equitable access; harness knowledge, science and technology; and strengthen governance, leadership and accountability.

1. Investing in health to reduce poverty

47. 'Eradicate extreme poverty and hunger' is the first and most important Millennium Development Goal. In all countries, poverty is associated with high childhood and maternal mortality, and increased exposure to infectious diseases, malnutrition and micronutrient deficiency. The link with poverty goes both ways: improvement in health is indispensable for reduction of poverty, and vice versa.

48. To improve the health of the poorest will maximize the effectiveness of these poverty reduction efforts. To achieve this, health systems have to become more equitable. This can be achieved, for instance, by designing fairer financing systems to protect certain groups from being exposed to poverty because of health-related expenses. Such measures are linked to security: those at risk of absolute poverty need 'safety nets' to protect them from its worst effects. Cash transfers, food-related programmes, subsidies, public works and micro-credit are among the means of providing such protection. Ensuring that people have access to services essential for health may entail the use of such devices as vouchers, fee waivers for health care services, social health insurance, and fuel allowances for cooking and heating.

49. The role of government is central. Poverty reduction strategies, where they exist, enable policy-makers to define programmes across departments such as education, environment and health in one coherent policy process. Their success, however, depends on government

ownership, and public sector capacity to focus on outcomes and track progress. Some of the most useful and accurate indicators for this are on health status. The contributions of partners such as the World Bank, the UN, the European Commission, and bilateral aid agencies, together with the private sector, play an important role in these coordinated efforts to reduce poverty. New forms of financing, such as the International Financing Facility, are being introduced to complement and scale up existing efforts.

2. *Building individual and global health security*

50. Conflicts, natural disasters, disease outbreaks and zoonoses, such as avian influenza, are increasing in number. The continued increase in trade in food across borders, as well as the large numbers of people travelling between countries, can accelerate the transmission of disease to a widely dispersed population. The spread of HIV/AIDS, which has become a disaster in many countries, is an example. At the household level in poorer communities, prevention and control of infectious diseases is a priority, but equally important are the health risks pertaining to food and water insecurity. Across many parts of the world, sexual violence against women and rape is widespread and deeply ingrained. Such causes of ill-health and premature death can be minimized by awareness, preparedness and preventive measures. Increasing security reduces the risk of ill health.

51. Within communities, health risks are linked to broader factors such as education, gender equality, income, and availability of food, water, fuel, and land. Further afield, trade, taxation and farm subsidies are also involved. Government plays a decisive role in all these areas, both in protecting those most at risk, and in collaborating with other countries.

52. The United Nations system will continue to work with national authorities to build capacity to respond to health needs in times of crisis. When conflict or disasters occur, resources have to be mobilized quickly to support recovery and the transition to a sustainable health system. To the extent possible, safe and dependable primary health care, immunization, and hospital services must continue to be available in times of crisis. As the threat from pandemics such as avian influenza increases, the international community should work with national and international authorities to provide a rapid and cost-beneficial response.

3. *Promoting universal coverage, gender equality, and health-related human rights*

53. One of the critical problems that has to be solved all over the world is the lack of access by the poor and other marginalized groups to essential health services. To achieve universal coverage, equitable health systems are required, with marginalized groups receiving priority attention. All groups have the right to participate in the design, implementation and monitoring of health policies, programmes and legislation. In some settings it will be necessary to stress that these include people with disabilities, refugees and displaced or migrant populations, indigenous and tribal communities, ethnic and religious minorities, people living with HIV/AIDS, widows, children, adolescents, and the elderly. For participation to be successful, elimination of stigma and discrimination also has to be at the forefront of the global public health agenda. Other key health-related human rights in this context include the right to benefit from scientific progress and the right to access to health information and education.

54. The Millennium Development Goals acknowledge that women's empowerment and gender equality is a prerequisite for development, and all the health-related goals require action in this area if they are to be achieved. Women's health is adversely affected by the prevalence among them of poverty, lack of employment, violence and rape, limited power over their sexual and reproductive lives, and lack of influence in decision-making. Expanding access to reproductive health care is essential. Those working with governments and public health authorities must

actively promote a gender perspective in the design and implementation of health policies and programmes. Monitoring and evaluation should routinely use sex-disaggregated data.

55. Many countries are working to expand coverage with essential health services, by renewing their primary health care systems. This provides an opportunity to focus on those who have been excluded, to promote high quality population-based and personal care services, to orient the private sector to public health goals, and to improve access to reliable hospital care. International public health initiatives that aim to strengthen essential health services will do so through strengthening primary care services, and enabling health workers to locate and help those most in need.

56. Collaboration efforts facilitated by WHO and its partners, such as the Global Fund to Fight Tuberculosis, HIV/AIDS and Malaria, and the Global Alliance for Vaccines and Immunizations, will build on recent successes in disease control, such as polio eradication and measles reduction, combining forces in new ways as the need and the opportunity arise. Ownership at country level is a key to success. With such initiatives, and with increases in investments from governments and international agencies, all countries can develop their own innovative ways to reach marginalized populations, and make plans for universal coverage in areas such as immunization; reproductive health; continuum of care from pregnancy through motherhood, newborn care and beyond; outbreak surveillance and response; and prevention, treatment and care services for protection against infectious diseases such as HIV/AIDS, TB and malaria.

4. Tackle the determinants of health

57. Any serious effort to improve the health of the world's most vulnerable people and reduce health inequities must tackle the key determinants of health. Some of these, such as income, gender roles, education, and ethnicity, are related to social exclusion; others, such as living conditions, work environment, and the availability of food and water, are more related to exposure to risks. Broader economic, political and environmental determinants include urbanization, intellectual property rights, trade and subsidies, globalization, air pollution and climate change.

58. Unhealthy lifestyles, once considered a problem mainly for richer countries, have been exported throughout the world and exacerbated by increasing urbanization. The nutrition transition and the global marketing of foods high in sugar, fat and salt are driving forces in the growing epidemic of chronic noncommunicable diseases. These health problems can be reduced by a life-course approach to prevention and control, which includes maternal health and prenatal nutrition, exclusive breast-feeding for six months, health promotion in schools and in the work-place, and a healthy diet and regular physical activity from childhood into old age. Engagement with the food industry is also required.

59. The health effects of a rapidly changing climate are likely to be negative, particularly in poorer communities, which have contributed least to greenhouse gas emissions. The increase in heat-waves, threatened water supplies, flooding, reduced food production, and longer transmission seasons for vector-borne diseases are likely to affect poorer communities the most. Growing urbanization is bringing with it inadequate sanitary facilities and water supplies, poor housing, overcrowding, and unhealthy working environments. Much can be done to mitigate these problems. Well-designed urban transport systems, for instance, can reduce greenhouse gas emissions, and better insulation of houses can lead to lower fuel consumption and reduction of indoor air pollution.

60. Global food insecurity is being monitored by the United Nations, which assists in providing direct access to food, and social safety nets in extreme cases. The Codex Alimentarius Commission will continue to implement the Joint FAO/WHO food standards programme to protect consumers and to facilitate trade in food.

61. The action required to tackle most of these determinants goes beyond the influence of ministries of health, and involves a large number of government and commercial responsibilities. If these determinants are to be dealt with effectively, therefore, the boundaries of public health action have to change. Governments, especially health ministries, must play a bigger role in formulating public policies to improve health, through collective government action across many sectors. It is the responsibility of WHO to keep governments informed of the situation, raise awareness, and advocate policies to tackle the determinants when opportunities arise. This has been illustrated by the WHO global strategy on diet, physical activity and health; the Framework Convention for Tobacco Control; and the Commission on Intellectual Property, Innovation and Public Health. Such policy options will increase after the Commission on Social Determinants of Health publicizes its findings. For many areas, governments, with assistance from WHO, will need to engage with industry around a commonly agreed public health agenda.

5. Strengthen health systems and equitable access

62. Without sustained and serious investment, health systems will not be able to progress towards universal coverage, and gaps in implementation will not be closed. Strengthening health systems will be linked to broader processes of government, such as civil service reform, public expenditure reviews and reform, decentralization and poverty-reduction strategies. All of these processes have an impact on health, yet historically health professionals have contributed little to them.

63. Critical systems to strengthen at all levels include: leadership and governance; knowledge production; facilities and management capacity for better health service delivery; and technologies, including interventions and medicines. The work on strengthening these systems should be focused on such objectives as: increased provision of effective services to all people in need; improved patient safety and financial protection; greater efficiency, expanded capacities, and better coordinated, more participatory and more accountable policy formulation and implementation. Building up managerial skills at all levels and accommodating reform is critically important as is the delivery of primary health care. Better national and district-level health information systems will increase the variety and effectiveness of strategies and interventions possible. Fully functional referral processes must be put in place so that people can have access to hospital or specialist care when they need it.

64. The problem of inequitable health outcomes for rich and poor people is an issue in all countries. This is often exacerbated by the private sector providing more care for the better off. The private sector has an important role to play, but government must show stewardship in its engagement, encouraging the business community to work towards public health goals. Social protection and financial risk sharing are needed to protect individuals from economic ruin because of their expenditure on health care.

65. The current crisis of shortages of health workers is a problem for many countries and is getting the attention of policy-makers worldwide. Demographic and epidemiological transitions, financing policies, technological advances and consumer expectations are also driving forces of change that affects health systems and workforce demands. Workers seek job opportunities in expanding international labour markets, resulting in accelerated professional migration from the poorer to the richer parts of the globe. At the national level, government leadership is necessary to foster health worker productivity by means of a national policy based on a well-informed understanding of problems such as retention, and on the views of the workers themselves. Educational activity will need to increase to prepare for the future, and financing of the health workforce should be coordinated and predictable enough to encourage equity and increases in volume. National and international efforts must be aligned to ensure adequate fiscal space for increasing investment in the workforce and to negotiate policies shaping migration and international labour markets, including mitigating the adverse impact on developing countries of the loss of health personnel.

66. Many groups in civil society make essential contributions and should be part of any consultative process for major change in the health system. These groups include private providers, traditional practitioners, community-based organizations, nongovernmental organizations and home-based care providers. Communities and individuals must be involved in decision-making which affects their health, and incentives are required to enable this to happen.

6. Harness knowledge, science and technology

67. The world's present burden of premature death and disease could be significantly alleviated by using relatively inexpensive and tested solutions within a more coherent and coordinated set of public health measures. Major scientific breakthroughs and new knowledge are also needed, however, as new knowledge and technology might provide effective treatments, and challenges may arise related to affordability, potential new inequities and their related ethical dilemmas

68. For example, new technologies are required to control sexually transmitted infections such as HIV/AIDS, TB and malaria and many of the chronic diseases, and the health problems associated with ageing populations. More research is required for a better understanding of the links between determinants and their consequences, and for how governments, in particular Ministries of Health, can best influence other government sectors. Research has not yet focused sufficiently on interventions most urgently needed by the poor, for example antibiotic delivery mechanisms for children with pneumonia, and access to treatment for neglected tropical diseases such as leishmaniasis, human African trypanosomiasis, schistosomiasis, Buruli ulcer, and Chagas disease. The generation and evaluation of new technologies and the uses of traditional medicines and other indigenous knowledge, will be an important area for the future.

69. To bridge the gap between knowing what to do and actually doing it, more effective national and global mechanisms are needed which apply existing knowledge and technology, and increase local capacity to conduct research. As new technology leads to more effective treatments, countries need to know how to make them affordable so as to prevent them from causing new inequities and ethical dilemmas. International finance mechanisms such as the Global Fund and Global Alliance for Vaccines and Immunizations provide some guarantee for manufacturers of a secure market that allows the necessary investment to scale up production. New international support for technology development, such as grants from the Bill & Melinda Gates Foundation, is contributing significantly to the production of new interventions for the poor. Such initiatives are a powerful instrument for change, and require increasing efforts by WHO and other partners to establish a common agenda, with reference to national and globally agreed priorities.

70. Global experience continues to expand on the use of media to raise awareness of health issues such as sexual and reproductive health in adolescents and young adults. Advances continue in the use of information and communication technology to provide health care for people in remote areas or who are otherwise hard to reach, to collate health data and research findings, and to distribute information and advice. These advances are beginning to benefit poorer communities. Understanding how best to use the internet to achieve public health goals is increasingly important. Direct marketing by the private sector is likely to increase, leading individuals to choose care and some treatments without professional support. This will require further work by governments and WHO to help develop standards that ensure quality and inform users.

7. Strengthen governance, leadership and accountability

71. At national level there is a need for strong political will, good governance, and wise leadership. Governments must have the population's health as one of their central concerns. All public policy-making is an opportunity to bring more coherence to the delivery of health outcomes. The Ministry of Health must show leadership in promoting policy dialogues and

16

intervention strategies across sectors, both public and private. This means dealing not only with health sector issues but with broader ones, such as civil service reform, macroeconomic policy, gender equality and health-related human rights.

72. The evidence showing the influence of health on economic growth and reductions in poverty means that health should feature prominently in national strategies for development, economic growth and reduction of poverty and inequalities. The macroeconomic dialogue between the health ministry and ministries of finance and planning should focus on providing more predictable, stable and long-term financing linked to agreed objectives.

73. Ministries of Health play the central role in shaping, regulating and managing health systems and clarifying the respective responsibilities of government, society and the individual. In considering the scaling up of interventions and services, national authorities and those that work with them should develop robust and realistic plans, based on cost-effectiveness, local commitment, and knowledge of what works locally. Pilot projects and islands of excellence do not usually lead to expanded coverage unless this is planned from the outset.

74. Where there is significant health sector investment by international partners, government needs the capacity to plan, manage and coordinate the cooperation. Governments, with WHO support, should persist in harmonizing and simplifying donor policies, and aligning them with commonly agreed priorities and management systems, as agreed in the 2005 Paris Declaration on aid effectiveness, which rightly states the five essential needs: ownership, harmonization, alignment, results, and mutual accountability. International donors, the UN and the global health partnerships need to follow through and ensure collective action on this agreement.

75. At the international level, governments will need to engage effectively with negotiated agreements such as TRIPS and the General Agreement on Trade in Services (GATS), given their increasing importance for health goods and services. Engagement with industry in general, covering areas such as food, pharmaceuticals and insurance, should continue, focusing on commonly agreed public health agendas. WHO has a responsibility to keep governments informed and engaged in the process.

76. Finally, the participants in public health outside government, whether they be activists, academics or business people, need forums through which they can contribute in a transparent way to global and national debates on health-related policies. Formal agreements on international health matters are generally adopted by governments in forums such as the World Health Assembly. Given the growing role of non-government actors, and their importance in ensuring good governance and accountability, additional global mechanisms and forums are required that bring the broader public health community together on issues of common concern.

D WHO - EVOLVING TO MEET THE CHALLENGES

The increasing demands

77. The challenges to global health, and the gaps in the current response, call for a health agenda which goes beyond what WHO alone can provide. To add maximum value to the work on the Millennium Development Goals, and enable member states to put health at the heart of national public policy, whether it be aimed at economic growth or reduction of poverty, WHO must focus on its comparative advantages and build on its existing strengths.

78. As the number of entities involved in health increases, the boundaries of WHO's work at all levels are expanding to include coordination with them. WHO needs to continue to develop innovative mechanisms for managing or participating in global partnerships and alliances,

including those with the private sector. The aim is to make the overall international health architecture more efficient and responsive to the needs of Member States.

The comparative advantages of WHO

79. WHO's authority in many areas is well recognized, in view of its neutral status and its nearly universal membership. WHO's close relations with governments through the World Health Assembly, the Regional Committees, and its Country Offices put the Organization on a firm footing of legitimacy. WHO is respected both for its impartiality and for its commitment to the core values expressed in its Constitution. WHO's strong convening power can enable diverse groups to talk and listen to each other and stimulate collective action across the globe.

80. WHO's role in tackling diseases is unparalleled, whether by marshalling the necessary scientific evidence, promoting global strategies for eradication, elimination or prevention, or identifying and controlling outbreaks. The International Health Regulations (2005) put WHO at the centre of a global network of institutions and public health agencies that attempts to protect the world from the spread of infectious diseases and similar hazards.

81. WHO has expanded its repertoire of global normative work through initiatives such as the adoption of the Framework Convention for Tobacco Control, the revision of International Health Regulations, and its Commissions on Macro-Economics and Health, Intellectual Property Rights, Innovation and Public Health, and the Social Determinants of Health. These and other achievements in WHO's normative work have been possible because global efforts are being matched by those made in countries, so that the legislation is owned by those with whom it must take effect.

82. WHO amasses evidence for health through its own work and that of the numerous formal and informal networks and collaborating centres around the world. These networks facilitate lively cooperation between scientists across nations in commonly agreed areas of research. Expert committees, such as for Biological Standardization, provide independent views on products and diagnostic kits. The knowledge gained from its regional and global networks enables WHO to advocate policies to be taken up by ministries of health and other sectors of government, and to mobilize technical expertise and financial resources for implementing new approaches and building national capacities. WHO therefore works in the first stages of development processes, supporting the updating of national policies as new evidence becomes available.

83. WHO's regionalized structure provides it with multiple opportunities for engaging with countries, with Geneva focusing on issues of global concern, and regional offices focusing on technical support and building national capacities. WHO's presence in countries allows a close relationship with Ministries of Health and its partners inside and outside of government. It can collaborate closely with the UN system, and can provide channels for emergency support when this is needed. The three levels of WHO secretariat, and its close working relations with governments, enable it to gather health information and monitor trends over time and across countries, regions and the globe.

The core functions of WHO

84. Building on WHO's mandate and an analysis of its comparative advantage, six core functions have been defined for WHO. These build to a large extent on the core functions defined in the 10th General Programme of Work but take into account the gaps identified, and how WHO best can respond to the global health agenda. These functions are carried out at all levels of the Organization according to what makes best sense, and this may vary by programme. The six core functions are set out below, together with examples of how they take effect.

18

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

85. WHO will continue to lead in facilitating the drafting and adaptation of international legal instruments to protect global health, and fostering similar processes to solve major global health problems. As global health threats arise, WHO convenes the relevant authorities and mobilizes collective action with its Member States.

86. WHO will remain a full partner in global health partnerships, such as the Global Fund to Fight Tuberculosis, HIV/AIDS and Malaria; the GAVI Alliance, the Stop-TB partnership; Roll Back Malaria Partnership; and the Partnership for Maternal, Newborn, and Child Health, which aim to scale up coverage of public health interventions. WHO will help maximize their effectiveness, provide technical assistance, and help to harmonize their work with other efforts, and promote the alignment of their investments with national policies and programmes. WHO will continue to lead collaborative efforts to bring in health-related relief in times of crisis.

87. WHO will engage with the major global and regional international financing institutions, in particular the World Bank, the European Union and regional development banks, as well as large bilateral partners. WHO will use international forums, such as the recent High Level Forum on Health, to advocate a common approach to priorities in strengthening national health systems, and more harmonized support for national development policies and poverty reduction strategies.

88. WHO will strengthen its collaboration with UN agencies such as UNICEF and UNFPA to take forward the evolving global health agenda, in conjunction with the Bretton Woods Institutions. WHO will engage fully in the UN reform efforts with the aims of streamlining the procedures of governance; bringing coherence to the formulation of norms, standards and policy guidance; clarifying divisions of labour, as done recently with UNAIDS and the Global Task Team; maintaining transparency in the use of data and knowledge; and providing a strong support for the UN Country Teams under one UN leadership. WHO will not duplicate the work undertaken by other organisations in the UN, and will focus on the health related aspects of cross-cutting issues such as security, environment, rights and gender.

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

89. WHO will continue to support activities across the health research spectrum that help to promote health, prevent and control diseases, strengthen health systems, accelerate the achievement of the health-related Millennium Development Goals, improve health equity, and strengthen the research process itself, the management of knowledge, and building capacity in developing countries as needed. The WHO Advisory Committee on Health Research promotes this work, in close cooperation with external institutions.

90. WHO will use knowledge gained from the appropriate review of existing research findings with implications for health improvement, participate in the design of essential tools and methods, and evaluate the quality and usefulness of interventions, methodologies, and programmes with a view to enhancing the quality of access to quality health products and services.

91. WHO will strengthen the role and functioning of its associated research programmes, such as those on cancer, reproductive health, tropical diseases, vaccines, and health systems, in their areas of comparative advantage. It will support research and associated capacity-building and knowledge management that is of particular significance for developing countries and for which coordinated global action is required.

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

92. WHO will set norms for areas of public health agreed with its Governing Bodies, based on the most complete and reliable scientific evidence available. Expert Committees, Advisory Panels and other advisory groups will oversee this work. These groups will continue to improve the quality of their work by ensuring that they are representative in terms of gender and geography, and recruit members in a transparent way, on the basis of their competence.

93. WHO's network of collaborating centres will work with WHO to help standardize the terminology and nomenclature used for diagnosis, treatment and prophylaxis, and for the substances, technologies, methods and procedures involved. This facilitates understanding and comparison of data on a worldwide basis. As part of this, WHO will continue with its flagship classifications the International Classification of Diseases (ICD) and the International Classification of Functionality, Disability and Health (ICF).

94. As consensus on standards set by WHO and its partners grows, and as the mechanisms for applying them become more clear, such as the pre-qualification process, WHO will develop strategies in consultation with partners to support countries in adhering to these standards. Examples of such strategies include: the Global Strategy on Infant and Young Child Feeding (2002); the Strategic Directions on Child and Adolescent Health (2003); the Global Strategy on Diet, Physical Activity and Health (2004); the Reproductive Health Strategy (2004); the WHO Medicines Strategy (2004-2007); the Global Strategic Plan of the Roll Back Malaria Partnership (2005-2015); the Global Immunization Vision and Strategy (2006-2015); the Global Plan to STOP TB (2006-2015); the 'Universal Access' global action plan (2006-2010) being developed with UNAIDS; and Sexually Transmitted Infections Strategy (2006). Global strategies will continue to be developed and expand to cover new priorities.

4. Articulating ethical and evidence-based policy options

95. WHO will provide Member States with reviews of policy options to consider in different settings. WHO will amass global evidence and facilitate its adaptation for inter-country work and confer directly with governments on its use in national and sub-national policies and programmes.

96. These efforts will review what is feasible in different social and economic environments, and be based on considerations of cost-effectiveness, ethics and equity. Examples in recent years include policy options for mental health, road traffic accidents, violence against women, chronic diseases, tobacco control, and patient safety. Information and experience for such guidance will continually accumulate and, where possible, be linked to advocacy programmes such as those that accompany the World Health Reports and World Health Days, and to the monitoring of standards.

97. Such evidence-based policy advice will continue to guide disease control and the development of health systems in areas such as human resources, social protection and health financing. It will expand to cover more of the determinants of health as the approaches needed become apparent.

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

98. Providing technical support to countries has been a central component of WHO's work since its inception and must continue to be so in the future. WHO's task in providing such support is to help make norms, standards and policy options available in countries. Rather than to implement programmes itself, WHO's role is to contribute to building sustainable institutional capacity. Well-established programmes will continue, such as those linked to building up capacity for surveillance and response to outbreaks, immunization, prevention, treatment and care for diseases such as tuberculosis, malaria and HIV/AIDS, and expanding support for the Integrated

Management of Childhood Illness. These areas are complemented by work on strengthening health systems and modifying broader determinants of health.

99. In emergencies and post-conflict situations, WHO works with the UN Office for the Coordination of Humanitarian Affairs to meet immediate health needs, and help the governments concerned to provide support for reconstruction and disaster preparedness.

100. WHO plays a critical role, together with some other members of the UN Country Team, in facilitating this technical support between countries, and in responding to demands from ministries of health and their partners, as defined in the Country Cooperation Strategy.

6. Monitoring the health situation and assessing health trends

101. WHO carries out its monitoring responsibilities in countries in collaboration with ministries of health and national statistical institutions, and at regional level by collating data on trends across nations, and working with partners across its programmes. At the global level, the annual *World Health Report*, the *Weekly Epidemiological Record* and *World Health Statistics* provide data on the state of global health in selected areas on a country by country basis. These compilations are supplemented by in-depth comparison of health indicators across the globe in global atlases located on the WHO web-site, covering, for example, communicable diseases, mental health, heart disease and stroke, children's health and the environment, and tobacco. WHO has a responsibility to ensure that all health data are gender-disaggregated.

102. WHO provides a global surveillance system covering both communicable and noncommunicable diseases, and provides support to build up national capabilities for surveillance and response, and mapping of public health risks and resources. The Health Metrics Network, hosted by WHO, is a global initiative involving collaboration in strengthening country health information systems to generate sound data for decision-making in countries and internationally. It brings together the work of health practitioners and statisticians to build up national capacity to marshal data for decision-making on health.

The challenges and future opportunities for WHO

103. Although its comparative advantages are clear, WHO must respond to important challenges if it is to realize its potential for effective action in the future. If health is to make its full contribution to reducing poverty, the case for more investment health in global health must be clearly and strongly made. Governments will require evidence to show that their health policies, for example, are improving school attendance, are allowing more adults to have a long and productive working life, and are making communities safer places to live in.

104. In health crises, WHO has to act rapidly in order to be an effective partner amongst the numerous other agencies working with governments. Ministries of Health will require plans agreed to in advance, so that when an emergency occurs, communication channels are clear, coordination mechanisms are quickly put in place, and the support from WHO and the rest of the UN is swift. WHO will continually review its procedures to allow for more prompt responses.

105. To tackle social injustice and its effects on health, WHO will be clear on its concept of health equity and build this into its guidance and resolutions. Its approach to health-related human rights will include building a greater understanding across the organization of what this means for participation in the design and implementation of health programmes and legislation. WHO will lead by example in mainstreaming gender, building this into all its technical guidance and normative work, and using sex-disaggregated data in the planning and monitoring of its programmes.

106.   To accelerate the scaling up of public health interventions, WHO will move beyond small pilot projects that gather evidence or test feasibility, and encourage governments and its partners to draw up realistic plans for expanding services linked to sustainable financing. WHO will do more to focus attention and action on ensuring that countries have sufficient human resources for health, and work to keep this concern at the forefront of national and international policy.

107.   Many of the determinants of health are outside WHO's direct sphere of influence, but WHO will work with ministries of health to build their understanding of what can realistically be done by working with other sectors. WHO will monitor global trends that are of significance to health in areas such as trade and agriculture, and keep Ministries of Health informed. WHO will engage more systematically with civil society and industry, including international health care and pharmaceutical industry, on a common public health agenda.

108.   WHO will need to be proactive in leading a dialogue on setting priorities and ethical standards for research, as scientific advances continue, for example in clinical research, social science, and genomics.

109.   WHO will engage strategically with its Member States, and build more effective alliances within the UN and the broader development community. It will work with them to harmonize the global health architecture at country level, and engage in the reform process towards an effective country team under a common UN lead.

110.   WHO will work with others to harmonize the global health architecture, and provide forums for the increasing number of players to engage in dialogue on local and global health challenges. WHO will continue to work with its governing bodies to help them become more effective and businesslike in their way of working.

Management challenges for the WHO secretariat

111.   WHO faces many challenges in its own management. Much of the necessary foundation has been laid with the introduction of the results-based management framework, and a more strategic approach to staffing, financing, and operational support. Challenges remain in making WHO more effective, able to pursue excellence in its core functions, and improve its accountability. For example:

   a. Financing of the organization is increasingly from voluntary contributions, the majority of which are earmarked for specific projects or programmes. This earmarking can distort priority-setting and may threaten the impartiality of WHO, as well increase its administration costs. WHO will develop strategies for increasing the proportion of un-earmarked funds, linked to more transparency in its assessments of performance.

   b. WHO has a strong country presence, with offices in almost 150 countries. It is taking forward its Country Cooperation Strategies so as to make its engagement with Member States more strategic, and to harmonize its efforts under a common UN lead.

   c. The quality of WHO's work must continually improve if the Organization is to fulfil its mandate. To do this, it must continually learn from its own experience and that of others. Mechanisms for improving quality are in place, such as technical advisory committees, performance management of staff, and peer review of plans and programmes, but these will be further strengthened around WHO's core functions and through more clearly specified systems of performance enhancement.

d. Work towards managing the Organization as one corporate body will continue, with an increasing level of common systems across the three levels. WHO's Constitution supports regional diversity, but within a common global results-based management framework, and corresponding performance and accountability systems.

e. WHO is committed to promoting a highly competent workforce and to strengthening its scientific and technical advisory bodies. As expectations of WHO change, the secretariat will need to devise more flexible ways to achieve and maintain excellence through new and existing staffing arrangements. WHO will strive to reach sex parity in senior management and in its advisory bodies.

Setting WHO priorities

112. The World Health Assembly, as the supreme decision-making body of WHO, directs the work of the Executive Board and the secretariat by adopting resolutions, setting targets and formulating policies. To help maintain the necessary balance, WHO will pursue a limited number of strategic objectives in the six-year Medium Term Strategic Plan. Each strategic objective will have its own targets, which are agreed with governing bodies and monitored accordingly. In addition, the resource implications of all new resolutions will be made clear. When a new resolution is adopted, WHO will have to indicate where commitments can increase in the Programme Budget, and where they can be reduced.

113. In accordance with the global health agenda, WHO's comparative advantage and its core functions, the Results-Based Management Framework is used for setting WHO's priorities and carrying out the work they entail. The priorities will be based on the preceding analysis, on global and regional resolutions, and the cumulative needs of countries. These priorities will be in the following areas:

a. *Providing support to countries in moving to universal coverage with effective public health interventions.* This applies particularly to areas such as communicable and noncommunicable disease control, reproductive health, infant, child and maternal health, environment-related health problems, and effective responses in times of crisis.

b. *Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health.* This will focus on minimizing life-style-related risk factors, advocating action on the broad social and economic determinants of ill health, and promoting healthier physical environments, better nutrition, and food safety, and food security.

c. *Increasing institutional capacities to deliver core public health functions under the strengthened governance of Ministries of Health.* This area will support the development of health systems that promote equitable health gains and better respond to men's and women's different needs; that improve quality, efficacy and safety; that have effective leadership and governance, and that extend social protection through fair, adequate and sustainable financing.

d. *Strengthening WHO's leadership at global and regional levels and by supporting the work of Governments at country level.* The secretariat will strengthen its ability to take forward its core functions through its reform process around results-based management, through strengthening WHO's work in countries, monitoring norms and standards in countries, improving its mechanisms for knowledge management, investing in staff development, and ensuring sustainable sources of financing. Externally it will strengthen its work on partnerships and engage more deeply in the

UN reform process, with a view to strengthening the UN's response to the global health agenda, and to improving overall efficiency.

Implementing the 11th General Programme of Work

114.   This will be taken forward with Member States through the development of a six-year Medium Term Strategic Plan for 2008-2013, with biennial Programme Budgets agreed with the Governing Bodies.

115.   Following the direction provided by the General Programme of Work, WHO will strengthen its engagement with international financing institutions and development partners, to mobilize more resources for health and to carry out agreed agendas to strengthen national health systems under the leadership of ministries of health. WHO will engage fully in the dialogue to improve the UN, to make it more effective and efficient, and will fully support all aspects of the reform process aimed at improving global health in line with governing body resolutions. WHO will set up mechanisms with the global public health community for engaging a wider range of stakeholders in the policy dialogue around the global health agenda, and use this to promote wider engagement in fulfilling WHO's core functions.

116.   The global health agenda and the response from WHO and the international community will be monitored in a participatory manner with a wide group of partners. A plan will be prepared for establishing mechanisms to take stock of progress, and evaluating how well the challenges and gaps are being addressed. Reports on progress will be made available to Governing Bodies.

Health in the Millennium Development Goals

Health Targets	Health Indicators
Goal 1: Eradicate extreme poverty and hunger	
Target 1 Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	
Target 2 Halve, between 1990 and 2015, the proportion of people who suffer from hunger	4. Prevalence of underweight children under two years of age 5. Proportion of population below minimum level of dietary energy Consumption
Goal 2: Achieve universal primary education	
Target 3 Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of Primary schooling	
Goal 3: Promote gender equality and empower women	
Target 4 Eliminate gender disparity in primary and secondary education, preferably by 2005, and at all levels of Education no later than 2015	
Goal 4: Reduce child mortality	
Target 5 Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	13. Under-five mortality rate 14. Infant mortality rate 15. Proportion of one-year-old children immunized against measles
Goal 5: Improve maternal health	
Target 6 Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	16. Maternal mortality ratio 17. Proportion of births attended by skilled health personnel
Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 7 Have halted by 2015 and begun to reverse the spread of HIV/AIDS	18. HIV prevalence among pregnant women aged 15-24 years 19. Condom use rate of the contraceptive prevalence rate 20. Ration of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Target 8 Have halted by 2015 and begun to reverse the incidence of Malaria and other major diseases	21. Prevalence and death rates associated with malaria 22. Proportion of population in malaria-risk areas using effective Malaria prevention and treatment measures 23. Prevalence and death rates associated with tuberculosis 24. Proportion of tuberculosis cases detected and cured under DOTS (Directly Observed Treatment Short-course)
Goal 7: Ensure environmental sustainability	
Target 9 Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	29.. Proportion of population using solid fuels
Target 10 Halve by 2015 the proportion of People without sustainable access to safe drinking-water and sanitation	30. Proportion of population with sustainable access to an improved water source, urban and rural
Target 11 By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers	31. Proportion of population with access to improved sanitation, Urban and rural
Goal 8: Develop a global partnership for development	
Target 12 Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Target 13 Address the special needs of the least developed countries Target 14 Address the special needs of landlocked countries and small island developing states Target 15 Deal comprehensively with the debt problems of developing countries through national and international Measures in order to make debt sustainable in the long term Target 16 In cooperation with developing countries, develop and implement strategies for decent and productive Work for youth	
Target 17 In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	46. Proportion of population with access to affordable essential drugs on a sustainable basis
Target 18 In cooperation with the private sector, make available the benefits of new technologies, especially information on communications	

11th GPW: Current Health Situation - interesting facts

Mid-range population estimates suggest a global population of approximately nine billion by 2050. There will be rapid increases in the absolute and relative numbers of **older people** in both developing and developed countries; a 300% increase in the elderly population is predicted by 2050. An overwhelming majority of the world's **young people** – 86% – now lives in developing countries.

Road traffic injuries kill an estimated 1.2 million people annually, injuring as many as 50 million Projections indicate that these figures will increase by about 65% over the next 20 years unless there is new commitment to prevention. Over 70%of people killed in road traffic injuries are under 45 years of age.

Of the estimated total of 58 million deaths in 2005, approximately 17.5 million were due to infectious diseases or perinatal, maternal and nutritional disorders. Three million deaths were caused by **HIV/AIDS**, which is the leading cause of mortality among adults aged 15 to 59, representing 15% of global deaths (2.4 million deaths) in this age group.

Today, nearly all child deaths (97%) occur in low-income countries, and almost half of them in Africa. Overall, 35% of Africa's **children** face a greater risk of dying today, as compared with 10 years ago. Communicable diseases still represent seven out of the top 10 causes of child death, and cause about 60% of all child deaths.

At least one million people die from **malaria** every year, and the disease is likely to be a contributing factor in another two million deaths. There are still 1.7 million deaths from **tuberculosis** worldwide every year. Ninety-eight per cent of these unnecessary deaths occur in developing countries.

Chronic noncommunicable diseases, including mental ill-health, already represent 60% of the current global disease burden, and account for 35 million deaths, of which 16 million occur in people under the age of 70 years. One quarter of all chronic disease deaths occur in people under 60 years of age. Four of the 10 leading causes of death in the world are related to **smoking**. There were an estimated 1.2 million lung cancer deaths in 2002, an increase of nearly 30% in the 11 years from 1990, reflecting rising tobacco consumption in low-middle and middle-income countries.

Environmental determinants, including access to safe food and water, not only accounted for 1.8 million deaths from diarrhoea in 2004, but are also responsible for a significant (but inadequately estimated) chronic-disease burden related to chemical contamination of food and water sources, especially in the poorest countries.

> **11th GPW: The Country Cooperation Strategy**
>
> The WHO Country Cooperation Strategy (CCS) is a medium term strategic framework for WHO cooperation with a particular country. It represents a balance between country priorities, as analysed by the Secretariat in full consultation with national stakeholders, and regional as well as Organization wide orientations and priorities.
>
> It is a vehicle for WHO *alignment* with national health and development plans and strategies - for example, Poverty Reduction Strategies/Sector-wide approaches (SWAps) - and for *harmonizing* WHO's cooperation with the work of United Nations agencies and other partners.
>
> The CCS is an Organization-wide reference for country work, which guides planning, budgeting and resource allocation.

The Results chain in WHO: from the General Program of Work to Program Budget

11th GPW
(2006-15)

Global Health Agenda

- **A seamless process**

Medium-term Strategic Plan
(2008-13)

Strategic Objectives

- **Allows for multi-year strategic planning**

- **Clearly links operational planning to broad Organizational priorities**

Program Budget
(2006/7; 2008/9; 2010/11; 2012/13)

Organization-wide Expected Results

- **Adaptable at regional and country level**