



WORLD HEALTH ORGANIZATION

**EXECUTIVE BOARD
117th Session
Provisional agenda item 5.1**

**EB117/16
12 December 2005**

Eleventh General Programme of Work, 2006-2015

Report by the Secretariat

1. The Eleventh General Programme of Work (at Annex) is designed to be the first step in WHO's results-based management process, giving broad direction to the work of WHO. It focuses on the actions and responsibilities of WHO as the world's specialized health agency and its role in global health, while examining the interrelatedness of the many sectors and disciplines influencing health. In contrast to previous editions, this General Programme of Work is a call for collective action to improve health over the next decade in the form of a global health agenda.

ACTION BY THE EXECUTIVE BOARD

2. The Board is invited to review the proposed Eleventh General Programme of Work and to consider the following draft resolution:

The Executive Board,

Having reviewed the draft Eleventh General Programme of Work, 2006-2015;¹

RECOMMENDS to the Fifty-ninth World Health Assembly the adoption of the following resolution:

The Fifty-ninth World Health Assembly,

Having considered the draft Eleventh General Programme of Work, 2006-2015, submitted to it by the Executive Board, in accordance with Article 28(g) of the Constitution;

Mindful of the changing context of international health, and the need for WHO and partners to respond effectively to these changes;

¹ Document EB117/16, Annex.

Welcoming the framework provided by the General Programme of Work 2006-2015, and the interrelatedness of the General Programme of Work and the medium-term strategic plan, which reflects an effort to introduce a more strategic approach in the Secretariat's planning, monitoring and evaluation, and the Organization's work with partners;

1. APPROVES the Eleventh General Programme of Work, 2006-2015;
2. URGES Member States to identify their role and specific actions to be taken to fulfil the global health agenda and to engage partners across disciplines in such action;
3. REQUESTS the Director-General to use the Eleventh General Programme of Work, 2006-2015 as the basis for strategic planning, monitoring and evaluation during its lifespan; to review and update the General Programme of Work 2006-2015 as needed to reflect the changing state of global health; and to report to the Sixty-third World Health Assembly and Sixty-seventh World Health Assembly on the continued relevance and use of the General Programme of Work 2006-2015.

Together towards a healthier future

WHO
Eleventh General Programme of Work
2006–2015

Table of Contents

FOREWORD BY DR LEE JONG-WOOK, DIRECTOR-GENERAL.....	3
INTRODUCTION	3
HEALTH IN A CHANGING GLOBAL ENVIRONMENT.....	4
<i>Health: a defining characteristic of the twenty-first century.....</i>	<i>4</i>
<i>Health actors: a changing world.....</i>	<i>5</i>
<i>The current health situation</i>	<i>6</i>
<i>International declarations and agreements.....</i>	<i>9</i>
THE CHALLENGES TO HEALTH: CLOSING THE GAPS	10
<i>Gaps in social justice</i>	<i>11</i>
<i>Gaps in responsibility and synergies.....</i>	<i>11</i>
<i>Gaps in implementation</i>	<i>12</i>
<i>Gaps in knowledge</i>	<i>13</i>
<i>Closing the gaps</i>	<i>14</i>
A GLOBAL HEALTH AGENDA.....	14
<i>Ensure universal coverage and promote equity in health</i>	<i>15</i>
<i>Build individual and global health security</i>	<i>15</i>
<i>Promote health-related human rights and gender equality.....</i>	<i>16</i>
<i>Reduce poverty and its effects on health</i>	<i>18</i>
<i>Tackle the social determinants of health</i>	<i>18</i>
<i>Promote a healthier environment.....</i>	<i>20</i>
<i>Build fully functioning and equitable health systems</i>	<i>21</i>
<i>Ensure an adequate health workforce.....</i>	<i>23</i>
<i>Harness knowledge, science and technology</i>	<i>24</i>
<i>Strengthen governance and leadership</i>	<i>25</i>
WHO – EVOLVING TO MEET THE CHALLENGES.....	26
<i>The context for renewal: WHO's achievements and challenges.....</i>	<i>27</i>
<i>WHO's core functions</i>	<i>28</i>
<i>Responding to the gaps</i>	<i>28</i>
<i>Strategic domains: WHO's contribution to the global health agenda.....</i>	<i>29</i>
<i>A more effective and efficient Organization.....</i>	<i>30</i>
CONCLUSION	31

FOREWORD, by Dr LEE Jong-wook, Director-General

1. Every few years, we get an opportunity to step back from our work and take a broad look at the health of the world; to look into the future, predicting the impact of current trends, developing a common vision, setting goals and identifying the steps needed to fulfil specific health objectives. The General Programme of Work provides that opportunity for WHO, its Member States and its partners.

2. An intelligent view of the future requires an informed understanding of the past. This General Programme of Work has been developed following an extensive review of past successes and failures and a wide-ranging process of consultation and debate.

3. This Eleventh General Programme of Work covers a 10-year period from 2006 to 2015, coinciding with the target date for achieving the Millennium Development Goals. It reaffirms our understanding of the determinants of health and the measures required to improve the health of populations, communities, families and individuals. It explicitly recognizes health as a shared resource and a shared responsibility. It concisely describes the priority problems, and how the world must tackle them.

4. The 192 Member States of WHO each have a unique health profile. Although that diversity is enormous, there are broad issues in common. Positive factors, such as stable economies, strong health systems and supportive social environments, generally result in a high level of well-being and security. But there are still too many areas where, despite a huge potential for improvement in life and health, this improvement is not happening, and negative factors lead to inefficiency, instability and exclusion from the benefits of progress.

5. 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 disease pandemics – illustrate how quickly situations can change and how precarious health security can be. The answer is 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 proposed in the General Programme of Work and remaining accountable to them.

6. I invite all those reading this document to take time to consider its implications, to think about how their work and their aims influence health outcomes, and how they and WHO can best work together. This is an opportunity for a renewal of responsibility in a challenging world.

INTRODUCTION

7. In many ways, the world has changed almost beyond recognition since 1946, when the WHO Constitution was adopted. Scientific advances – for instance new and safer immunizations – have allowed millions more lives to be protected every year. However, many of the public health problems have remained the same. Alleviating the disease burden remains a primary focus, although the epidemiological profile has changed. Chronic noncommunicable diseases today form the majority of that burden; their ubiquitous presence in rich and poor societies alike is a result of changing lifestyles and behaviours rather than patterns of pathogen transfer. Infectious diseases still claim many lives, especially HIV/AIDS, which has become a human, social and economic disaster with far-reaching implications for individuals, communities and countries. There, containment challenges also reflect social and economic realities, health-system weaknesses and global vulnerability to vastly expanded communication networks.

8. The scale and global implications of the problems have changed: the disease burden in Africa has merited the attention of the United Nations Security Council. Interdependence has deepened: an outbreak of severe acute respiratory syndrome (SARS) in the Western Pacific has an impact on the

Americas; and the continued transmission of poliomyelitis in South-East Asia or Africa jeopardizes the polio-free status of nations near and far.

9. For all but the very poorest, for whom choices remain highly limited, the world offers a vastly different environment from that of 1946, an environment in which the movement of information, people, pathogens, Internet images – everything – continues to accelerate. Advances in technology have made the world more interconnected and interdependent than ever before. Immense progress has taken place in recent decades, particularly in the areas of science and technology. Wealth – financial and intellectual – is being created at an accelerated rate, even though too few countries and people share its benefits or influence the process. Life expectancy is increasing in most countries, but the fruits of development have not improved the health and well-being of all. The root causes of these imbalances need to be more clearly understood, since they have a significant impact on health.¹

10. There are significant discrepancies between the potential opportunities for change and improvements, and the current global realities of inequalities and ill-health. Those discrepancies in well-being need to be reduced; the “gaps” closed.

11. What are these gaps? Gaps in social justice; crucial components of equity, health-related human rights and gender equality are missing in policy-making and decisions. Gaps in responsibility and synergies occur where no-one takes the lead or can be held accountable for the many factors outside the health sector which, nevertheless, have consequences for health, or where potential synergies between the activities of the growing number of global, national and local players are not optimized. There are implementation gaps, where systems and services are inadequate to the task of delivering what is needed, and where national and international structures are not sufficiently effective. Lastly, there are knowledge gaps where, despite advances in science and technology, despite extensive investment in research, essential answers are missing or incomplete; information is not shared effectively and education is inadequate or denied to certain groups.

12. No single entity, however global its remit, can bridge those gaps on its own. The solution is to create, jointly, an environment where ethical considerations are mainstreamed; where responsibility is taken in synergy by all: civil society, the private sector, governments, international organizations and the multitude of individuals involved; where process and implementation are comprehensively addressed; and where life-saving or life-enhancing knowledge is sought and shared. The Global Health Agenda proposed in this document is a step towards such a response. Its content is a selective review of the most important forces affecting health now and for the next 10 years, highlighting areas for collective action to address the challenges these represent.

13. Many of the issues are not new; they will all be instantly recognizable. The novelty – and the difficulty – lies in promoting joint action by actors within and outside the conventional health sector, and in making the commitment to resolving those issues. Therein lies the challenge of a renewed role for WHO, as the directing and coordinating authority in international health work.

HEALTH IN A CHANGING GLOBAL ENVIRONMENT

Health: a defining characteristic of the twenty-first century

14. Health now occupies a prominent place in development debates. This new awareness is well reflected in the United Nations Millennium Declaration and in the central role accorded to the internationally agreed health-related development goals, including those contained in the Millennium Declaration (hereafter “Millennium Development Goals”) in national and international poverty-reduction strategies.

¹ World Commission on the Social Dimension of Globalization. *A fair globalization: creating opportunities for all*. Geneva, International Labour Organization, 2004.

15. Increasingly, health is seen as a fundamental dimension of human security, a concept which attracted increased interest during the 1990s. There can be no peace without equitable human development, there can be no security without peace. None of these can be achieved without health. The threat of bioterrorism and the possibility of new infectious disease outbreaks are conspicuous examples of health's importance, but they are not the only ones. Poverty and deprivation are central issues in human security. Health status is closely connected with violence and conflict: primarily because violence contributes significantly to preventable morbidity and mortality, but also because the instability associated with poor population health likewise accelerates institutional failure, the erosion of social capital and the proliferation of violence.

16. Health is a key element of human rights and social justice. Every country in the world is now party to at least one international treaty that recognizes the right to the highest attainable standard of health (hereafter "right to health") and/or other health-related human rights. This means that governments have committed themselves to progressively realizing these rights, paying particular attention to the most vulnerable population groups. Health's centrality has been affirmed in a wide range of international agreements over the last 20 years and by a wide set of stakeholders, going far beyond the health sector and ministries of health.

17. The scale of funding advanced for health-related programmes grew by an average of 8% per annum between 1993 and 2003. Enormous resources are increasingly being dedicated by public-private partnerships to health-related programmes, with greater awareness of the need for better implementation. However, many of these resources have been devoted to the HIV/AIDS crisis. There is still a dramatic shortfall in the resources required to meet the Millennium Development Goals and other health needs, but the 2005 World Summit (High-Level Plenary Meeting of the 60th session of the United Nations General Assembly, 14-16 September 2005) acknowledged the need for increased investment in health systems in developing countries and in those with economies in transition.

18. Health remains a strongly scientific and medical field; many of the challenges to world health can still traditionally be described in terms of their disease burden. However, health improvement at global level is more linked to improvements in public policy than to any other type of intervention. Central to a multidimensional understanding of health today is the recognition that health concerns and health actions reach far beyond medical care alone. Broader social, economic, environmental, political and institutional arrangements determine health opportunities and outcomes and the way that health – and vulnerability to ill-health – are distributed across social groups. This is still an appropriate starting-point at a time where new questions, new challenges and new forms of responsibility are emerging in a globalizing and interdependent world.

19. It is up to the global health community and WHO to build on these new opportunities and to change the way they respond to the challenges represented by this more complex understanding of health. For action to be most effective, health issues must be tackled from many angles. Substantial progress can be made only when health is perceived as a vital aspect of all situations.

Health actors: a changing world

A world of multiple actors

20. The past decade has witnessed dramatic changes in public-health governance and international cooperation. Health's position has been charted in a wide range of national and international agreements and affirmed in action by a wide-ranging set of stakeholders. A multiplicity of new actors is redefining the boundaries of the health sector, each with its own unique expertise and vision.

21. Groups of individuals united in a particular cause, such as patient or civil-society groups, are becoming major players, creating powerful lobbies and raising public awareness of issues. Use of the Internet and other new communication tools has allowed consumers a certain degree of informed

freedom of choice. An increasing number of nongovernmental organizations have stepped in to deliver care and complement the efforts of national health systems.

22. Research and academic institutions continue to shape the directions and use of knowledge. There is an ever-stronger need for broadly-based scientific collaboration to tackle major health problems and a growing awareness of the central role of research in informing action.

23. The private sector is a powerful driver for research and development and a massive force behind marketing and production of goods. It is also an influential player in decision-making in economic and health-policy issues.

A world of multiple partnerships

24. The last five years have seen a dramatic increase in the number of partnerships in health. These partnerships are highly diverse in nature, scope and size. A number of partnerships target a single disease. As many as 60% relate to AIDS, malaria and tuberculosis; some of them relate to product development, product access or research and development. New mechanisms for health financing (e.g. the Poverty Reduction Strategies, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunization), and the scale of resources brought in by new partners are changing the way health is funded in many countries, and its relative profile and status.

25. The proliferation of partnerships and the involvement of new partners such as not-for-profit foundations and the private sector have introduced new dynamics into the international scene. They have taken public health beyond its traditional medical confines to include the wider goals of development and human rights, and brought a new complexity to relationships, planning and the need for delineation and harmonization of responsibilities.

26. Partnerships offer the potential to combine the different strengths of public and private organizations, along with civil-society groups, in addressing health problems in poor countries. They are fundamental to scaling up the response to global health needs, they can mobilize awareness, funding, expertise and a wider range of actors. They can achieve great success at country level through better coordination (for instance in maternal, newborn and child health). However, they also give rise to some challenges and controversies. Health activists and researchers have criticized partnerships for increasing the fragmentation of international cooperation in health, overwhelming national capacity, distorting national priorities, diverting scarce human resources and marginalizing the United Nations. The lack of accountability, the lack of involvement of civil society in shaping partnerships, and the potential negative impact on global inequities caused by focusing on “relatively narrow” issues rather than broader and more difficult problems are also causes for concern and positive remedial action.

27. Despite these issues, the number of partnerships will continue to grow in years to come, and partnerships and partners will continue to diversify. Greater success is possible; however, it will be necessary to resolve some difficult questions. These include realizing the potential of partnerships, ensuring sustainability, and building country capacity.

The current health situation

Overall context

28. The global population is still increasing, but its 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. The challenges presented by population changes and growth include poverty, the decimation caused by HIV/AIDS in certain areas, migration, and living conditions.

29. Crises – whether natural or manmade – pose both direct and indirect threats to human life. Each year, one in five countries experiences a crisis, characterized by high levels of suffering and death. The increasing numbers of situations of conflict or emergency have created new demands for skills in disaster preparation and management, data-monitoring capacity and the development of policies for countries in recovery.

30. 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. The obligation to treat the chronic conditions which become more common in old age – cancers, diabetes mellitus, heart disease, dementia and a range of nutritional imbalances – falls squarely on the health services, often involving expensive long-term tertiary care and exerting pressure to divert funding from primary health care, when in many countries the national health budget is static or decreasing.

31. An overwhelming majority of the world's young people – 86% – now lives in developing countries. The lives of millions of adolescents worldwide are at risk because they do not have the information, skills, health services and support they need to go through sexual development during adolescence and postpone sexual activity until they are more physically and socially mature and better able to make well-informed, responsible decisions.

32. By 2007, it is expected that half of the world's population will be living in urban areas. In developing regions, 43% of the urban population lives in slums, and in the least developed countries, 78% of urban residents are slum-dwellers. It is estimated that households headed by women constitute 30% or more of total households in slums. Road traffic injuries kill an estimated 1.2 million people annually and are linked with poor urban and transport planning and with wider social and behavioural factors, such as alcohol use or low rates of observance of speed limits.

Global health

33. Over the last 20 years, life expectancy at age 15 has increased by between two and three years in most regions. This overall remarkable improvement in health is generally due to socioeconomic development, the wider provision of safe water and sanitation facilities allowing greater personal hygiene, and to some extent the expansion of national health services in certain countries. Nevertheless, there are widening health inequalities between and within countries, between rich and poor, between men and women, and between different ethnic groups. The former Soviet countries experienced significant health reversals in the early 1990s, while in Africa steady gains in child health have been reversed over the last 15 years in about 15 countries, owing to a combination of infectious diseases, crumbling health services and deteriorating social and economic conditions. Globalization has had positive effects, improving communications with the poorest areas of the world, for example. However, some of its other effects – hostile or damaged environments, detrimental urbanization, unfair trading practices, system failures – have had an increased negative impact on the health of women and other vulnerable population groups and on social and health services. More than one billion of the world's poorest people are not benefiting from the health revolution.

34. Of the expected total of 58 million deaths in 2005, 17.5 million will be due to infectious diseases or perinatal, maternal and nutritional disorders. Three million deaths will be 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. HIV/AIDS exemplifies the challenge facing the health sector: the fact that the majority of health concerns and health actions reach far beyond medical care.

35. Excluding HIV/AIDS, deaths from infectious diseases, perinatal, maternal and nutritional disorders have fallen from one third of total deaths in 1990 to one quarter in 2005. Virtually all of these deaths are in low-income and middle-income countries. Today, nearly all child deaths (97%) occur in low-income countries, and almost half of them in Africa. Some African countries have made considerable advances in reducing child mortality; however, the majority of African children live in

countries where the survival gains of the past have been wiped out or even reversed, largely as a result of the HIV/AIDS epidemic. 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.

36. Major infectious diseases such as tuberculosis and malaria are still taking a heavy toll in poor countries. 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. Pregnant women, children and unborn babies are at particular risk. Tuberculosis is reappearing in certain groups in developed countries. There are still 1.7 million deaths from tuberculosis worldwide every year. Ninety-eight per cent of these unnecessary deaths occur in developing countries. Standard treatments against both tuberculosis and malaria have become useless in some settings, owing to multidrug resistance. Neglected tropical diseases affect at least one billion people. These include Buruli ulcer, Chagas disease, lymphatic filariasis, intestinal parasites, leprosy and others. New diseases, such as pandemic influenza and SARS, regularly appear, making it even more difficult to prevent the spread of epidemics. The illness and disability caused by all these diseases have a tremendous social and economic impact.

37. The target date of 2015 for the achievement of the Millennium Development Goals is just 10 years away, yet the trends for goals relating to health are not encouraging; it is possible that the majority of poor countries will not meet them. Few developing countries are currently on track to meet the child mortality target. 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 increased death rates. However, data on health interventions are more encouraging: measles immunization coverage is on the rise in many countries, leading to a dramatic reduction in mortality, and the proportion of women assisted by a skilled medical attendant during delivery has increased rapidly in some regions, especially in Asia.

38. 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. These chronic conditions result from years of exposure to risk factors and behaviours such as tobacco-smoking, alcohol use, lack of physical activity, and diets dominated by processed foods and lack of fresh fruit and vegetables. 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.

39. Environmental factors, mostly associated with indoor and ambient air pollution, cause over one third of the disease burden attributable to lower-respiratory-tract infections. In addition, 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.

40. Overall, adult health is characterized by three major trends: the slowing down of health gains and widening health gaps, the increasing complexity of the burden of disease, and the spread of health risks to new parts of the world. Major risk factors for chronic diseases, including mental ill-health, are increasingly prevalent in middle-income and even in low-income countries, creating a further burden of disease over and above the remaining unconquered infectious diseases and the still-uncontrolled HIV/AIDS epidemic. Not only length of life, but quality of life is seriously affected.

41. The solutions to such public-health challenges involve changes in the wider socioeconomic and cultural context of industrial practices (tobacco, food security, etc.), transport systems, agriculture, trade and legislative decisions on control of products and labelling. It requires a rethinking of the

determinants of health, and demands a commitment to greatly increased advocacy and a range of behavioural changes at all levels of society.

Health systems

42. Where health systems function well, they contribute significantly to maintaining and improving individual, community and population health. In many countries, the failure to generate sufficient public resources and use them efficiently has led to health systems with a low operational capacity, inadequate primary and secondary care, weakened public health programmes, health-worker shortages, the absence of reliable supply chains for diagnostics and drugs and poor management capacity. High out-of-pocket payments often contribute to the further impoverishment of individuals and households. Many of the known and effective interventions depend on essential medicines, yet today almost two billion people have no regular access to these medicines. Similarly, much of the world is facing shortages of skilled health workers. The likelihood of sustained growth and unmet labour needs in industrialized countries suggests that health-worker migration will continue to grow in the medium to long term. This will result in an increased burden of care in communities and homes in developing countries, which will be borne disproportionately by women and girls.

43. The range of non-State actors providing care and other services is increasing substantially in many countries, very often targeting the wealthier sectors of the population. Although too rarely assessed in term of quality, the advantages of these services can be significant for the population as they improve availability, but the challenge remains to align their practices with public health goals and to hold them accountable through coordinated oversight mechanisms and regulatory approaches. This is particularly difficult in countries where the leadership and steering role of the government is weak and where lack of capacity in the competent government agencies prevents them from developing relevant policy frameworks and oversight mechanisms within the health sector and promoting sector-wide pro-health policies. Values that guide health-system goals need to be made explicit, irrespective of the range of instruments that can potentially achieve these goals. Gaining a better understanding of instruments appropriate to the context of each country will help to create integrated services that reinforce national health-system capacities, absorb innovations effectively and move towards impact-oriented monitoring.

44. The health care sector as a proportion of the global economy has grown enormously over the past 100 years, amounting in absolute terms to between three and four trillion United States dollars in expenditure annually. Although battling with escalating costs, industrialized countries continue to increase spending on health in response to growing expectations. Countries with economies in transition face major problems in managing and financing the improvement of their health systems. In many poor countries, the health care sector has stagnated or even contracted over the last 25 years, whilst the demands on it have grown exponentially. Few poor countries are spending on health at a level that corresponds to their needs. Economic pressures lead to low or dwindling health budgets and in many countries to very high out-of-pocket payments by individuals or households for health services. Most countries in the world face major difficulties in extending or sustaining social protection or other mechanisms that will protect individuals and populations from expenditure on medical care and ensure their independent ability to pay. The process of developing a strategic social and economic policy which will bring more benefits for the poor is not always country-driven and may not identify inefficiencies and the barriers inhibiting the capacity to absorb and implement external funding. Currently, public services are failing to get funding to the peripheral service-delivery level. Strong support from the community is important for well financed health systems, especially where the majority of income generation takes place in the informal sector.

International declarations and agreements

45. The right to health has been codified in numerous legally binding international and regional treaties. Far-reaching commitments relating to that right have been made in several United Nations

world conferences. Since the 1990s, human rights principles have been integral elements of development work as well as humanitarian assistance, serving as tools to enhance accountability, multisectoral approaches, empowerment, participation and a focus on segments of the population that often experience discrimination, such as women and vulnerable populations including children, older persons, persons with disabilities, indigenous persons, or those living with HIV/AIDS.

46. Many of these conferences took place over the last decade, demonstrating the power of goals negotiated through intergovernmental processes and their greater legitimacy, even if the processes are often difficult to manage and consensus is hard to reach. Today, the global health agenda is increasingly shaped by commitments taken by world leaders. In September 2000, the United Nations Millennium Declaration committed States to a global partnership to reduce poverty, improve health and promote peace, human rights, gender equality and environmental sustainability. The Millennium Development Goals have gained acceptance in rich and poor countries alike. Health features prominently in many recent international declarations, including the World Trade Organization Declaration on the TRIPS² Agreement and Public Health (Doha, 2001), the Monterrey Consensus of the International Conference on Financing for Development (Monterrey, Mexico, 18-22 March 2002) and the outputs of the World Summit on Sustainable Development (Johannesburg, 26 August-4 September 2002).

47. The 2005 World Summit made a number of key commitments in the fight against poverty, debt relief and development. It supported the need for increased investment to improve health systems, to increase HIV prevention and care, to address 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.

48. The *Millennium Development Goals* have a considerable contribution – direct or indirect – to make to health status, but they do not cover all aspects. Other issues also need attention, including sexual and reproductive health, emerging infectious diseases like SARS and avian influenza, and the new epidemics of chronic diseases which currently account for the majority of deaths worldwide. The growing burden of these diseases, along with mental ill-health and injuries in middle-income and low-income countries, have the potential to hold back social and economic development and cripple already overstretched health systems. The global health agenda therefore goes beyond the specific diseases and issues identified by the Millennium Development Goals.

THE CHALLENGES TO HEALTH: CLOSING THE GAPS

49. There are too many areas where there is clear potential for people's lives to be improved, yet it is not happening. This is the task of the world community and WHO today: both to provide a response to the diseases known and predicted to damage human health, and to identify and act on the areas where health is being negatively influenced by other determinants, and where no adequate response is currently in place. These can be broadly characterized as gaps in social justice, gaps in responsibility and synergies, gaps in implementation, and gaps in knowledge.

50. They include shortcomings in the way that ethical and human-rights considerations, such as equity and gender equality, are reflected in public and private attitudes, policies and plans. They relate to situations where there are evidently complex factors causing ill-health, yet it is not clear who is responsible for them, or what kind of authority can be exerted in order to develop more synergy in action. They include flaws in implementation and processes, where opportunities to improve health have been missed for lack of adequate systems or capacities. Lastly, important elements are missing in the way that science, knowledge and technology are generated and used to promote global well-being.

² World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights.

Gaps in social justice

51. Crucial components of equity, health related human rights and gender equality are often overlooked in policy-making and planning. Limitations in access to essential social services exclude the poor and other socially vulnerable groups and lead to widening health inequalities within countries. For example, in many settings, being born male or female still determines the opportunities individuals will have to enjoy the living and working conditions and services which will enable them to achieve their full potential for health. Prejudice, stigma and discrimination persist, affecting people's ability to participate in society or business.

52. One obvious shortfall is that between those people who have a healthy life and those who do not. This discrepancy exists between countries and also within countries, even in the developed world. The peoples of Africa and India together bore almost half the total global burden of disease in 2002, although they comprise only one third of the global population. In many countries, including developed countries, there are more than 20 years' difference in life expectancy between people belonging to the most privileged social classes and people having no access to essential social services. The differences between prosperous urban residents and poor people and members of minorities living in rural areas is even more marked. The growing inequalities in life expectancy and health are a major threat to social cohesion. Access to HIV treatment exemplifies these inequalities: people in some countries can get the drugs they need to survive, while others cannot.

53. There will be inequities in any country where the health system is underperforming, as without adequate health services, there cannot be equal access. Those who are the most underserved are likely to be those with the greatest needs – the most likely to live in remote regions, escape immunization coverage, have little or no access to maternal and child health care and no access to culturally appropriate information.

54. In every country, rich or poor, there are discriminatory policies and practices. In very many countries, it is easy to find prejudice and unequal treatment of women, indigenous people, ethnic minorities, slum dwellers, poor communities, people living with HIV/AIDS, disabled people (including the mentally handicapped), migrants and other underprivileged groups. All discriminatory policies and practices have a negative impact on health.

Gaps in responsibility and synergies

55. Well-being is influenced by factors outside public health. People's health suffers or benefits not just from their domestic environment and personal choices, but also from decisions made at national level and outside their own countries. There are multiple examples of such problems: environmental changes and policies have a direct bearing on infectious diseases; liberalization of services has immediate consequences for health services; global economic and political forces are undermining the modern nation-State and its ability to sustain a welfare policy; failure to integrate trade policy into national poverty-reduction strategies often skews the benefits of trade towards those with access to assets; conflicts and crises and the human-rights violations which accompany them have a very high human development cost. Modern communications and travel have changed the way in which authority can be exercised. Information and pathogens can move across the world in ways that are not susceptible to monitoring, control or regulation. In addition, legislative systems do not always have an adequate health perspective, and macro-negotiations in different sectors do not yet take health issues systematically into account in international policy and business.

56. Within public health, there are also many examples showing that the majority of health concerns and health actions go far beyond medical care. The conventional routes of protection and prevention, such as simple, effective medicines and modified environments, are being threatened. For example, antimicrobial resistance, which has undermined malaria control efforts, now threatens tuberculosis and other disease control. The resource implications of developing and using alternative therapies take

global control of these diseases into the realms of research and development budgets and agendas, patent law, intellectual property rights and international trade and finance. HIV/AIDS, currently one of the greatest challenges for communicable disease control, cannot be controlled using “traditional” means: it requires expertise which goes beyond the mandate and the current skill-base of the traditional health sector.

57. Chronic noncommunicable diseases for example, which currently account for the greatest number of deaths in the world, result from years of exposure to risk factors and behaviours such as tobacco and alcohol use, lack of physical activity and an unhealthy diet. Only 20% of chronic disease deaths occur in high-income countries. The economic consequences – lost income and direct health-service expenditure – are borne by the low and middle-income countries least able to afford them. Treatment of these chronic conditions – cancers, diabetes, heart disease and a range of nutritional imbalances – falls squarely on the health services, often involving expensive long-term tertiary care. The problems created by the rapidly-growing chronic disease burden are gaining increased attention. It is less clear who is responsible for reducing the population’s exposure to the risk factors that underlie them.

58. The rapid advance of chronic diseases cannot be stopped by medical science alone. Change will be required in a wider socioeconomic and cultural context, involving industrial practices, transport systems, national legislative decisions on control of products, ingredients and labelling and agricultural, trade and finance requirements. Individual risk factors and health-compromising behaviours such as tobacco smoking are disproportionately concentrated in poor and socially disadvantaged groups in countries at all levels of economic development, but wide-ranging behavioural change will be required at all levels of society. States will need the political will to amend the structures that determine people's unequal position within the social hierarchy, such as the education system and the labour market.

59. Besides the responsibility gap described above, there is often a gap in synergies, where the players fail to work together cumulatively and effectively on behalf of health. The global health architecture is characterized by a huge range of global, national and local organizations and players. Sustainability, coordination within and between sectors and partners and coherence of action are often not pursued effectively. Mechanisms and processes for intersectoral dialogue are weak.

60. However, much has changed in public health work to accommodate these evolving demands and to reflect an understanding of the dynamics and effects of this changing environment. The Framework Convention on Tobacco Control was a recent landmark. Its entry into force in February 2005 marked the fulfilment of WHO’s mandate to propose international instruments, tackling the determinants of disease and proposing unified international action. It is an example both of a new kind of synergistic responsibility and of a new kind of process. This new approach has been taken forward by entities such as the Commission on Macroeconomics and Health and the Commission on Social Determinants of Health.

Gaps in implementation

61. Policy formulation and planning at country level and in the broader agenda are often weak points which inhibit effective implementation. They are often carried out in isolation, with limited technical expertise, little linkage of plans with budgets, and unclear definition of priorities.

62. Systems and services are often inefficient or incapable of delivering what is needed. There is an urgent need to improve coherence in delivery and execution, to scale up interventions, to improve management ability, to secure financial and human resources and to ensure that policies are effectively implemented. These are imperatives for the health sector and for policy-makers and decision-makers at all levels.

63. Vast resources have gone into improving the protection of populations against disease, but none of these advances do anything to protect the health of the neediest if health systems do not deliver the services, or if they deliver them inequitably. For example, building equitable health systems entails, among other things, fair and sustainable financing and the removal of financial, physical and cultural barriers to access to high-quality care for women.

64. Harmonization and simplification of various donor policies and alignment with the recipient country's priorities and systems have received increased attention. More action is needed to increase the uptake of resources, improve the effectiveness of aid in improving health and make sure that new donors are included in the aid-effectiveness debate in the future.

Gaps in knowledge

65. Lastly, there are gaps in what is known, and between what is known and what is done. Despite advances in science and technology, despite extensive investment in research, some of the key questions are not asked and essential answers are missing; research is not aimed at developing pharmaceuticals and vaccines for diseases which mainly affect the poor; divergent interests mean that beneficial information is not shared; education is inadequate or denied to certain groups.

66. Research is very often not adequately directed towards delivery of the most urgent interventions to those in greatest need. In the biomedical field, the exponential growth of knowledge, in particular in relation to genomics, has produced few new products so far, though its potential for doing so is widely recognized. Where new products are forthcoming, they are often not evaluated for optimal use in resource-poor settings, nor are they scaled up so that they reach all those in need. It is essential to strengthen the translation, dissemination and use of knowledge and to set targets that will have an impact on people's lives.

67. New tools, technologies and cost-effective approaches are needed to tackle the double burden of disease, adverse demographic and epidemiological trends and an ageing population. However, the best way of financing and producing these public goods for health is not yet obvious. Furthermore, the need for downstream implementation research to assess how best to utilize these tools, link them to an evidence-based policy and scale up their use in national programmes is rarely adequately addressed.

68. In all fields of health, there is evidence and experience that has not been applied for the benefit of entire populations. For example, a significant proportion of today's global death and disease burden from environmental risks could be avoided using relatively inexpensive and tested solutions, given more coherent and coordinated preventive and public-health measures. In many wealthy countries, death rates from cardiovascular disease have been reduced through a combination of preventive and treatment strategies, many of which are extremely cost-effective. Unfortunately, this knowledge is not reaching populations at especially high risk of these diseases, especially in low-income and middle-income countries.

69. Lack of basic health information and ignorance of best practice are critical failures in health systems. Simple measures can reverse mortality trends. Where information is unreliable, inconsistent or unavailable at district level, there can be no reliable planning. There is a chronic lack of mapping and understanding of the dynamics of health information across the different levels of health systems. For example, gender-disaggregated data are rarely collected, published or used for decision-making. Institutions must be helped to understand that information better in order to learn, adapt and develop. District health information systems must be strengthened and integrated so that decisions can be made at the district level in order to improve service provision.

70. Knowledge, skills, enhanced capacities: these are vital elements of a motivated and accomplished workforce and strengthen the performance of health systems. However, serious

problems arise when health workers become an attractive export and move abroad, depriving the domestic market of their expertise.

71. Knowledge is related to fundamental liberties. In many countries, women and children remain poorly educated because of cultural practices, the social or economic situation or the lack of access to education facilities. Knowledge and education provide vital opportunities to improve household security and quality of life. A knowledge of best practices in reproductive health, nutrition, sustainable environmental and agricultural practices and appropriate sanitation is a foundation for crucial choices for raising families safely. When schoolchildren learn health-promoting and health-protecting measures from an early age and take them home, whole communities can benefit. Those who lack this knowledge are materially deprived.

Closing the gaps

72. The gaps represent four fundamental strategic problems in relation to health, relevant to all countries, and to most of the priority issues the world must tackle. Their combined result is inefficiency, instability and exclusion from the benefits of progress. What is needed is an environment where ethical issues are taken fully into consideration and placed in the mainstream of policies and actions; in which individuals, civil society, the private sector, governments and international organizations can take joint responsibility and ensure the best synergies for health; where the solutions are delivered through appropriate processes and implementation mechanisms; and where life-saving and life-enhancing knowledge is produced, shared and used. The novelty — and the difficulty — lies in constructing joint action among actors within and outside the conventional health sector, and in making the commitment to resolving those issues.

A GLOBAL HEALTH AGENDA

73. The global health agenda outlined below identifies 10 priority areas and explores the action needed in each to make the most of the available opportunities and to overcome obstacles. It is intended to prompt and lead change and to stimulate awareness of how new or revitalized coalitions can better meet global health needs. These priority areas are not new: the innovative element here is the fresh appreciation of their complexity and the more sophisticated response required for global health problems such as HIV/AIDS. Progress towards a healthier world requires strong political will, well thought-out policies and strategies and broad participation. Although experience shows that government commitment is a key factor in improving health, whatever the country's level of socioeconomic development, the power to make the necessary changes does not lie solely with governments and international organizations, but with many different bodies in civil society, the private sector and voluntary groups. Ways of taking action must be changed at all levels – individual, community, national, regional and global – by all stakeholders and in all sectors. This action, undertaken jointly, will help to close the gaps described earlier in this document.

74. Throughout, the global health agenda reflects the values and principles of the WHO Constitution, the Declaration of Alma-Ata, the policy of Health for All in the 21st Century and the United Nations Millennium Declaration, and interprets them in the new global context. These principles are: the recognition that the enjoyment of the highest attainable standard of health is a fundamental human right; the building of countries' capacity to assume complete responsibility for fulfilling their own health needs; a commitment to universal coverage according to need; support for policies and systems that promote greater equity, including gender equality; a fostering of society's sense of collective responsibility; the promotion of active and direct involvement in shaping health agendas.

Ensure universal coverage and promote equity in health

75. One of the critical problems which needs to be solved all over the world is the lack of access by the poor and other marginalized groups to the essential services that will support improved health. Potentially deadly infections, such as HIV/AIDS, malaria, tuberculosis, neglected diseases and diarrhoeal disease, affect poor people disproportionately; malnutrition, child mortality and maternal mortality are more prevalent among the poor. Good primary health care services – immunization, prevention (scaled up as chronic diseases become more prevalent) and disease control (with an increasing emphasis on environmental and social action) – can achieve an enormous amount. They are a fundamental tool for building efficient and effective health systems and ensuring universal coverage.

76. Where primary health services fail, there are no choices. They often fail in areas with a mobile population, in situations of extended conflict, or in areas of extreme poverty and social dislocation. These are the populations with the greatest need for the benefits of primary health care, with the lowest survival rates, with the lowest capacity to overcome economic or environmental challenges to survival. These are the 20% that routine immunization efforts, even at their best, do not reach.

77. Another key problem is to increase access to high-quality services in an equitable way. The delivery of health services often excludes the poor and other marginalized groups. Rarely, if ever, is there a focus on the risk factors that are the root causes of their ill-health. Services are rarely designed with the poor and other marginalized groups in mind. Poor women, in particular, often face greater constraints, shown by the distance they have to travel to obtain services, how long the journey takes them and how much it costs and the length of time they have to wait for treatment. Any of these factors may put up financial barriers to obtaining services, in addition to official and nonofficial hospital, laboratory or medication charges.

78. There is an urgent need to expand access to essential quality health services, overcome financial, managerial, logistical, gender-based, geographical and social constraints and organize effective referral systems, including appropriate hospital care. The “Reaching Every District” strategy developed for immunization is helping to build and strengthen primary care services throughout countries, creating the channels through which health workers can locate and help those most in need, especially children. Building up services with communities and households that reflect people's health needs and legitimate expectations is often advocated – but not acted upon – in the design and provision of health services. Recognizing the importance of demand-side opportunities as a necessary complement to supply-side approaches is perhaps one of the most neglected areas in the organization and delivery of health services.

79. All health actors to work together to strengthen integrated primary health care and core public-health functions and to reorient private providers towards public-health goals in order to secure universal coverage in collaboration with the community.

80. These efforts must aim towards reducing morbidity and mortality; increasing immunization coverage and introducing new vaccines; better integration of interventions aimed at children; scaling up services for mothers and babies during delivery and after birth; urgent implementation of proven strategies and programmes for prevention, treatment and control of HIV/AIDS, TB and malaria; and, innovative approaches for targeting hard-to-reach and marginalized populations.

Build individual and global health security

81. Conflicts, natural disasters, disease outbreaks and zoonoses such as bovine spongiform encephalopathy and avian influenza are increasingly in the news. There are close links between these

health challenges and security at individual, local, national and global levels. All have a major impact on human security; it is important to be prepared for such dangers and to minimize the risks.

82. Prevention and control of epidemics of fatal infectious diseases have long been among the most visible roles of public health. As illustrated by the recent outbreaks of SARS and the preparations made for the next pandemic of influenza, diseases in the 21st century can rapidly spread across national borders and affect communities worldwide. Global response capacity to cope with outbreaks needs to be enhanced, with close collaboration between concerned sectors and health authorities. Global and national infectious disease surveillance should be improved, public-health systems should be strengthened, and the International Health Regulations (2005) should be fully applied.

83. The enormous increase in trade in food across borders may enable the transmission of unintentional or intentional contamination, leading to serious outbreaks of disease. The large numbers of people travelling on public transport – aeroplanes, trains, subway systems, buses – means that pathogens are transferred with great speed and efficiency from one location to another. The vulnerable populations here are not only the poor and deprived: they also include the business community, commuters and tourists. Strategies are needed to respond to the rapid evolution of such threats to public health.

84. Food insecurity continues to be a major issue for health care. Malnutrition exacerbates existing vulnerabilities and acts as a persistent drain on productivity. Many external factors significantly threaten food security. They include household education levels, income, the availability of food and fuel, food preparation and storage, the structure of the family (e.g. working mothers) and access to water. Currency fluctuations affect trading patterns; farming subsidies affect pricing and supply. Increasing numbers of displaced people move from areas which are unsafe, afflicted by conflict, or environmentally damaged and are thus separated from their traditional sources of sustenance.

85. Conflict and civil unrest increase people's vulnerability to health risks, with violence adding to preventable morbidity and mortality. The instability associated with poverty and poor health accelerates institutional failure and the proliferation of violence. Social problems affect health – homelessness, violence against women and children, crime, substance abuse. The illegal employment of children may include work in hazardous environments, and trafficking in children for domestic and sex work is another increasingly important health issue. Insecurity of land tenure may encourage farmers to engage in poor farming practices, leading to soil erosion, deforestation and health and nutrition impacts.

86. Pursue actions that will improve global health security, decrease conflicts and humanitarian crises and strengthen international cooperation to respond to threats to public health.

87. Enhance global response capacity to cope with potential disease outbreaks; improve global and national infectious disease surveillance; fully implement the International Health Regulations (2005); improve food security and safety.

88. Develop health strategies which respond to the rapid evolution of both old and new threats to global public health – HIV/AIDS, re-emerging infectious diseases, new infectious diseases like SARS, chronic noncommunicable diseases, mental ill-health, violence, especially against women and children.

Promote health-related human rights and gender equality

89. 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”. In recent years, the scope and content of health-related human

rights have been further clarified in international law. They cover the right to accessible, affordable, culturally acceptable and good quality health care, as well as the underlying determinants of health, such as access to safe food and water, adequate sanitation and access to health-related education and information. They oblige governments to work for the progressive realization of these rights, individually and through international assistance and cooperation, using the maximum available resources.

90. There is still a long way to go before health-related human rights can be realized in practice. New and creative ways must be found to apply international human rights laws, and institutional mechanisms must be established and/or strengthened. Many different actors can help in raising the profile of health in relation to fundamental human rights, calling for more equitable research agendas, a higher priority for underserved populations and neglected diseases and more wide-ranging dissemination of research findings.

91. Critical components of the right to enjoyment of the highest attainable standard of health include freedom from discrimination on the grounds of race, ethnicity, gender, language, religion, national or social origin, social and health status, disease and the rights to participation, privacy and health-related information and education. There should be a particular focus on the most vulnerable and marginalized population groups in society, including people with disabilities; refugees and displaced or migrant populations; indigenous or tribal populations; and people living with HIV/AIDS. Special attention needs to be given to the health needs and rights of women, especially poor, vulnerable and marginalized women, whose ability to access the resources needed to achieve the highest attainable standard of health is further affected by gender inequality. The prevalence among women of poverty and economic dependence, their experience of violence, negative attitudes towards women and girls, the limited power many women have over their sexual and reproductive lives and their lack of influence in decision-making are social realities which affect their health.

92. Women use basic health resources differently – and unequally. They have different – and unequal – opportunities to promote and maintain their health. Health policies and programmes frequently perpetuate gender stereotypes, fail to consider socioeconomic disparities and other differences between women and men and among different groups of women, and do not take due 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.

93. Finally, the pursuit of equity includes the promotion of equal treatment, a response to gender inequality and other adverse social determinants of health, social protection, the fight against stigmatization and the guarantee of universal coverage of services, regardless of the individual's ability to pay. It highlights the need for community participation, research and development, an integrated health system that is responsive to local priorities, monitoring and accountability.

94. International human-rights law to be consistently and coherently applied in the relevant national and international policy-making processes, and the attention of governments and civil society to be drawn to health-related human rights.

95. Action to foster equal treatment, social protection and universal coverage to appropriate and quality health care, information and related services to be supported by all stakeholders at all levels, with strong community participation.

96. Action to fight discrimination and stigma to be at the forefront of any health agenda. Particular attention needs to be paid to women; the gender perspective must be central to all health policies and programmes, so that all decisions are preceded by an analysis of their potential effects on both women and men, and legislation is adopted to ensure equal access by women and men to health services and to penalize violence against women and children in all countries. Attention should also be given to vulnerable people, such as those

with disabilities and mental disorders, displaced and minority populations and people living with HIV/AIDS.

Reduce poverty and its effects on health

97. Poverty remains a major impediment to good health. In all countries, poverty is associated with high childhood and maternal mortality, exposure to infectious diseases, malnutrition and micronutrient deficiency. To tackle these areas of ill-health, action must be taken to reduce the vulnerabilities caused by poverty. Poor housing, unsafe water supplies, lack of sanitation, malnutrition and illiteracy are still too often the daily experience of a large proportion of the world's population. In many countries, this will mean making major efforts to reduce inequality of access to social services such as education and health and to create health strategies which bring more benefit to the poor.

98. At the same time, good health is a driver of growth: investment in health produces positive economic returns. Illness adds to the burden of the poor: preventing and treating disease helps to create a healthy population and a healthy economy.

99. Entrenched inequalities in health status exist in all countries and are not all due to material poverty. It is possible, for example, for poor communities to have outstanding life expectancies so long as attention is given to other important health determinants, especially education, women's empowerment and primary health care.

100. In many areas, the need to pay for indispensable health care can drive a family into absolute poverty. Women who are solely responsible for their families are particularly exposed to poverty caused by health-related expenses. Gender inequality and poverty often combine to create multiple barriers to the well-being of women.

101. Unemployment and underemployment remain key problems in all societies, leading to social marginalization, violence and an increased flow of migrants from poor countries to wealthier ones and from poor areas to wealthier areas within the same country.

102. Build leadership capacity within health ministries to engage ministries of finance and planning and make sure that health is properly addressed in strategies dealing with poverty and that macroeconomic and health policies have a direct impact on poverty and inequality.

103. Develop social protection for all and frame policies that protect people from getting into poverty or help them to find ways out of it.

104. Improve mechanisms and processes for intersectoral dialogue and action on the most important interventions for decreasing poverty and social inequality and consolidating health.

Tackle the social determinants of health

105. Mortality and morbidity patterns can be largely attributed to socially mediated factors, of which poverty is just one. Other social determinants of health powerfully affect health outcomes and shape health inequities. These determinants include: early childhood living conditions; education; social exclusion based on gender, ethnicity, occupation, geography and other factors; access to water and sanitation; food; housing and habitat; transport; employment and working conditions; and the economic and social processes associated with globalization. Social support and the quality of social environments also determine people's chances for health, as do cultural beliefs and behaviours. Health status can – and must – be improved by moving beyond the provision of curative medical services to address the factors that influence people's opportunities for health.

106. Any serious effort to improve the health of the world's most vulnerable people and to narrow health gaps between and within countries must be based on strategies which address key social determinants of health. The well-known vicious circle of malnutrition and diarrhoea caused by unsafe water and food can only be broken by taking a holistic view of the preventive interventions which promote health.

107. Not enough attention has been paid to the social and health inequalities that exist within and between societies. Even in the most affluent countries, people who are socially disadvantaged generally experience more frequent and severe illness and have shorter lives than people in privileged social groups (this phenomenon is known as the “social gradient” of ill-health). This poses a major challenge for national and global health policy, but it also offers an opportunity for building broad political consensus. The impact of social conditions on health affects not only the very poorest, but all members of society.

108. Because of the close link between social conditions and health, the social, economic and technological transformation of a globalizing world will translate into changing epidemiological profiles. Unhealthy lifestyles, once considered a problem only for developed countries, have been exported throughout the world by open trade and global marketing and encouraged by increasing urbanization. There has been a corresponding increase in chronic diseases in all regions, which now amounts to 60% of the current global disease burden and is projected to increase even further. The nutrition transition and the global marketing of foods high in sugar, fats and salt are driving forces in the growing epidemic of chronic diseases.

109. The rapid ageing of the world's population is a compounding factor. The changing age profile in countries presents new challenges. The growing populations of adolescents and elderly people require adjustment of policies and consideration of the best ways to communicate important prevention messages to these age groups.

110. Unhealthy consumption (including tobacco, alcohol and other psychoactive drugs), together with reduced physical activity, has a significant negative impact on individual and population health. Its consequences place an increasing economic and social burden on societies. Priority should be given to controlling those risks that are well-known and widespread, and for which effective and acceptable risk-reduction strategies are available. For instance, a substantial increase in tobacco taxes would produce significant health benefits at very low cost. At the same time, many key risk factors and health-damaging behaviours, including smoking, exhibit a consistent social gradient in both low-income and high-income countries, i.e. these risks are disproportionately concentrated among the socially disadvantaged and disempowered. Substantially reducing the prevalence of these factors requires action on the “causes of the causes” of ill-health: the social structures and conditions that increase disadvantaged people's exposure and vulnerability to health risks.

111. Significant numbers of people are migrating within countries and between countries, driven by crises or a search for better opportunities. This has implications for security of living conditions and access to health care and other vital services. The current system for dealing with migration and human settlement issues is very weak and must be addressed. Biological agents are carried by people, animals and food, in increasing quantity and at speeds of air travel that are often faster than the incubation period of infectious diseases. Speed of and access to information has helped the private sector and civil society to influence international and domestic situations. These social and cultural influences are mediated by global trade and travel, marketing, media, and traditional and popular culture, all of which are beyond the traditional reach of public-health control.

112. If the determinants of health are to be addressed more effectively, the boundaries of public-health action have to change. Public policy must focus on the creation of social conditions that ensure good health for the entire population. Governments, especially health ministries, must play a stronger role in formulating risk-prevention policies and in catalysing action to tackle the social conditions that increase vulnerability in disadvantaged groups. Health and health equity are prime indicators of how

well a society and governance institutions are performing. Greater efforts are needed to sustain economic growth with equity, gender equality, social cohesion, social protection and environmental integrity. For this, health must be seen as a collective governmental concern to which numerous sectors contribute. The links between determinants and their consequences need to be more clearly spelt out in order to promote greater responsibility. Just as importantly, research must identify the political processes and structures that can position health as a collective goal across government departments and among social stakeholders.

113. Increase global awareness, leadership and action on the social determinants of health and promote an approach to health that addresses them appropriately in order to improve population health overall and reduce health inequities.

114. The health sector to exercise leadership and advocacy to promote effective action on health determinants and health equity by actors in a variety of sectors and at all relevant levels of policy.

115. Priority given to controlling the well known and widespread risks for which effective and acceptable risk-reduction strategies are available.

Promote a healthier environment

116. Current evidence suggests that an estimated one quarter of the global burden of disease is linked to environmental factors – rising to nearly one third in very poor regions such as sub-Saharan Africa. Poor and vulnerable groups, and particularly the women and children among them, typically suffer from the highest burden of environmentally-related diseases, above all those associated with indoor air pollution and unsafe water and sanitation.

117. In developing countries, nearly two million women and children die annually from exposure to indoor air pollution. The high incidence of and mortality from acute and chronic respiratory infections caused by smoke from cooking fuels also reflect the lack of occupational health protection in the home, where many women work.

118. Approximately 1.1 billion people still do not have access to sufficient safe drinking-water, while 2.4 billion people lack adequate sanitation. Over 40% of the population in sub-Saharan Africa do not have access to safe drinking-water or sanitation facilities – which are important factors in the incidence of diarrhoeal disease, as well as in epidemics of diseases such as cholera and hepatitis A. Increasing industrialization places greater demands on a limited water supply. Already, three billion people are living in water-stressed regions, and it is predicted that nearly half the world's population will experience water shortages by 2025.

119. Human actions are depleting freshwater supplies (especially aquifers), grain yields are falling as a result of climate change, and the ocean's fish stocks are becoming exhausted. The resulting increases in malnutrition, starvation and conflict will cause disability, disease and premature death.

120. In 10 years' time, the majority of the world's population will live in cities. This heralds a significant change in the way people live and the determinants of individual health. Growing urbanization affects human living conditions, and may mean lack of access to sanitary facilities or adequate water supplies; poor housing, overcrowding, an altered or inadequate diet and an unhealthy working environment.

121. Many environmental risks and hazards are shaped by economic, social, political and institutional forces that lie beyond the health sector's immediate jurisdiction. These include such factors as the loss of biodiversity and the long-term impact of exposures to chemicals or radiation. The health impact of such new and emerging environmental risks may be delayed in time and/or displaced in space, making

it even more difficult to link specific environmental risks with specific health outcomes and to assign accountability. For instance, certain chemical substances – e.g. persistent organic pollutants (POPs) – may travel great distances from their point of emission or origin, as they bioaccumulate in food sources such as fish.

122. Changes in climate and ecosystems also affect the emergence and spread of infectious diseases and the production of basic crops. For example, a surge in the incidence of dengue, a vector-borne disease, has been associated with deforestation and urbanization, among other factors.³ Droughts related to such changes may have a direct impact on the nutritional status of subsistence farmers who rely on marginal lands for their food and livelihood. More generally, the loss of forests contributes to erosion, failed flood control, climate change and the loss of biodiversity. Nearly half the world's households still rely on solid fuels, including wood, biomass, dung and coal, for their cooking and heating needs.

123. Many countries are developing action plans designed to slow the rate of global environmental change. However, the global response has not been commensurate with the seriousness of the threats to the sustainability of our current way of life. There are still question-marks hanging over the sustainable supply of fuel to industrialized countries. There is still controversy about energy sources – their use, their repercussions for present and future generations and their unquantifiable health impacts.

124. Integrated strategies for health and environmental management are needed if any sustained reduction in childhood mortality is to be achieved. Proactive policies on climate change are needed. These include efforts to reduce air pollution, with all their implications for rapidly growing populations in urban areas globally, which are vulnerable to many environmental hazards and deficiencies in urban planning.

125. Launch a two-pronged initiative for accelerating improvements in the management of the environmental determinants of health, focusing on supporting health-sector engagement in environmental management for health, and working on partnerships with sectors that directly manage the environmental determinants of disease.

126. Focus on water-related determinants, which are associated with a large and preventable disease burden. The focus will include both direct factors (such as access to basic services by human populations) as well as intermediate factors (e.g. floods, droughts, use of water in food production) and underlying driving forces (e.g. freshwater depletion and deterioration and ecosystem change).

127. Promote proactive policies on climate change, focusing on reducing air pollution, especially in the world's major urban areas.

Build fully functioning and equitable health systems

128. Without more efficient and equitable health systems that put people at their centre, countries will not be able to scale up the disease prevention and control programmes required to achieve the Millennium Development Goals specifically related to health, stop the proliferation of communicable diseases, cope with new epidemics and meet the needs of ageing populations. This requires a capable, responsible government with a functioning health system, fair, adequate and sustained funding, strong public-health capacity and robust health facilities. For instance, the implementation of the International Health Regulations (2005) will require very strong national capacities for detection, verification and response to disease outbreaks and other events. Without sustained and serious investment in health, health systems will not be able to continue their progress towards universal

³ *Millennium ecosystem assessment. Ecosystems and human well-being: synthesis.* Washington, DC, Island Press, 2005.

coverage, and the gaps in implementation will not be closed. The problem of inequitable health outcomes for rich and poor people is an issue in all countries. For many countries, the essence of an approach intended to benefit poor people and other marginalized populations is to renew or reinvigorate the primary health care strategy through services and activities that benefit those who have been excluded, investing in high-quality population-based and personal-care services, orienting the private sector towards public-health goals and improving access to hospitals.

129. A challenge facing many countries is to find a better definition of what makes up the health system, the various roles and responsibilities associated with it, and its support for the vital role of families, households and communities in the provision of preventive, curative and palliative care. Primary health care remains the central core of health service provision, and is especially important in developing countries. In some countries, private care providers supply over 80% of health services: how they are managed and regulated, and encouraged to work towards public-health goals, remains an important challenge that cannot be neglected. Secondary care must not be neglected either, given the essential role it plays in such prominent problems as injuries and perinatal and neonatal morbidity and mortality. Better district-level health information systems will make it possible to develop specific strategies and interventions. Fully functional referral processes must be put in place so that people can gain access to hospitals when they need it.

130. There are many entry points for efforts to strengthen health systems and make progress towards universal coverage and social protection. These include efforts to improve structures and policies, such as service-delivery and pooled financing arrangements, legal and regulatory frameworks and incentives; key administrative systems for payrolls, accounting or information technology; and the skills and knowledge, not only of health care providers, but also of policy-makers, record-clerks, personnel officers and consumers. Approaches which will influence policies and strengthen activities are needed at various levels, within sector-wide policy processes, health-sector processes, service-delivery institutions, households and communities. The critical system areas to strengthen at each of these levels include: leadership and governance; knowledge creation, exchange and uptake; the health workforce; facilities and management capacity for better health service delivery; health systems financing and social protection; technologies – including interventions, medicines and other products.

131. The broader processes of government, such as civil-service reform, public-expenditure reviews and reform, decentralization and poverty-reduction strategies, have a profound impact on health, yet historically health professionals have contributed little to them. The lack of mechanisms for consultation and the lack of capacity within ministries of health need to be addressed, and the health sector must reassert its leadership in promoting policy dialogues and intervention strategies across sectors. Poor countries have little or no capacity for planning, managing and coordinating international cooperation. This is a fundamental disadvantage which must be addressed. Similarly, all countries need the mechanisms and skill-bases appropriate to the negotiation of agreements such as TRIPS and the General Agreement on Trade in Services (GATS), since these affect national governments' ability to regulate health-service provision.

132. Action to strengthen health systems has significant financial and management implications. On a national level, an effective macroeconomic dialogue must be conducted with ministries of finance, planning, etc., in order to increase the resources allocated to health, and more predictable and stable longer-term financing must be obtained from both national and international sources. While the benefits of strengthening health systems are clear, the source of the funding required to do it is much less obvious. This poses challenges of resource mobilization, management and sustainability.

133. There is a dramatic shortfall in the resources needed for strengthening health systems. Many countries, in particular low-income countries with a weak infrastructure and poor levels of health and education, could make a much stronger case for a rapid increase in public expenditure financed from external development assistance, but lack capacity in planning, managing and coordinating

international cooperation. Decisions on the level of resources that could usefully be absorbed, and where it should be directed, should be made on a country-by-country basis.

134. Social protection is crucial to protect individuals from economic ruin because of their expenditure on health care. Financial barriers to health care can mean that households go without the care they need, reduce their spending on other basic needs or are thrust into poverty. It is crucial to break the vicious circle of need and deprivation and replace it with a beneficial cycle of improved system functioning and resources.

135. In the health system as a whole, private providers, traditional practitioners, community-based organizations, nongovernmental organizations and home-based care make essential contributions and should be part of the consultative process for change. Incentives are needed to encourage users and communities to become more involved in shaping health policies. Health policies and planning do not currently take gender discrimination or inequalities sufficiently into account. Policies must be developed and implemented to allow all actors to provide services within an overall framework set by the government in a consultative process.

136. Develop a consensus on goals and priorities for improving the functioning of the health system, while at the same time recognizing that its essential elements are interdependent. Action to strengthen health systems should be drawn from a generally agreed list, but with specific priorities and the timetable for action being determined by national circumstances.

137. Renew the primary health care strategy by investing in quality public-health and personal-care services, ensuring social protection and equitable financing mechanisms, and linking up with other sectors which influence health outcomes, such as education, water, food, sanitation and the environment.

138. Mobilize additional resources from national and international sources (Global Fund to Fight AIDS, Tuberculosis and Malaria, the proposed International Finance Facility, etc.) to rebuild local and national public-health systems throughout the developing world, by means of close partnerships between international donors, national authorities and local civil society organizations.

Ensure an adequate health workforce

139. Behind every area of vulnerability in health systems nationally and globally lies a lack of appropriate staff. Much of the world is facing shortages of skilled public-health workers. Richer nations meet their needs by recruiting professionals from developing countries. The migration of skilled public-health workers away from developing countries to those with more, and more lucrative, financial or career opportunities has been a drain on the health system of poorer countries.

140. Ensuring an appropriate mix and distribution of health workers and training the health workforce are of critical importance. If training is not appropriately focused on immediate and future national health needs, the health services cannot be delivered efficiently or effectively. Human-resources policies need to be strengthened and harmonized across all the levels of the health system. Women make up the majority of paid and unpaid health workers, yet they are concentrated at the lower end of the health labour force. Equal opportunities for women and men must become a central feature of human-resources planning. Medical and public-health education needs to be consistently refocused on the major health determinants and related problems; this applies equally to front-line health workers operating at village or district levels. Mechanisms must be developed and implemented for retaining and motivating the workforce.

141. In the countries most affected by the human-resources crisis, both national and global approaches are needed, along with the cooperation of many actors, both within and across countries. International institutions – including those dealing with trade, immigration and employment-policy authorities and regulatory regimes – must form part of the response. The underlying macroeconomic issues need to be analysed and taken fully into account, together with issues relating to public-sector reform and coordination of human-resources policies.

142. Strengthen coordination and harmonization of human resources policies across service delivery channels and levels of the health systems as well as across sectors (education, labour, trade and health sectors) and improve partnerships with private providers, nongovernmental organizations and community partners.

143. Adapt the skill-mix of health workers to ensure an adequate distribution geographically and by specialty, including matching the skills and competences of graduates of health-professional institutions with specific national priorities and health care needs.

144. Enhance the enabling environment to increase motivation, effectiveness and retention of the workforce at national level (addressing the incentive barriers for recruiting, retaining and motivating staff – salaries, career structure, working conditions, etc.) and develop realistic and long-term global and regional solutions to manage outflows of workers, including meeting the requirements of national health systems and respecting the rights of individuals to cross national boundaries.

Harness knowledge, science and technology

145. Addressing the world's urgent health problems requires the generation, translation and dissemination of scientific knowledge in biomedicine, epidemiology and public health; health and pharmaceutical technology; environmental sciences; social and behavioural sciences; health systems research; managerial and political sciences. This is the only way to close the gap in knowledge.

146. The world still expects scientific breakthroughs to provide new tools for controlling infectious diseases, including HIV/AIDS. New tools, technologies and approaches are needed to tackle the double burden of disease, adverse demographic and epidemiological trends and an ageing population. Research has not yet focused sufficiently closely on achieving the generation and delivery of the most urgent interventions to those in greatest need. The research agenda for health needs to be expanded to encompass the multidimensional determinants of health and ensure cross-linkages with other sectors beyond its traditional boundaries. The development and evaluation of appropriate new technology, including the utilization of traditional medicines and other indigenous knowledge, will be an important area for the future.

147. New knowledge and science provide new challenges related to affordability, potential new inequities and ethical dilemmas. It is essential that, where new scientific discoveries have the potential to support a “quantum leap” in health, no obstacles, or only minimal ones, are placed in the way of their application. This includes the need to establish appropriate research capabilities in all countries. Knowledge should be made available where it is needed most, and appropriate policies and institutions should be developed to ensure that essential goods are produced, financed and used in an equitable manner.

148. No systems have yet been designed for financing and producing these kinds of essential goods for health. International finance mechanisms remain crucial to the creation of incentives for the development and production of new interventions for the poor. They are a powerful instrument for change, but they need to focus on the directions agreed in a common agenda, with reference to national, regional and global priorities and needs, rather than being determined by donor priorities alone. Similarly, more attention should be paid to disease burden and health needs when allocating

health research funding. Current market and public international priorities have resulted in the bulk of these funds being targeted at the medical needs of affluent populations. Country capacity to conduct such essential research will remain an important way of ensuring that research is conducted in accordance with public-health priorities. Certainly, it is essential to strengthen the translation, dissemination and use of knowledge.

149. In all fields of health, there is much evidence and experience that has not been generally applied. Lack of basic health information and ignorance of best practice are critical causes of failure in health systems. Advances in the development of vaccines and their delivery systems have already made enormous – and very cost-effective – changes to the protection available to vulnerable groups. The tools and equipment available to health care professionals in developed countries continue to improve at a staggering pace. A significant proportion of today's global death and disease burden could be avoided using relatively inexpensive and tested solutions, given more coherent and coordinated preventive and public-health measures. Ongoing innovations in science, agriculture, communication and transport are of value to the developing world and need to be made available globally. Ensuring that best practices are consistently applied and inequities in access to such technologies are eliminated remains a challenge.

150. Continue to promote innovative research directed towards “high-impact” discoveries in basic knowledge, its translation and development into new tools, methods and strategies and the development of appropriate policies and institutions to ensure that these essential goods are produced, financed, delivered and used in an equitable manner.

151. Expand the research agenda for health to include the multidimensional determinants of health and ensure cross-linkages beyond its traditional boundaries and categories.

152. Further develop mechanisms and capacities at national and global levels to take full advantage of knowledge and technology, and promote research capacity-building and technology transfer.

Strengthen governance and leadership

153. Leadership and governance are needed at global, national and local levels to create a positive environment for action on the global health agenda and to close the gap in responsibility and synergies. The demand for coordination and direction in health has never been greater. At global and national levels, the landscape for health has changed. It now features new health initiatives and partners – many with their own mandate, priorities and administrative processes. The actors include the private sector, transnational corporations, nongovernmental organizations, civil society and international and regional multilateral institutions. Furthermore, the expanded role envisaged for health, focusing on development, human security and broader health determinants and working in partnership with many other sectors, requires leadership and good governance – the capacity to play a central role in framing national and international policy, speak out on health issues and promote participation.

154. At the global level, inclusive and participatory mechanisms such as the World Health Assembly must be strengthened so that multiple stakeholders can address global health issues within a broad economic and political framework. Health policy-makers and WHO need to be fully involved in all international forums where issues affecting health status are discussed. This is particularly important in a time of interdependence and worldwide social and economic integration, which have direct and indirect consequences for health.

155. Harmonization and simplification of various donor policies in relation to developing countries and alignment with country priorities and systems are essential for improved governance and effectiveness, and their practical implications should remain as key points on the aid agenda. The new

Global Health Initiatives (GHI) also need to ensure that their activities support national health policy and strategy and help to strengthen national capacity.

156. Finally, the new global health agenda needs a strong public-health movement, able to play a more central role in global debates and national policy development and coordinate the work of multiple actors.

157. At national level, there is likewise a need for strong political will, good governance and leadership. The State has a key role in shaping, regulating and managing health systems and identifying the respective health responsibilities of government, society and the individual. Governments are expected to manage health issues and bring about the best possible results with the available resources. This means dealing with health-sector issues but also with broader economic policies and government reforms (e.g. civil-service reform), which can have a profound impact on the delivery of health services and on transparency and accountability.

158. In many countries, it is a challenge for the ministry of health to persuade ministries of finance and economic planning that health is important and deserves a central place in national plans and budgets. The health sector needs to exercise strong advocacy and leadership skills to promote effective action on health determinants by actors in a variety of sectors and at all relevant policy levels.

159. The volume of business transacted by the health care industry puts it in a powerful position. Commercial decisions about the availability of medicines and medical products have a great impact on the developing world. The pharmaceutical industry is increasingly involved in negotiation on development issues, such as intellectual property rights and vaccine patents, which have enormous public-health implications. Health insurance is a major influence on health care. In the interests of stewardship and leadership, it is essential to take into account the influence which such entities exert over decision-making, and the kind of relationship needed to harmonize commercial and public-health interests.

160. Finally, participatory processes are extremely important mechanisms for ensuring that communities and individuals (consumers and patients) are involved in decisions which can directly or indirectly affect their health.

161. Strengthen global mechanisms to enable multiple stakeholders to address global health issues more effectively; continue to improve accountability and effectiveness; develop a strong global public-health movement.

162. Protect the public interest by strengthening the stewardship role of the government in shaping, regulating and managing health systems; build leadership capacity within ministries of health to address issues within and outside the health sector.

163. Ensure that participatory processes can operate in the formulation, implementation and evaluation of health and social policies and programmes.

WHO – EVOLVING TO MEET THE CHALLENGES

164. The mandate and values of the Constitution underpin all of WHO's work, reinforced by the vision, principles and values laid down in the Global Strategy for Health for All and Health for All in the 21st Century. These values, of social justice, the right to health, equity, gender equality and the participation of all peoples and communities, are incorporated into all aspects of WHO's activities and influence policy choices. While these fundamentals have not changed, the nature of demands on health and health leadership has evolved radically, requiring a careful reappraisal of the role and functions of WHO, both as a supportive secretariat, responsive to the technical needs and wishes of its Member

States, and as the authoritative world leader, the overall coordinating and directing authority in international health, acting as the representative of those Member States.

The context for renewal: WHO's achievements and challenges

165. As the United Nations' specialized agency for health, WHO continues to have a unique role in the global health agenda and in bridging the gaps identified in this document. However, WHO cannot – and should not – attempt to do everything. The Organization's role in world health must be carefully defined, taking into account the clear advantages which it enjoys in comparison with other actors at international and national levels.

166. WHO's lead is generally well recognized and respected, given its impartiality and a near-universal membership; the emergence of multiple players and new alliances offers the Organization both the challenge of managing diversity and the opportunity to reposition itself, renew its leadership and stimulate collective action.

167. WHO's mandate specifies concern for the health of all peoples. It has a specialized stewardship role, enabling it to act in neglected or sensitive areas, such as control of tropical diseases, improvement of reproductive health or enhancement of biosafety. In areas such as emergency preparedness and response to health crises, it is developing greater authority and expertise. However, limited growth in funding and the rising proportion of earmarked funds are compounding challenges.

168. WHO can mobilize collective action and resources through its capacity to promote partnerships and consensus, as exemplified in the negotiation of such international instruments as the WHO Framework Convention on Tobacco Control and the International Health Regulations (2005).

169. WHO has the technical ability to draw upon the best scientific advice in the world (expert technical networks, etc.), and thus has access to the most perfected technologies and methods that exist. WHO's scientific and technical information, including the preparation of standards, is universally acknowledged as being of high quality and value. Yet this information is not always optimally translated into effective action. A more proactive and dynamic attitude is required for collaboration with the research community, civil society and intersectoral organizations and agencies, such as the United Nations.

170. WHO's direct link to health ministries offers clear political legitimacy and the ability to encourage high-level political leadership. However, the broader determinants of health act far beyond the traditional parameters of ministries of health and require a commitment to correspondingly broader and better coordinated responses. Advocacy will be essential to gain that commitment and develop the recognition, in both the public and the private sectors, of areas where they need to take greater responsibility for reducing the negative influences on health and promoting the positive ones. WHO requires a presence in countries that goes beyond responding to the specific demands of the ministry of health. It can tackle this broader agenda through expanded negotiation, dialogue and collaboration with other ministries and partners.

171. WHO has a unique position and plays an important role at country level. In many countries, increased national capacity must be fostered in order to develop national health policies and strategies and run country programmes independently, as well as making use of the increased external resources now being devoted to health activities. Building national capacity to plan, manage, execute and sustain the proposed programmes is an important challenge. In many cases, countries have not been able to absorb the funds proposed or allocated: support is not used, progress is not made. Given the increasing demands on WHO for effective leadership

in health, we must improve the overall match between WHO support and country needs if we are to make the best use of available resources.

WHO's core functions

172. The definition of WHO's core functions (distilled from the list of 22 functions laid down in Article 2 of WHO's Constitution) has implications for programme priorities and budget levels. It is a dynamic process that should be responsive to change. The functions outlined below arise from an analysis of the current context, the four gaps identified above and the advantages enjoyed by WHO compared with other stakeholders. They are also based on the original parameters of the WHO Constitution, and those of the Tenth General Programme of Work. They include:

- **providing leadership on matters critical to health and engaging in partnerships where joint action is needed**
- **articulating ethical and evidence-based policy positions**
- **setting norms and standards, and promoting and monitoring their implementation**
- **shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge**
- **providing technical support, catalysing change and developing sustainable institutional capacity**
- **monitoring the health situation and assessing health trends.**

173. The WHO Secretariat will focus on these six core functions, which show how it can most effectively contribute to the global health agenda. They summarize the most important activities which will be carried out by the Secretariat at all levels of WHO. The appropriate balance and combination of functions will evolve globally and in countries as global and national situations change. The functions must continue to evolve with new challenges to public health and changing demands on WHO.

174. The WHO Secretariat may take on additional functions in response to global or country needs, including some implementation activities, as in the case of poliomyelitis and the response to emergencies and natural disasters.

Responding to the gaps

175. If WHO is to respond effectively to the changing global environment and to the gaps in social justice, responsibility and synergies, implementation and knowledge, new approaches will be called for.

176. ***Social justice:*** Adopting a stronger orientation towards social justice, human rights, gender equality and fairness of treatment for all, fighting against discrimination and stigmatization and recognizing that the right to better health includes the wider determinants of health – education, access to safe drinking-water, etc.

177. ***Responsibility and synergies:*** Promoting vigorous engagement among all partners in the common global health agenda and encouraging them to show greater accountability and responsibility in meeting health challenges; assuming a more active role in broadening the national and international consensus on health policy, strategies, norms and standards; taking on

a high-level advocacy and leadership role and occupying a visible and influential place in the major forums of international debate and global policy-making.

178. **Implementation:** Emphasizing the promotion of good health and the prevention of disease through primary health care; triggering more effective action to improve service delivery, scale up essential health interventions and strengthen national capacity; promoting increased flows of internal and external resources into health, and creating the conditions for harmonization and alignment of programmes and activities at country, regional and global level; supporting and encouraging legislative action with a health perspective.

179. **Knowledge:** Ensuring that research is adequately directed towards delivery of the most urgent interventions to those in greatest need; creating effective linkages and mechanisms to assure prompt and equitable translation of information into policy, programmes, tools and practice; supporting research capacity in developing countries, including the capacity for ethical review; promoting the sharing of accurate information and data of all kinds, particularly with and among developing countries.

Strategic domains: WHO's contribution to the global health agenda

180. The global health agenda sets out the collective action which the world community needs to take to ensure improved health and to combat ill-health, particularly in the most vulnerable groups. The four strategic domains listed below will provide a broad and interrelated framework for focusing WHO's technical work within the global health agenda. The points outlined under each domain are broadly indicative of WHO's technical response to the issues raised in the agenda. Specific activities will be elaborated in the WHO Medium-Term Strategic Plan and related planning exercises.

181. **Health outcomes:** Ensuring the maximum attainable level of health gains in terms of sustaining health, preventing illness and disability, controlling and containing disease and reducing health inequalities.

182. This means: creating an environment – globally and nationally – in which countries can establish policies and implement effective strategies to reduce the burden of HIV/AIDS, tuberculosis, malaria, neglected diseases, vaccine-preventable and other communicable diseases; enabling countries to develop policies and practices that will improve newborn, infant, child, maternal and reproductive health outcomes, in ways that contribute to reductions in avoidable morbidity and mortality across the entire life-cycle; enabling countries to develop policies, strategies and interventions to prevent and reduce disease, disability and death from noncommunicable diseases, including mental ill-health, violence and injuries; generating and supporting society-wide responses to emerging and acute threats to life and health.

183. **Determinants of health:** Generating and sustaining action in collaboration with relevant sectors and partners to address the behavioural, social, economic and environmental determinants of health.

184. This means leading effective action to minimize lifestyle-related risk factors; tackle the broader social and economic determinants of ill-health, including poverty, equity, gender, human rights and violence; promote a healthier physical environment, including water and sanitation, working conditions, housing and human settlements, air pollution and climate; and contribute to optimal nutrition, food safety and food security.

185. **Health policies, systems and technologies:** supporting action and mobilizing all relevant sectors and actors to achieve universal coverage and equitable outcomes.

186. This means supporting action to achieve universal access to population-based and personal-care services through health systems oriented to equitable health gains that respond to people's needs, legitimate demands and expectations; ensure improved quality of appropriate health technologies, interventions and products, with an emphasis on safety and efficacy; develop and institutionalize capacities for more effective leadership and governance, coordinated policies and management, appropriate human resources and infrastructure and knowledge and information for professional and public decision-making; and extend social protection through fair, adequate and sustainable financing of health systems.

187. *Global health agenda and WHO response to needs, demands and expectations:*

developing action to advance the global health agenda and implementing policies and measures to enable the WHO Secretariat to carry out its functions effectively and efficiently.

188. This means leading effective action to put forward a strong case for health on the global agenda; address the broader policy environment – nationally and internationally – which influences health; strengthen leadership and governance at all levels; and support countries and partners in addressing global health issues more effectively. For the WHO Secretariat, it means continuing to increase its own efficiency and effectiveness, ensuring coherence and synergy in policies at all levels of the Organization and within each level; focusing on results, better targeting of resources and greater accountability; developing a strategic country presence and creating an institutional environment that supports the timely implementation of activities.

189. The activities under each strategic domain will build on existing strategies, policies, resolutions and conventions, and also on an analysis of the global environment. More than ever, WHO must be flexible and adapt itself to a world which can change very drastically and quickly, for instance in the case of a new pandemic or of major political events.

A more effective and efficient Organization

190. If WHO is to contribute to the global health agenda and to bridging the gaps described above, it must maximize its effectiveness and efficiency in processes, deliverables and monitoring. It must increase its capacity to plan and act strategically and respond quickly in a rapidly changing and increasingly complex environment.

191. ***Focusing on results and ensuring accountability:*** Throughout the period 2006-2015, the General Programme of Work will form the top layer of WHO's results-based management system, giving broad direction to the work of the Organization. Other tools, such as the Medium-Term Strategic Plan, will determine the direction of WHO's technical activities, following the General Programme of Work. WHO employs robust monitoring and evaluation mechanisms that will feed back into the strategic and operational planning processes, ensuring higher success rates in implementation and a greater impact over time. Strategic planning efforts will examine cross-cutting issues and how they can best be addressed in order to maximize financial and human resources. WHO's efforts to ensure accountability and its commitment to achieving results will maintain and increase the world's confidence in the Organization.

192. ***Setting priorities and working with others:*** Continuous dialogue between the Secretariat and governing bodies of WHO on the role and functions of the Organization will help to define WHO's comparative advantage in varying areas of global public health. WHO will continue to lead, but it must also promote strong collaboration and accountability from those players whose strengths make them particularly valuable in specific areas of the global health agenda. WHO will focus its efforts on what it does best, and play a supportive role in areas where other partners are better equipped to meet the challenge.

193. WHO must also continue to champion greater harmonization and simplification across the expanse of contributors to global public health. Working with partners – the United Nations, academic institutions, civil society, nongovernmental organizations, the private sector – WHO will serve as a catalyst for collaborative action on health matters, and encourage and convene partnerships where they will enhance the intervention.

194. ***Making a difference at country level:*** Putting countries at the heart of WHO's work is a shared responsibility across all levels of the Organization. WHO's management and resource-allocation framework focuses resources and results at country level. In each Member State, strategic mechanisms, such as the WHO country cooperation strategies, will be used to work with local professionals and partners, engaging the global health agenda in ways that meet current and projected needs, while harmonizing with national priorities. Increased mobility and rotation of WHO Secretariat staff will ensure that experience gained at country level contributes to the creation of regional and global knowledge.

195. ***Promoting a modern, competent and learning Organization:*** These qualities are essential for sustainable high performance in a changing environment. WHO's agenda includes a management culture that embraces and manages change; promoting cooperation and collaboration across all parts of the Organization; making WHO a learning organization through greater networking, mobility and rotation; improving human-resources management to attract and retain high-quality staff, ensure greater geographical diversity and a more equitable gender balance; and ensuring that staff profiles match programme requirements.

CONCLUSION

196. The Eleventh General Programme of Work provides a considered view of the status of public health, emphasizing what is impeding progress in global health now and into the future, namely: gaps in *social justice*; gaps in *responsibilities and synergies*; gaps in *implementation*; and gaps in *knowledge*. Acting on the global agenda provides the opportunity to address these deficiencies, and bring about positive change.

197. The work of public health can no longer be considered separately from that of economics, trade, security, domestic and international policy-making or any other field. Governments can no longer make domestic policies, bilateral or multilateral agreements on trade, agriculture, the environment or labour without considering the impact on the health and livelihood of their own people – and all people.

198. WHO will lead the global health agenda in four strategic domains: *health outcomes; determinants of health; health policies, systems and technologies*; and *response to needs, demands and expectations*. WHO's core functions and decentralized structure empower it to fulfil its commitment to the global health agenda at regional, country and global levels. WHO will take responsibility for monitoring its work on the global health agenda as a part of its strategic planning and evaluation efforts. Further, WHO will continue to examine the General Programme of Work and the global health agenda to ensure their ongoing applicability to the global situation. Adaptable leadership and flexibility in the design of WHO's work are vital to ensure relevance and success.

199. In this General Programme of Work, WHO has taken the first step and named its role within the global health agenda. This document is WHO's commitment to the people of the world, as the international leader in public health, to work across disciplines, with partners old and new, to improve the state of the world. We ask the same of our partners, since the world holds us all accountable for this task.

= = =