



WORLD HEALTH ORGANIZATION

FIFTY-NINTH WORLD HEALTH ASSEMBLY
Provisional agenda item 14

A59/25
24 April 2006

Eleventh General Programme of Work, 2006-2015

1. As agreed upon by the Executive Board at its 117th session, an extraordinary meeting of the Programme, Budget and Administration Committee was held in Geneva on 24 February 2006 to discuss further and validate on behalf of the Executive Board, the draft Eleventh General Programme of Work, 2006-2015, with a view to its submission to the Health Assembly.¹ The list of participants is attached (Annex 1).
2. The Committee noted that significant work had been done on the revised draft in line with the comments made by the Committee and the Executive Board at their third meeting and 117th session, respectively. Committee members made additional edits online.
3. Significant new text was incorporated in the following areas: health and human rights; sexual and reproductive health; WHO's role within the United Nations family and the outcome of the United Nations reform process; noncommunicable diseases; health financing; human resources for health; health promotion and the underlying determinants of health; relationship between the Eleventh General Programme of Work and operational planning; Millennium Development Goals; global health security; monitoring and evaluation of the General Programme of Work. The revised document is attached at Annex 2.

ACTION BY THE HEALTH ASSEMBLY

4. The Health Assembly is invited to consider the following draft resolution:

The Fifty-ninth World Health Assembly,

Having considered the draft Eleventh General Programme of Work, 2006-2015, submitted to it by the Programme, Budget and Administration Committee on behalf of the Executive Board;

Noting that the General Programme of Work 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;

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

¹ See document EB117/2006/REC/2, summary record of the ninth meeting.

Noting that the General Programme of Work calls for collective action to improve health over the next decade through a proposed global health agenda;

Acknowledging that the General Programme of Work is designed to be the first step in WHO's results-based management process, giving broad direction to the work of WHO;

Welcoming the framework provided by the General Programme of Work and its underpinning of the medium-term strategic plan in preparation, 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,

APPROVES the Eleventh General Programme of Work, 2006-2015;

URGES Member States to identify their role and specific actions to be taken to fulfil the global health agenda, and to encourage multidisciplinary partnerships;

INVITES concerned organizations of the United Nations system, international development partners and agencies, nongovernmental organizations and the private sector to consider harmonizing their work in line with the global health agenda contained in the Eleventh General Programme of Work;

REQUESTS the Director-General to use the Eleventh General Programme of Work as the basis for strategic planning, monitoring and evaluation of WHO's work during the period 2006-2015; to review and update the General Programme of Work, as needed to reflect the changing state of global health; and to report to the Sixty-third World Health Assembly and the Sixty-seventh World Health Assembly on the continued relevance and use of the Eleventh General Programme of Work.

ANNEX 1

**PROGRAMME, BUDGET AND ADMINISTRATION
COMMITTEE OF THE EXECUTIVE BOARD**

First extraordinary meeting
24 February 2006

LIST OF PARTICIPANTS

MEMBERS, ALTERNATES AND ADVISERS

Australia

Ms J. Halton (Chairperson)

Ms C. Patterson (Adviser)
Mr M. Sawers (Adviser)

Bahrain

Dr S. Khalfan (alternate to Dr N.A. Haffadh)

Bhutan

Dr J. Singay

Mr P. Wangchuk (Adviser)
Ms D. Tshering (Adviser)

Canada

Mr D. Strawczynski (alternate to Mr I. Shugart)

Mr P. Oldham (Adviser)

France

Dr J.-B. Brunet (alternate to Professor D. Houssin)

Mrs J. Tor-de Tarlé (Adviser)

Iraq

Dr E.A. Aziz (alternate to Dr A.M. Ali Mohammed Salih)

Jamaica

Dr B. Wint (alternate to Mr J. Junor)

Lesotho

Mr T. Ramatsoari (alternate to Dr M. Phooko)

Portugal

Professor J. Pereira Miguel

Mr J. de Sousa Fialho (Adviser)

Rwanda

Mr A. Kayitayire (alternate to Dr J.D. Ntawukuliryayo)

Thailand

Dr Viroj Tangcharoensathien (alternate to Dr Suwit Wibulpolprasert)

Tonga

Dr V. Tangi

MEMBER STATES NOT MEMBERS OF THE COMMITTEE

Miss D. Soltani (Algeria)

Mrs S. Miranda (Angola)

Dr H. Friza (Austria)

Mrs F. Gustin (Belgium)

Mr Yang Xiaokun (China)

Mrs L. Arango (Colombia)

Ms M. Kristensen (Denmark)

Ms M. Hessel (Denmark)

Mr M. Korslund (Denmark)

Mrs A. Damigou (Greece)

Mrs E. Gouldman-Zarka (Israel)

Ms T. Tsujisaka (Japan)

Dr H. Gashut (Libyan Arab Jamahiriya)

Mrs C. Goy (Luxembourg)

Mr J.-M. Rasolonjatovo (Madagascar)

Mrs D. Valle (Mexico)

Miss C. Lanteri (Monaco)

Mrs G. Vrieling (Netherlands)

Mrs T. Kongsvik (Norway)

Mr A. Pavlov (Russian Federation)

Mrs D. Mafubelu (South Africa)

Mrs I. Elamin (Sudan)

Mrs H. Pedersen (Sweden)

Mrs S. Sammalkivi (Sweden)

Dr C. Presern (United Kingdom of Great Britain and Northern Ireland)

Mr T. Kingham (United Kingdom of Great Britain and Northern Ireland)

Mr D. Hohman (United States of America)

ANNEX 2



WORLD HEALTH ORGANIZATION

Draft Eleventh General Programme of Work, 2006-2015

A global health agenda

FOREWORD BY DR LEE JONG-WOOK, DIRECTOR-GENERAL

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

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

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

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

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

The engagement of new partnerships for health has increased during the last years. This is a welcome reflection of political and financial commitment, but it also presents a more complex health architecture, with new challenges and expectations for WHO. WHO continues to play a proactive role in the United Nations system, with a specific focus on what happens in countries and the overall management reforms.

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

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Appendices :

1. Health in the Millennium Development Goals
2. Summary of the scenarios discussed in preparation for the Eleventh General Programme of Work
3. Health data: short description of trends and illustrations of current situation
4. WHO results chain – from the General Programme of Work to the Medium-term Strategic Plan
5. Key topics to be proposed for future Health Assemblies
6. WHO targets to 2015 for selected public health outcomes, in addition to the Millennium Development Goals

EXECUTIVE SUMMARY

Purpose of the WHO's Eleventh General Programme of Work

The General Programme of Work is a requirement specified in Article 28(g) of the WHO Constitution. This document, covering the period of 2006-2015, is more far-reaching than the previous General Programme of Work, and is linked to the Millennium Development Goals. It examines current global health problems, the challenges they imply, and the ways in which the international community, not just WHO, must respond to them over the next decade.

The broad directions for the work of WHO as the world's health agency, are set out in this General Programme of Work. The more specific priorities will be set out in the WHO Medium-term Strategic Plan 2008-2013 where they are defined as strategic objectives, and in the two-yearly Programme Budgets, as expected results.

Health in a changing global environment

Health is increasingly seen as a key aspect of human security, and occupies a prominent place in debates on the priorities for development. Over the last 20 years, there have been major gains in life expectancy, but there are widening gaps in health. There have been sharp contrasts in health trends across the world, with reversals in some areas due to factors such as infectious diseases, in particular HIV/AIDS, collapsing health services and deteriorating social and economic conditions.

The target year for achieving the improvements set out in the Millennium Development Goals is 2015, but the trends for goals relating to health are not encouraging. The missing elements can be summarized as:

- gaps in social justice;
- gaps in responsibility;
- gaps in implementation; and
- gaps in knowledge.

The Global Health Agenda

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

To deal with some of the underlying determinants of health, a global framework for a health promotion strategy is needed. The agenda outlined here is for all the stakeholders, not just WHO. It highlights seven priority areas:

1. Investing in health to reduce poverty;
2. Building individual and global health security;
3. Promoting universal coverage, gender equality, and health-related human rights;
4. Tackling the determinants of health;
5. Strengthening health systems and equitable access;
6. Harnessing knowledge, science and technology;
7. Strengthening governance, leadership and accountability.

WHO – EVOLVING TO MEET THE CHALLENGES

The comparative advantages of WHO

WHO's strengths lie in its neutral status and nearly universal membership, its impartiality and its strong convening power. WHO's role in tackling diseases is unparalleled. WHO has a large repertoire of global normative work. Many countries rely on WHO standards and assurances in medicines and diagnostic equipment. WHO promotes evidence-based debate, and has numerous formal and informal networks around the world. WHO's regionalized structure provides it with multiple opportunities for engaging with countries.

WHO Core Functions

Building on WHO's mandate and its comparative advantage, six core functions have been defined for the Organization.

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

The challenges and future opportunities for WHO

WHO must respond to important challenges if it is to realize its potential for effective action in the future. In health crises, WHO has to act rapidly in order to be an effective partner amongst the numerous other agencies working with governments. WHO will continually review its procedures to allow for more prompt responses.

WHO will provide a clearer understanding of health equity and health-related human rights. WHO will lead by example in mainstreaming gender equality building this into all its technical guidance and normative work. WHO will do more to focus attention and action on ensuring that countries have sufficient human resources for health, and work to keep this concern at the forefront of national and international policy. WHO will work with ministries of health to strengthen health systems and to build their understanding of what can realistically be done by working with other sectors. WHO will engage more systematically with civil society and industry, including international health care and pharmaceutical industries.

Setting WHO priorities

WHO will develop its priorities through a review of resolutions. Its Results-Based Management Framework will be used for setting priorities; a limited number of strategic objectives will be outlined in the six-year Medium-term Strategic Plan 2008-2013. These priorities will be in the following areas:

- *Providing support to countries in moving to universal coverage with effective public health interventions;*
- *Strengthening global health security;*
- *Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health;*

- *Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health;*
- *Strengthening WHO's leadership at global and regional levels and supporting the work of governments at country level.*

Implementing the Eleventh General Programme of Work

This will be taken forward with Member States through the development of a six-year Medium-term Strategic Plan for 2008-2013, with biennial Programme Budgets agreed with the governing bodies. The global health agenda of this General Programme of Work will be reflected in future agendas of the Health Assembly.

WHO will strengthen its engagement with international financing institutions and development partners. WHO will engage fully in the process of United Nations system reform. WHO will set up mechanisms with the global public health community for engaging a wider range of stakeholders in the policy dialogue around the global health agenda. WHO will evaluate its contribution to carrying out this agenda through the Medium-term Strategic Plan.

The adequacy of the contribution made by the WHO Secretariat will be assessed by evaluating performance every two years. This will include an assessment of progress to the Millennium Development Goals and other health-related targets within the period 2006-2015.

A. INTRODUCTION

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

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

3. In giving leadership to the global health agenda, WHO fully supports the ongoing United Nations reform process. WHO acknowledges the importance of complementing it, avoiding duplication and overlap with its own work and that of other United Nations bodies engaged in health-related activities.

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

B. HEALTH IN A CHANGING GLOBAL ENVIRONMENT

Health as a defining value of the twenty-first century

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

6. Health is increasingly seen as a key aspect of human security. Actual or potential health emergencies are objects of intense public attention and debate. Violence contributes significantly to preventable morbidity and mortality. Diseases linked to poverty accelerate societal breakdown.

Wider concerns about security include the dependence of health on safe food and water, financial security, and protection from the effects of climate change.

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

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

The current health situation

9. Over the last 30 years, life expectancy has increased by between six and seven years globally. This improvement is due to social and economic development, the wider provision of safe water and sanitation facilities, and the expansion of national health services. Nevertheless, there are widening health inequities between and within countries, between rich and poor, between men and women, and between different ethnic groups. More than a billion of the world's poorest people are not benefiting from the major advances in health care (see Appendix 3) and several countries, particularly in sub-Saharan Africa, have seen a decline in life expectancy due in part to the HIV/AIDS epidemic.

10. There have been sharp contrasts in health trends across the regions of WHO. For example, the countries of the former Soviet Union experienced health reversals in the early 1990s, while in Africa earlier gains in child health have been reversed over the last 15 years in about 15 countries. These reversals reflect various combinations of infectious diseases, in particular HIV/AIDS, as well as collapsing health services and deteriorating social and economic conditions. Substantial population growth, linked to a growing unmet need for family planning, is also contributing to a deteriorating situation.

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

12. A shift in the balance of the major causes of death and disease has already occurred in developed countries and is under way in many developing countries. Chronic noncommunicable diseases, including mental disorders, already represent 60% of the current global disease burden. One quarter of all chronic disease deaths occur in people under 60 years of age. A few major risk factors account for the majority of noncommunicable and chronic disease morbidity and mortality; these include tobacco use, unhealthy diets, physical inactivity and alcohol abuse. The potential for improving health by health promotion and disease prevention is still largely untapped.

13. Road traffic incidents kill an estimated 1.2 million people annually, injuring as many as 5.2 million. Over 70% of road traffic fatalities are under 45 years of age. Projections indicate that the number of road traffic casualties will increase by about 65% over the next 20 years unless there is a new commitment to prevention.

14. The target year for achieving the improvements set out in the Millennium Development Goals is 2015, see Appendix 1, but the trends for goals relating to health are not encouraging. The majority of poor countries are unlikely to meet them. Few developing countries are currently on track to meet the target for reducing child mortality, despite this being largely due to common conditions for which knowledge and effective interventions exist. Neonatal deaths have not

declined as much as other infant and child deaths. Although the maternal mortality ratio has declined in countries with lower levels of mortality, those with high maternal mortality rates are experiencing stagnation or even higher death rates. Gaps in mortality rates within countries are still large. Data on health interventions are more encouraging, however: progress towards the targets for tuberculosis control is on course; and measles immunization coverage is on the rise in many countries, leading to a dramatic reduction in mortality. The proportion of women assisted by a skilled medical attendant during delivery has increased substantially in some regions, especially in Asia.

15. Poverty remains a major problem, and the upheavals coming with globalization and rapid economic development, together with interventions such as poverty reduction strategy papers, are not having the desired effect on major sections of the global community.

16. Trends in the world's population show that it is still increasing although the rate of growth has slowed, with nearly all growth now occurring in developing countries. Mid-range population estimates suggest a global population of approximately nine billion by 2050, compared with the present six billion.

17. This demographic trend will include a significant increase in the proportion and number of older people, as well as in the number of young people, in the world. This, together with deteriorating environmental conditions, unhealthy behaviour, and inadequate nutrition has led to a rise in several chronic diseases, including mental and substance abuse disorders, and a consequent surge in demand for expensive long-term tertiary care. For developing countries where communicable diseases remain common, this means a double burden of disease. As more children survive into adulthood, there will also be a larger numbers of young people. Their lives will be at risk, however, if they do not have the information, life skills, health services and support they need to ensure a healthy adolescence. Without these, they are exposed to tobacco-related diseases, harmful use of alcohol, substance abuse, sexually transmitted infections, unwanted pregnancy, and other health problems related to behaviour. About half of the world's population now lives in urban areas. In developing countries, 43% of the urban population lives in slums, and in the least developed countries, 78% of urban residents are slum-dwellers, with 30% of families headed by women.

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

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

20. Many developing countries raise a large part of domestic revenues for health from user charges, which prevent some people, especially in poorer groups, from obtaining care, and result in severe financial hardship for some of those who do obtain it. Most developing countries rely heavily on external resources for health, and the volatility of these funds can inhibit the development of medium and longer term strategies for the sector. Increasing the funding allocated to health, increasing the predictability of revenue from external sources, and taking steps to measure and monitor the extent to which health financing systems achieve universal coverage will be indispensable in future years.

21. Development assistance for health is estimated to have risen by 26% from US\$ 6.4 billion in 1997 to US\$ 8.1 billion in 2002, but development assistance in general remains below the target of 0.7% of GDP. Much of the increase was due to new funds committed to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Although considerable resources have been mobilized, in particular for the HIV/AIDS pandemic, many other areas have received inadequate attention. There is still a massive shortfall in the overall resources required to meet the Millennium Development Goals and deal with other growing health problems such as weak health systems, chronic diseases, and related areas of research.

22. Shortages of skilled health workers are increased by the migration of health workers to wealthier societies offering higher pay and better conditions of service. Reversing this trend requires action by both developed and developing countries. It will lead in some situations to shortages of urgently needed health workers, and will add to the burden of care borne by some communities and homes, particularly by women and girls, thereby increasing inequities.

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

Health actors and partners: a changing world

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

25. Global health partnerships offer the potential to combine the different strengths of public and private organizations, along with civil society groups, in tackling health problems. They provide ways to scale up responses to global health needs and step in where the market fails to mobilize the necessary research and development. Partnerships can activate awareness, money, expertise and a wider range of participants. They also give rise to further challenges, however, such as duplication of effort between initiatives, high transaction costs to government and donors, unclear accountability, and lack of alignment with country priorities and systems. Although some shaking down can be expected, the number of partnerships is likely to grow. They will achieve many of their aims if they obtain long-term, predictable funding and focus on building country capacities.

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

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

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

International declarations and agreements

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

30. Health-related human rights have been codified in numerous international and regional treaties. Far-reaching political commitments have been made in several United Nations world conferences, focusing on segments of the population that often experience discrimination, such as women, children, older people, those with disabilities, indigenous minorities, or those living with HIV/AIDS. Of particular importance is the outcome of the United Nations International Conference on Population and Development (Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995), which covered women's rights, sexual and reproductive health, and the elimination of violence against women and girls. The common understanding of the United Nations of the need for a human rights-based approach to development (2003) has given further impetus to the codification of these rights.

31. Health features prominently in many recent international agreements, including the World Trade Organization Declaration on Trade-Related Aspects of Intellectual Property Rights (the TRIPS Agreement and Public Health, Doha, 2001), the Monterrey Consensus of the International Conference on Financing for Development (Monterrey, 2002) and the products of the World Summit on Sustainable Development (Johannesburg, 2002).

32. The 2005 United Nations General Assembly World Summit made a number of commitments to the fight against poverty, debt relief and development. It called for increased investment to improve health systems; to increase HIV prevention, treatment and care; to control malaria and tuberculosis; to ensure universal access to reproductive health by 2015; to mainstream human rights in the United Nations system and to support the full implementation of the revised International Health Regulations (2005), including the Global Outbreak Alert and Response Network of WHO.

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

34. The declarations made at the Mexico Ministerial Summit on Health Research in 2004 proposed an important agenda for future research, and the Bangkok Conference on Health Promotion in 2005 reaffirmed the importance of tackling the determinants of health and the negative health effects of globalization.

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

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

Gaps in social justice

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

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

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

Gaps in responsibility

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

40. For example, environmental changes resulting from growing economies and international trade have a direct bearing on infectious diseases in different parts of the globe. International conflict and national crises may lead to human rights violations and disruption of social services. Global economic forces and the migration of populations, including skilled health workers, are influencing the modern nation state and its ability to sustain health and welfare policies.

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

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

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

Gaps in implementation

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

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

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

Gaps in knowledge

47. Lastly, there are gaps in what is known about how to tackle some of the major health challenges. Research is sometimes not focused on areas of greatest need. Even where there is agreement on existing or new research priorities, the best way of financing the discovery, production and delivery of these public goods for health, and making them affordable by poor countries, is seldom clear. Examples include research on tackling neglected infectious diseases, promoting healthy lifestyles among adolescents, and the needs of an ageing population. Where effective interventions are available, knowledge on how to scale up their availability is inadequate.

48. Governments and public health institutions are not always aware of the need for evidence-based decisions for better health policies and strategies. For example, sex-disaggregated data are rarely collected or used for decision-making, yet such information is known to be indispensable for effective and gender-sensitive services. Access to information through modern and appropriate communication channels is still highly erratic in poor parts of the world and

contributes to widening gaps in knowledge on subjects such as hygiene and dietary practices, physical activity, road safety and injury prevention, and tobacco and substance abuse.

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

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

C. A GLOBAL HEALTH AGENDA

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

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

53. To deal with some of the underlying determinants of health, a global framework for a health promotion strategy is needed. This is a responsibility of all government ministries at all levels, as well as communities and corporate and civil society. To take up this challenge, action in line with the Ottawa Charter is recommended: to build healthy public policies, create supportive environments, strengthen community action, develop personal skills, and reorient health services.

1. Investing in health to reduce poverty

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

55. Improvement in the health of the poorest will maximize the effectiveness of these poverty reduction efforts. To achieve this, health systems have to become more equitable. This can be achieved, for instance, by designing fairer financing systems. This entails aligning contributions with ability to pay, and use of services with degree of need, thereby protecting people from being exposed to poverty because of health-related expenses. Such measures are linked to security: those at risk of absolute poverty need ‘safety nets’ to protect them from catastrophic expenditure and further impoverishment. Cash transfers, food-subsidy programmes, public works and micro-credit are among the means of providing such protection. Ensuring that people have access to services essential for health may entail the use of such devices as vouchers, fee waivers for health care services, social health insurance, and fuel allowances for cooking and heating.

56. The role of government is central. Poverty reduction strategies, where they exist, enable policy-makers to define programmes across departments such as education, environment and health in one coherent policy process. Their success, however, depends on government ownership, and public sector capacity to focus on outcomes and track progress. Some of the most useful and accurate indicators for this are on health status. The contributions of partners such as the World Bank, the United Nations, the European Commission, and bilateral aid agencies, together with the private sector, play an important role in these coordinated efforts to reduce poverty. New forms of financing, such as the International Financing Facility, are being introduced to complement and scale up existing efforts.

2. Building individual and global health security

57. Global health security has become a prominent item in the international agenda. Conflicts, natural disasters, disease outbreaks and zoonoses, are increasing in number. The risk of a pandemic in humans arising from avian influenza and the associated human cases is an example. The continued increase in trade in food across borders, as well as the large numbers of people travelling between countries, can accelerate the transmission of disease to a widely dispersed population. The spread of HIV/AIDS, which has become a disaster in many countries, is an example.

58. At the household level in poorer communities, prevention and control of infectious diseases is a priority, but equally important are the health risks pertaining to food and water insecurity. Across many parts of the world, sexual violence against women and rape is widespread and deeply ingrained. Such causes of ill-health and premature death can be minimized by awareness, preparedness and preventive measures.

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

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

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

61. 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. In recent years, the scope and content of health-related human rights have been further clarified in international law. They oblige governments to work for the progressive realization of these rights.

62. One of the problems that has to be solved all over the world is the lack of access by the poor and other marginalized groups to essential health services. To achieve universal coverage, health systems characterized by adequate and equitable financing and distribution of reliable health care are required, with marginalized groups receiving priority attention. Ensuring everyone's right to the enjoyment of the highest attainable standard of health entails expanding access to sexual and reproductive health care for all. All groups have the right to participate in the design, implementation and monitoring of health policies, programmes and legislation. In some settings it will be necessary to stress that these include people with physical or mental disabilities,

refugees and displaced or migrant populations, indigenous and tribal communities, ethnic and religious minorities, people living with HIV/AIDS, widows, children, adolescents, and older people. For participation to be successful, elimination of stigma and discrimination also has to be at the forefront of the global public health agenda. Other key health-related human rights in this context include the right to benefit from scientific progress and the right to access to health information and education.

63. The Millennium Development Goals acknowledge that women's empowerment and gender equality are prerequisites for development, and all the health-related goals require action in this area if they are to be achieved. Women's health is adversely affected by the prevalence among them of poverty, lack of employment, violence and rape, limited power over their sexual and reproductive lives, and lack of influence in decision-making. Expanding access to sexual and reproductive health care is essential. Those working with governments and public health authorities must actively promote a gender perspective in the design and implementation of health policies and programmes. Monitoring and evaluation should routinely use sex-disaggregated data.

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

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

4. Tackling the determinants of health

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

67. Unhealthy lifestyles, once considered a problem mainly for richer countries, have been exported throughout the world and exacerbated by increasing urbanization. The nutrition transition and the global marketing of foods high in sugar, fat and salt are driving forces in the growing epidemic of chronic noncommunicable diseases. Harmful use of alcohol is a further cause of chronic disease and mental disorders. These health problems can be reduced by a life-course approach to prevention and control, which includes maternal health, exclusive breast-feeding for six months, health promotion in schools and in the work-place, sex education, a healthy diet, and regular physical activity from childhood into old age. Engagement with industry is also required. Actions on some of these fronts could require government regulatory functions including law and improved enforcement capacity.

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

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

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

5. Strengthening health systems and equitable access

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

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

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

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

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

6. Harnessing knowledge, science and technology

76. The world's present burden of premature death and disease could be significantly alleviated by using relatively inexpensive and tested solutions within a more coherent and coordinated set of public health measures. Further scientific breakthroughs and new knowledge are also needed, however, as new knowledge and technology might provide effective treatments. For example, new technologies are required to control tuberculosis, malaria, HIV/AIDS, chronic diseases, and the health problems associated with ageing populations.

77. More research is required for a better understanding of the links between determinants and their consequences, and for how governments, in particular ministries of health, can best influence other government sectors. Research has not yet focused sufficiently on interventions most urgently needed by the poor, such as antibiotic delivery mechanisms for children with pneumonia, access to perinatal care, and access to treatment for neglected tropical diseases such as leishmaniasis, human African trypanosomiasis, schistosomiasis, Buruli ulcer, and Chagas disease. Opportunities provided by traditional medicines and other indigenous knowledge are also overlooked. The generation and evaluation of new technologies is an important area for the future.

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

79. Global experience continues to expand on the use of media to raise awareness of health issues such as sexual and reproductive health in adolescents and young adults. Advances continue

in the use of information and communication technology to provide health care for people in remote areas or who are otherwise hard to reach, to collate health data and research findings, and to distribute information and advice. These advances are beginning to benefit poorer communities. A clear understanding of how best to use the internet to achieve public health goals is increasingly needed. Direct marketing by the private sector is likely to increase, leading individuals to choose care and some treatments without professional support. This will require further work by WHO – Member States and Secretariat – to help set standards that ensure quality and inform users.

7. Strengthen governance, leadership and accountability

80. At national level there is a need for strong political will, good governance, and wise leadership. Governments must have the population's health as one of their central concerns. All public policy-making is an opportunity to bring more coherence to the delivery of health outcomes. The ministry of health must show leadership in promoting policy dialogues and intervention strategies across sectors, both public and private. This means dealing not only with health sector issues but with broader ones, such as civil service reform, macroeconomic policy, gender equality and health-related human rights.

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

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

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

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

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

D WHO - EVOLVING TO MEET THE CHALLENGES

The increasing demands

86. The challenges to global health, and the gaps in the current response, call for a health agenda which goes beyond what WHO alone can do. To add maximum value to the work on the Millennium Development Goals, and enable Member States to put health at the heart of national public policy, whether on matters such as economic growth and reduction of poverty, WHO must focus on its comparative advantages and build on its existing strengths.

87. As the number of entities involved in health increases, the boundaries of WHO's work at all levels are expanding to include coordination with them. WHO needs to continue to develop innovative mechanisms for managing or participating in global partnerships and alliances, including those with the private sector. The aim is to make the overall international health architecture more efficient and responsive to the needs of Member States.

The comparative advantages of WHO

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

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

90. WHO has expanded its global normative work through initiatives such as the adoption of the WHO Framework Convention for Tobacco Control, the revision of International Health Regulations, and its Commissions on Macroeconomics and Health, Intellectual Property Rights, and the Social Determinants of Health. These and other achievements in WHO's normative work have been possible because global efforts are being matched by those made in countries, so that the legislation is owned by those with whom it must take effect. Many countries rely on WHO standards and assurances in medicines and diagnostic equipment. WHO will continue to encourage efforts, including those of industry, to produce affordable global public health goods.

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

92. WHO's regionalized structure provides it with multiple opportunities for engaging with countries, with Geneva focusing on issues of global concern, and regional offices focusing on technical support and building national capacities. WHO's presence in countries allows a close

relationship with ministries of health and its partners inside and outside of government. It can collaborate closely with the United Nations system, and can provide channels for emergency support when this is needed. The three levels of WHO secretariat, and its close working relations with governments, enable it to gather health information and monitor trends over time and across countries, regions and the globe.

The core functions of WHO

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

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

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

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

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

97. WHO will strengthen its collaboration with the other relevant parts of the United Nations system and other international organizations to take forward the evolving global health agenda, in conjunction with the Bretton Woods Institutions. To this effect, WHO will place particular emphasis on strengthening its collaboration with UNICEF and UNFPA through regular strategic policy and technical dialogue. These collaborations will facilitate the review, better alignment and focus of WHO activities to achieve the Millennium Development Goals. They will also build on WHO's comparative advantage, and ensure that all levels of the Organization provide coherent support to these efforts.

98. According to its mandate, as provided by its Member States and in line with recommendations from the United Nations General Assembly, WHO will strengthen its role as the directing and coordinating authority on international health. In its relations with the United Nations, WHO will place particular emphasis on emerging issues in global public health and security, as well as on cross-cutting issues such as environment, human rights and gender.

99. WHO will engage fully in the United Nations reform efforts with the aims of streamlining the procedures of governance; bringing coherence to the formulation of norms, standards and policy guidance; clarifying divisions of labour, as done recently with UNAIDS and the Global Task Team; maintaining transparency in the use of data and knowledge; and providing strong support for the United Nations Country Teams under one United Nations leadership.

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

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

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

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

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

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

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

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

Strategy (2006-2015)]. Global strategies will continue to be developed and expand to cover new priorities.

4. Articulating ethical and evidence-based policy options

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

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

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

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

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

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

111. WHO plays a critical role, together with some other members of the United Nations Country Team, in facilitating this technical support between countries, and in responding to demands from ministries of health and their partners, as defined in the Country Cooperation Strategy (see Appendix 4).

6. Monitoring the health situation and assessing health trends

112. WHO carries out its monitoring responsibilities in countries in collaboration with ministries of health and national statistical institutions, and at regional level by collating data on trends across nations, and working with partners across its programmes. At the global level, the annual *World Health Report*, the *Weekly Epidemiological Record* and *World Health Statistics* provide data on the state of global health in selected areas on a country by country basis. These compilations are supplemented by comparison of health indicators across the globe in global atlases located on the WHO web-site, covering, for example, communicable diseases, mental

disorders, heart disease and stroke, children's health and the environment, and tobacco. WHO has a responsibility to ensure that all health data are sex-disaggregated.

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

The challenges and future opportunities for WHO

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

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

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

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

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

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

120. WHO will engage strategically with its Member States, and build more effective alliances within the United Nations and the broader development community. It will work with them to

harmonize the health architecture at country level, and engage in the reform process towards an effective country team under a common United Nations lead.

121. WHO will work with others to harmonize the global health architecture, and provide forums for the increasing number and type of entities involved to engage in dialogue on local and global health challenges.

122. WHO will continue to strengthen its governing bodies, given their importance for WHO's effectiveness and vitality.

Management challenges for the WHO Secretariat

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

- a. Financing of the organization is increasingly from voluntary contributions, the majority of which are earmarked for specific projects or programmes. This earmarking requires consultations with individual donors to align contributions with WHO priorities. WHO will continue to work with Member States to increase the proportion of un-earmarked funds, linked to more transparency in its assessments of performance.
- b. WHO has a presence in almost 150 countries. This presence should be strengthened. It is taking forward its Country Cooperation Strategies so as to make its engagement with Member States more strategic, and to harmonize its efforts under a common United Nations lead.
- c. The quality of WHO's work must continually improve if the Organization is to fulfil its mandate. To do this, it must continually learn from its own experience and that of others. Mechanisms for improving quality are in place, such as technical advisory committees, performance management of staff, and peer review of plans and programmes, but these will be further strengthened around WHO's core functions and through more clearly specified systems of performance enhancement.
- d. Work towards managing the Organization as one corporate body will continue, with an increasing level of common systems across the three levels. WHO's Constitution supports regional diversity, but within a common global results-based management framework, and corresponding performance and accountability systems.
- e. WHO is committed to promoting a highly competent workforce and to strengthening its scientific and technical advisory bodies. As expectations of WHO change, the secretariat will need to devise more flexible ways to achieve and maintain excellence through new and existing staffing arrangements. WHO will strive to reach gender balance in senior management and in its advisory bodies.

Setting WHO priorities

124. The Executive Board and the Health Assembly, as the supreme decision-making bodies of WHO, direct the work of the Secretariat by adopting resolutions, setting targets and formulating policies. To help maintain the necessary balance, WHO will pursue a limited number

of strategic objectives in the six-year Medium-term Strategic Plan. Each strategic objective will have its own targets, which are agreed with governing bodies and monitored accordingly.

125. A review of all resolutions adopted by the Health Assembly since its inception will be conducted and a report prepared for the Sixty-first World Health Assembly with a prior review by the Executive Board. The review will catalogue all resolutions, identifying actions to be taken by Member States and the Director-General. The outcome of the review will clarify the mandate of the Organization in specific areas, and their links to planning documents such as the General Programme of Work and the Medium-term Strategic Plan. This review will be updated on a regular basis.

126. In addition, the resource implications of all new resolutions will be made clear. When a new resolution with resource implications is proposed, WHO will have to indicate where commitments can increase in the programme budget, and where they can be reduced.

127. In accordance with the global health agenda, WHO's comparative advantage and its core functions, the Results-Based Management Framework is used for setting WHO's priorities and carrying out the work they entail (see Appendix 4). The priorities will be based on the preceding analysis, on global and regional resolutions, and the cumulative needs of countries. These priorities will be in the following areas:

- a. *Providing support to countries in moving to universal coverage with effective public health interventions.* This applies particularly to areas such as communicable and noncommunicable disease prevention and control and research; sexual and reproductive health; infant, child, adolescent and maternal health and the health of older persons; environment-related health problems, and effective responses in times of crisis.
- b. *Strengthening global health security.* This should further support an integrated approach to a society-wide response to emerging and acute threats to health, including disaster and conflict situations, and incorporate preparedness planning for such threats.
- c. *Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health.* This will focus on minimizing lifestyle-related risk factors, advocating action on the broad social and economic determinants of ill health, and promoting healthier and safer physical environments, better nutrition, food safety, and food security.
- d. *Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health.* This area covers support for the development of health systems, including human resources for health, that promote equitable health gains and better respond to men's and women's different needs; that improve quality, norms, efficacy and safety; that have effective leadership and governance; and that extend social protection through fair, adequate and sustainable financing.
- e. *Strengthening WHO's leadership at global and regional levels and by supporting the work of governments at country level.* The secretariat will strengthen its ability to take forward its core functions through its reform process around results-based management, through strengthening WHO's work in countries, monitoring norms and standards in countries, improving its mechanisms for knowledge management, investing in staff development, and ensuring sustainable sources of financing. Externally it will strengthen its work on partnerships and engage more deeply in the

United Nations reform process, with a view to strengthening the response to the global health agenda, and to improving overall efficiency.

Implementing the Eleventh General Programme of Work

128. This will be taken forward with Member States through the development of a six-year Medium-term Strategic Plan for 2008-2013, with biennial programme budgets approved by the governing bodies.

129. The global health agenda of this General Programme of Work will be reflected in future agendas of the Health Assembly. Appendix 5 highlights some proposed topics for the Health Assembly for the period 2006-2015. These include topics for which the Health Assembly has already identified the need for a global strategy; topics related to reports of WHO commissions and other high-level forums; topics which reflect proposed themes for World Health Day and the World Health Report; adoption of strategic programme plans and budgets; and elections.

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

131. WHO will evaluate its contribution to putting the global health agenda into effect through defining strategic objectives in the Medium Term Strategic Plan. The adequacy of contributions from the WHO Secretariat will be assessed by evaluating performance every two years, linked to the Programme Budget. In addition, thematic evaluations will be a regular aspect of the overall management of WHO's programmes, and country performance will be regularly assessed.

132. The global health agenda and the response from WHO and the international community will be monitored in a participatory manner, with a wide group of partners. This will include an assessment of Millennium Development Goals and other health-related targets within the period 2006-2015. An overview of existing WHO targets is provided in Appendix 6. A review of health-related targets adopted by the Health Assembly and scheduled to be met within the period 2006-2015, together with an assessment of achievement of previous health-related targets up to 2005, will be presented to the Sixtieth World Health Assembly. A plan will be prepared for establishing mechanisms to take stock of progress, and evaluating how well the challenges and gaps are being dealt with. Reports on progress will be made available to the governing bodies.

Appendix 1: Health in the Millennium Development Goals

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

Sources: "Implementation of the United Nations Millennium Declaration", Report of the Secretary-General, A/57/270 (31 July 2002), first annual report based on the "Road map towards the implementation of the United Nations Millennium Declaration", Report of the Secretary-General, A/56/326 (6 September 2001); United Nations Statistics Division, Millennium Indicators Database, verified in July 2004; World Health Organization, Department of MDGs, Health and Development Policy (HDP). www.who.int/mdg

Appendix 2: Summary of the scenarios discussed in preparation for the Eleventh General Programme of Work

Scenarios are tools for strategic thinking about possible future situations. They are neither predictions nor projections, but try to summarize what is known about some driving forces and anticipate what may happen. WHO developed the following four scenarios in order to stimulate creative thinking about its place in the global health architecture.

1. *Steady change to 2015.* The world will not change drastically. Global trends in relation to health will continue on their current path. Health improves globally, though with great disparities between rich and poor in economics, health and health care.
2. *Decline.* The world becomes compartmentalized, undergoes economic recession, great disparities, violence, water and food shortages, and other major setbacks. Global cooperation breaks down, health systems are under-funded resulting in negative health trends.
3. *Improved health stemming from a responsible market.* The world situation improves, with a well functioning market leading to increased social and economic well-being, equitable growth, fair trade, security, and cooperation among nations. Overall improvement of health indicators due to stronger health systems, social protection, technology, prevention policies, and the like.
4. *Improved health stemming from international cooperation.* The world achieves sustainable development and equity, global and local governance, pro-poor economic growth, attention to social determinants, increase in development assistance, and the like. Health improves in most sectors through effective health promotion, high quality prevention and care services accessible to all, and social protection policies.

This exercise showed the need for WHO to be a flexible yet robust organization with clear priorities and a distinct role to play.

Appendix 3: Health data: short description of trends and illustrations of current situation

Mid-range **population** estimates suggest a global population of approximately nine billion by 2050. A 300% increase in the elderly population is predicted by 2050. The majority of the world's young people (below 25 years old) – 87% – now live in developing countries.

Road traffic injuries kill an estimated 1.2 million people annually, injuring as many as 5.2 million. Projections indicate that these figures will increase by about 65% between 2002 and 2020 unless there is new commitment to prevention. Two-thirds of people killed in road traffic injuries are under 45 years of age.

In 2002 an estimated 1.6 million people died as a result of **violence**. Just over half these deaths were suicides, more than one-third were homicides, and approximately one-tenth were war-related. The vast majority of these deaths occurred in low- and middle-income countries.

In 2005, 3.1 million deaths were caused by **HIV/AIDS**, which is the leading cause of mortality among adults aged 15 to 59, representing 15% of global deaths (2.4 million deaths) in this age group.

The annual total of 529 000 (2000) **maternal deaths** includes often sudden, unpredicted deaths occurring during pregnancy itself, during or after childbirth.

Each year 3.3 million babies are stillborn, about 4 million die within 28 days of birth, and a further 6.7 million **children** die before their fifth birthday. Today, nearly all child deaths (97%) occur in low-income countries, and almost half in Africa. Communicable diseases still represent biggest threats of child death, and cause about 60% of all deaths of children under 5 years old.

Mortality from many of the **vaccine-preventable diseases** decreased in the past few decades, especially among children under the age of five. Among these childhood deaths, 395 000 were caused by measles and 257 000 by neonatal tetanus.

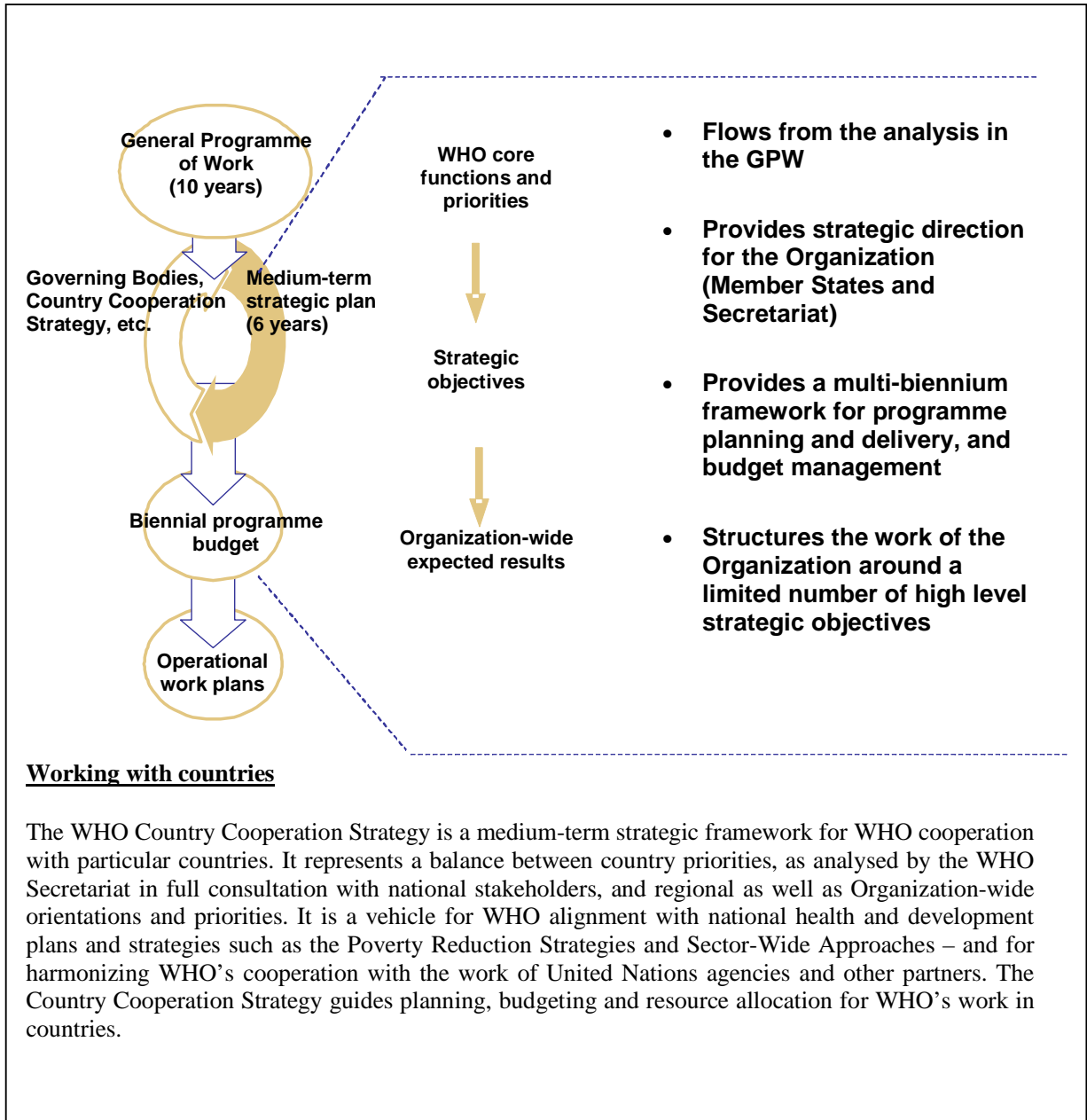
About one million people die from **malaria** every year, and the disease is likely to be a contributing factor in another two million deaths. There are still 1.6 million deaths from **tuberculosis** worldwide every year, 98% occurring in developing countries.

Over half of all child deaths occur in children who are **underweight**. Malnutrition increases the risk of dying from diseases such as pneumonia or diarrhoea. Meanwhile, an estimated 17.6 million children under five years old and more than 1 billion adults are **overweight** worldwide.

Chronic noncommunicable diseases, including mental ill-health, account for 60% of the current global disease burden and 35 million deaths. One quarter of all chronic disease deaths occur in people under 60 years of age. There were at least one million more deaths in 2000 than in 1990 attributable to **tobacco**, with the increase being most marked in developing countries.

Environmental determinants of health, including lack of access to safe food and water, accounted for 1.9 million deaths from diarrhoea in 2002. They are also responsible for a significant chronic-disease burden related to chemical contamination of food and water sources, especially in the poorest countries.

Appendix 4: WHO results chain – from the General Programme of Work to the medium-term strategic plan



Appendix 5: Key topics to be proposed for future Health Assemblies

Sixtieth World Health Assembly (2007)

- Medium-term Strategic Plan 2008-2013
- Proposed programme budget 2008-2009
- Health and security: The World Health Report
- Gender and health: Global Strategy
- Election of External Auditor

Sixty-first World Health Assembly (2008)

- Election of Director-General
- Performance Assessment Report 2006-2007 as well as Audited Financial Report
- Social Determinants of Health: Report of Commission
- Sixtieth anniversary of World Health Organization
- Review of progress towards Millennium Development Goals

Sixty-second World Health Assembly (2009)

- Proposed programme budget 2010-2011

Sixty-third World Health Assembly (2010)

- Performance Assessment Report 2008-2009 as well as Audited Financial Report
- Review of progress towards Millennium Development Goals

Sixty-fourth World Health Assembly (2011)

- Eleventh General Programme of Work – summary of progress
- Proposed programme budget 2012-2013
- Election of External Auditor

Sixty-fifth World Health Assembly (2012)

- Performance Assessment Report 2010-2011 as well as Audited Financial Report
- Review of progress towards Millennium Development Goals

Sixty-sixth World Health Assembly (2013)

- Election of Director-General
- Medium-term Strategic Plan 2014-2019 and Proposed programme budget 2014-2015

Sixty-seventh World Health Assembly (2014)

- Report on the implementation of the Medium-term Strategic Plan (2008-2013)
- Performance Assessment Report 2012-2013 as well as Audited Financial Report
- Twelfth General Programme of Work
- Review of progress towards Millennium Development Goals

Sixty-eighth World Health Assembly (2015)

- Proposed programme budget 2016-2017
- Election of External Auditor

**Appendix 6: WHO targets to 2015 for selected public health outcomes,
in addition to the Millennium Development Goals**

PUBLIC HEALTH AREA	TARGET (source)	DATE
Health-related targets of the Millennium Development Goals		
Nutrition (MDG 1)	Halve the proportion of people who suffer from hunger (Target 2)	2015
Child mortality (MDG 4)	Reduce by two-thirds the under-five mortality (Target 5)	2015
Maternal health (MDG 5)	Reduce by three-quarters the maternal mortality ratio (Target 6)	2015
HIV/AIDS, malaria and tuberculosis (MDG 6)	Halted and begun to reverse the spread of HIV (Target 7) and the incidence of malaria, tuberculosis and other major diseases (Target 8)	2015
Environment (MDG 7)	Halve the proportion of people without sustainable access to safe drinking water and sanitation (Target 10)	2015
Development (MDG 8)	In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries (Target 17)	2015
Other selected WHO targets		
Avoidable blindness	Reduce blindness prevalence to less than 0.5% in all countries, or less than 1% in any country (resolution WHA56.26)	2015
Chagas disease	Elimination of Chagas disease (WHA51.14)	2010
Chronic Disease	Reduce death rates from all chronic diseases by 2% per year during the next ten years (Preventing Chronic Disease, 2005)	2015
Immunization	Ensure full immunization of children under one year of age, at 90% coverage nationally, with at least 80% coverage in every district or equivalent unit (resolution WHA58.15)	2015
	Global childhood morbidity and mortality due to vaccine-preventable diseases will be reduced by at least two-thirds compared to 2000 levels (resolution WHA58.15)	2015
Influenza	Vaccination coverage of the elderly population of at least 75% (resolution WHA56.19)	2010
Iodine deficiency	Universal salt iodization for the elimination of iodine deficiency disorders (resolutions WHA49.13 and WHA52.24; United Nations General Assembly resolution S-27/2, Annex)	2015
Measles	Reduce the number of measles deaths worldwide by 90% compared to 2000 level (resolution WHA58.15)	2010
Poliomyelitis	Global interruption of transmission of poliomyelitis, with the exception of Nigeria (Advisory Committee on Polio Eradication)	2006
	Interruption of transmission of poliomyelitis in Nigeria (Advisory Committee on Polio Eradication)	2007
Reproductive health	Achieve universal access to sexual and reproductive health (resolutions WHA57.12; WHA58.30; WHA58.31; United Nations General Assembly A/60/492/Add.2)	2015