WORLD HEALTH ORGANIZATION
Regional Office
for the Eastern Mediterranean
ORGANISATION MONDIALE DE LA SANTE
Bureau regional de la Mediterranee orientale

منظمة الصحة العالمية
المكتب الإقليمي
لشرق البحر المتوسط

ش م/ل إ٣٩/٦
تموز/يوليو ١٩٩٢
الأصل: بالإنكليزية

اللجنة الإقليمية لشرق البحر المتوسط

الدورة التاسعة والثلاثون

البند ٨ من جدول الأعمال

استعراض السياسة والإطار البرنامجي لبرنامج العمل العام التاسع (١٩٩٦ ـ ٢٠٠١)

ينص دستور منظمة الصحة العالمية على أن يقدم المجلس التنفيذي برنامج عمل عاماً يشمل مدة محدّدة، إلى جمعية الصحة العالمية للنظر فيه وإقراره.

وفي أعقاب اعتماد جمعية الصحة العالمية للاستراتيجية العالمية لتوفير الصحة للجميع بحلول سنة ألفين، تم تقسيم الحقبة الممتدة من سنة ١٩٨٤ إلى سنة ٢٠٠١ إلى ثلاث مُدَد يستغرق كل منها ست سنوات، سُمِّيت برامج العمل العامة، السابع، والثامن، والتاسع، على التوالي.

ولا يخفى أن برنامج العمل العام التاسع يشمل المدة المتبقية حتى سنة ٢٠٠١ (١٩٩٦ ـ ٢٠٠١).

ويحدّد برنامج العمل مجالات الأولوية لأعمال المنظمة في القطاع الصحي، وغيره من القطاعات ذات العلاقة بالصحة. كما يبيّن الأساليب التي ينبغي للمنظمة اتّباعها لتشجيع وتنسيق ودعم الجهود التي تبذلها الدول الأعضاء، فرادى ومجتمعة، في سبيل بلوغ هدف توفير الصحة للجميع. ثم إن البرنامج يستهدف كذلك دعم البلدان في تنقيح وتنفيذ استراتيجياتها الوطنية لتوفير الصحة للجميع، وفي تقييم التقدّم المحرز نحو بلوغ هذا الهدف.

ويُلاحظ أن برنامج العمل العام التاسع المقترح مختلف بعض الشيء عن البرنامجين السابع والثامن، لاسيّما في تصنيف البرامج، الذي تم تعديله لإبراز القضايا الهامة وللاستفادة من الخبرة المكتسبة من تنفيذ برنامجي العمل الماضيين.

وبَعْد، فإن مشروع الوثيقة هذا معروض على اللجنة الإقليمية لمناقشته واقتراح ما ترى إدخاله من تعديلات عليه، كي ينظر فيها المجلس التنفيذي في كانون الثاني/يناير ١٩٩٣.

WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTE

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POLICY AND PROGRAMME FRAMEWORK FOR THE NINTH GENERAL PROGRAMME OF WORK

A DRAFT FOR DISCUSSION BY THE PROGRAMME COMMITTEE OF THE EXECUTIVE BOARD

Article 28(g) of the Constitution of the World Health Organization requires its Executive Board to submit to the Health Assembly for consideration and approval a general programme of work covering a specific period. The Eighth General Programme of Work (1990-1995) was approved in May 1987. The Ninth General Programme of Work for the period 1996-2001 will be submitted to the Health Assembly in May 1994.

In the following document are presented a draft outline of the policy and programme framework for the Ninth General Programme of Work, and a programme classification, as background for discussion at the session of the Programme Committee of the Executive Board to be held in August 1992. Parallel to its discussion by the Programme Committee of the Executive Board, this material is being submitted for discussion, comment and proposals to regional committees at their September-October 1992 sessions. In the light of these discussions, it will be amended and submitted to the Executive Board in January 1993. The draft Ninth General Programme of Work will be prepared subsequently and submitted through the Programme Committee to the Executive Board at its ninety-third session in January 1994.

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INTRODUCTION: NATURE OF THE NINTH GENERAL PROGRAMME OF WORK

The Ninth General Programme of Work is the third of three general programmes of work that together ensure continuing support to Member States for the attainment of Health for All by the Year 2000.

During the implementation of its Seventh and Eighth Programmes of Work the World Health Organization promoted and supported the development of basic health care services and then primary health care. In both cases WHO responded to the nature of the dominant health problems facing countries at the time, building on and enhancing national health infrastructures.

The Ninth General Programme of Work is addressed to the decision-makers in the health sector, policy-makers in all health-related sectors of development and to the scientists and teachers responsible for moulding public opinion and attitudes. The Programme of Work identifies priority health problems and issues that must be and can be addressed.

The Ninth General Programme of Work will put emphasis on accelerating progress towards the goal of Health for All through promotion of a health perspective that includes both the health sector and other sectors in creating a social and physical environment in which health is seen as an integral part of human development.

Reduction of inequities in health through equitable access to appropriate information and care will be a major concern. Stress will be put on optimal use of resources for health in all sectors - public and private, involving individuals and communities and emphasizing cost-effective interventions.

Integration of essential elements of primary health care and linkage of first-level health care with the secondary and tertiary levels will also be an important focus for WHO action. The functions of the Organization can be summed up as: technical cooperation with countries and direction and coordination of international health work.

During the period of the Ninth General Programme of Work the main concern of the Organization will be to accelerate its collaboration with countries aimed at achieving significant improvement in health status and equity. Special efforts will be made to mobilize resources for health, in particular for countries most in need. The Programme of Work will be oriented in the following four policy directions:

- integrating health and human development in public policies;

- promoting and protecting health;

- ensuring equitable access to quality health services;

- preventing and controlling specific health problems.

WHO's managerial process will be adapted to strengthen and accelerate implementation of activities at country level.

1. HEALTH PERSPECTIVE

The perspective presented below is intended to highlight some of the issues that determine the policy and programme framework for WHO action in the period of the Ninth General Programme of Work. More comprehensive information and analysis of the global health and socioeconomic situation and trends can be found in the Second Evaluation of the Implementation of the Global Strategy for Health for All by the Year 2000.

1.1 A changing world

Over the last decade one of the most important global trends was democratization of political systems and greater participation of people in determining their own future. Human rights, equity and social justice became basic issues in political planning processes. The need for global commitment to coherent ways of protecting the environment was recognized by all.

The end of the "Cold War" eliminated the tension between East and West, allowing for a reduction in armaments. However, areas of regional and intercountry tension and warfare have persisted. Hopes were high for reduced spending on arms and increased spending on health development. So far this so-called "peace dividend" has not materialized.

Global population growth continued to slow down from an estimated 2.1% in the 1960s to 1.7% by 1990. It is expected to fall to 1% by 2020. However, world population grew from an estimated 4851 million in 1985 to 5292 million in 1990. Much of the increase occurred in developing countries where younger age-groups constitute an increasing proportion of national populations. People under the age of 25 years now often account for over 50% of the total population.

In developed countries, birth rates continued to fall and life expectancy increased. By 1990 the proportion of the population of developed countries aged 65 and over had increased to 12.8%, or 145 million people. In developing countries, the proportion of the population aged 65 and over has changed only marginally - from 4.2% in 1985 to 4.5% in 1990, but their absolute numbers rose dramatically from 153 million to 182 million.

The number of people living in cities increased everywhere. By 1990 approximately 45% of the world's population was urban. Over the next 35 years, a threefold increase in the number of people living in cities is expected in developing countries.

Throughout the world there were large movements of people displaced by political unrest. In 1991 the number of refugees amounted to 17 million. Their physical and psychosocial needs called for relatively specialized services that were often beyond the capacities of existing national health and social systems.

The overall global economic situation continued to improve. However, the gap between the least-developed and other developing countries increased. The net flow of resources was from developing to developed countries because of debt servicing and repayment and unfavourable prices of raw materials. Structural adjustment policies in poor countries, aimed at improving economic performance, and often undertaken at the request of bodies like the International Monetary Fund, made the situation worse for some social groups. The absolute number of people living in poverty grew.

The impact of environmental pollution began to be felt more. The health effects of the depleted ozone layer, climatic changes and pollution of all kinds became evident. This began to influence both overall development policies and health policies.

There were renewed attempts to bring about international political consensus on how to reduce further violation of the natural environment. The United Nations Conference on Environment and Development (UNCED) adopted Agenda 21, an action programme for the 1990s and beyond, which addresses the pressing problems of the triad health-environment-development. It reflects a global consensus on and political commitment to the need for sustainable development and supports the global objectives of achieving a sustainable basis for health for all, providing an environment that promotes health, and making all individuals and organizations aware of their responsibilities for health and its environmental basis.

There were global improvements in a number of domains. Enrolment in primary, secondary and tertiary school programmes grew, even though girls and women continued to be underrepresented. Although levels of adult literacy improved generally, illiteracy among women and the poor continued to impede health and social development.

Radio and television became accessible to larger numbers of people than ever before. For better or worse they became important factors in the spread of new views of the world, especially among young people. Partially as a result of this, attitudes to, and expectations of, health and welfare systems changed, often resulting in unrealistic expectations and harmful changes of life-style. However, the media also showed their potential value as efficient instruments for promotion of health.

The structure of the family continued to change in most parts of the world. In response to economic and demographic pressures, it became more nuclear, and less able to provide health care. This resulted in increased dependence on health and social services, which were often not able to respond to increased demands.

The number of women entering the paid labour force for economic reasons in developing countries increased. However this often has adverse effects on their traditional family responsibilities. Particularly in developed countries the proportion of elderly people grew. Combined with decreasing age at retirement this created a relatively new social group with special needs but also with political experience and visibility.

1.2 Health and health system trends

Throughout the world improvements were noted in health care coverage and health status. Everywhere life expectancy improved, and rates of infant mortality continued to decrease, more so in developing than developed countries. Births were better spaced and families became smaller. Many countries succeeded in establishing effective family planning programmes resulting in rapid reduction in fertility.

However, high rates of maternal, perinatal and infant mortality, including from preventable diseases, continued to be reported from developing countries and from poor communities in developed ones, highlighting the need for improvement in quality of life and health care and the persistence of gross inequities.

Malnutrition and inadequate food availability remained major problems for millions of people. Diseases associated with poverty, including inadequate water and sanitation, persisted among these same populations. There were major outbreaks of cholera in some regions of the world. The emergence of AIDS, in addition to long-standing problems of communicable diseases such as tuberculosis and malaria and an increase in noncommunicable diseases, imposed a double burden on health care systems in developing countries.

In developed countries noncommunicable diseases, especially cardiovascular and tobacco-related illnesses, cancer, substance abuse and accidents, all continued to assume major importance, together with the health and welfare concerns of the elderly and the emergence of AIDS.

Commitment to the goal of Health for All and the principles of primary health care continued and major progress was made, for example, with respect to immunization. In many countries, however, implementation of health-for-all strategies and activities was slow, even though investments in health continued to be relatively well maintained. Major allocations of resources, however, still went to programmes with a focus on specific diseases, rather than to development of infrastructure which would be able to provide sustained and integrated health care.

Inequalities in access to health care continued and sometimes increased. Groups with special needs such as the elderly, the poorest, and rural populations were particularly disadvantaged. In many parts of the world women continued to be at a marked disadvantage in terms of the quality and extent of health care coverage available to them. Only recently did health care systems begin to respond to some of the unique physiological needs of women and the combined impact on health of their reproductive, family and occupational roles.

In many parts of the world there were major man-made and natural emergencies, many of which seriously tested the capacity of national and international bodies to respond with timely and appropriate interventions.

The capacity of many national health systems was also stretched because the demand for services increased. Rarely were available resources within the health sector able to keep pace with demand, and few countries were able to reallocate substantial resources from elsewhere.

The global and national maldistribution of health personnel continued to be felt. Even in countries with an excess of physicians and nurses, rural areas, poor communities and vulnerable groups were often underserved.

The increasing cost of health care prompted the exploration of new financing mechanisms. Mixed private and public actions, community financing schemes, health maintenance programmes, and innovative group health insurance projects within employment schemes were tried in different settings and with different outcomes. Coinciding as it did with global economic problems that affected all sectors, it is not yet clear whether provision of private care has effectively increased access to care, or detracted from the public sector and principles of equity. As the cost of care increased, however, and despite the many financing schemes that

were attempted, large groups of people continued to fall outside national or private insurance programmes and thus remained at risk of inadequate health care.

Analysis of the world situation makes it abundantly clear that there have been worldwide improvements in health status and in coverage by, and access to, health services but that these have not been equally shared by all. Nor have development efforts in sectors other than health always had a positive impact on health. Some current political and socioeconomic factors and forces may continue to have an adverse impact on health. Although appropriate technologies are available for many of the priority health problems, too often these have not been made available to those who need them most, nor used most effectively. Increased understanding of the importance of healthy life-styles and of a health-promoting environment point to the need for greater attention to health promotion and protection, rather than to health care alone. In order to achieve significant, sustained and equitable improvements in health status, it is proposed to orient public health action and resources along the following four main policy directions:

- integrating health and human development in public policies;

- promoting and protecting health;

- ensuring equitable access to quality health care;

- promoting and controlling specific health problems.

2. POLICY FRAMEWORK

The rapid and often unpredictable changes in the global political and economic situation, in social and health systems, and in the environment require WHO to sharpen and even reorient its priority areas of action, and modify its activities accordingly.

This section addresses two distinct issues: policy directions and WHO roles and functions. It begins by recalling the goal of Health for All, identifies a number of priority targets and outlines the main policy directions for WHO's action.

2.1 Goals and targets

The goal of Health for All by the Year 2000 was adopted by the Health Assembly in 1977 to express the Member States commitment to reducing the gaps between the haves and have-nots. Specifically, the main social target was the attainment by all people of the world of a level of health that would permit them to lead socially and economically productive lives. The goal and the target both have important aspirational value; they should be understood as a succinct statement of belief and conviction that all people of the world should have opportunities to improve and maintain their health. This remains as valid today as in 1977.

Primary health care was identified as the way to attaining the goal of Health for All. It can be looked at both as a philosophy and as a strategy. As a philosophy it is based on the principles of social justice and equity, self-reliance and community development. As a strategy, it seeks a reorientation of health systems in order to provide the whole population with effective essential care and to promote individual and community involvement as well as intersectoral collaboration.

The Global Strategy for Health for All, adopted in 1981, identified ten global targets that countries would need to address in the light of their socioeconomic and health situations. International commitment to reaching the ten targets remains as strong today as in 1981, as reflected, for instance, in a number of resolutions of the World Health Assembly.

Since then the predominant focus of international action has been on the control of specific diseases and the provision of basic elements of health care, with the expectation of a reduction of inequity largely as a consequence of such action. The results of the Second Evaluation of the Strategy for Health for All confirm that continued focus is needed on the control of diseases and on the provision of care. But, the evaluation makes it clear that inequity *per se* is a major issue deserving explicit attention in its own right.

For the Ninth General Programme of Work, WHO will therefore set its targets aiming explicitly at reducing premature mortality and controlling specific health problems and reducing inequities in access to health care between population groups.

The following targets include those to which countries are already committed as reflected in the Declaration of Alma-Ata, the World Declaration on the Survival, Protection and Development of Children in the 1990s, Agenda 21 (UNCED) and World Health Assembly resolutions. Other targets are set to meet the new challenges and emerging issues.

The following targets are **not** grouped according to the four policy directions, since action in the four policy directions influence progress towards all the targets.

By the end of the Ninth General Programme of Work:

- In all countries, the **infant mortality rate** will not exceed 50 per 1000 live births; the **under-five mortality rate** will not exceed 70 per 100 live births; **maternal mortality** will be reduced by half worldwide.

- All countries will have adopted strategies and implemented plans of action (for example through information and education, financial incentives, legislative and regulatory measures) in order to:

  - provide access to healthy living conditions;

  - ensure safe social and physical environments;

  - encourage healthy behaviour.

- Poliomyelitis and guinea-worm disease (dracunculiasis) will have been eradicated in all countries; leprosy, neonatal tetanus, measles, vitamin A deficiency and iodine deficiency disorders will not represent public health problems; malaria, and tuberculosis will represent lesser public health problems; and prevention and control of major noncommunicable diseases will be elements of public health policy and action.

- In all countries, severe, as well as moderate malnutrition among children under five will be reduced to half of the 1990 level; and iron-deficiency anaemia in women will be reduced by one-third of 1990 levels.

- In all countries, access to primary health care of good quality will be achieved and maintained so that:

  - at least 90% of children under one year of age will be immunized against the six diseases covered by the Expanded Programme on Immunization (diphtheria, measles, pertussis, poliomyelitis, tetanus and tuberculosis);

  - all women of child-bearing age will be immunized against tetanus;

  - all people will have access to adequate and safe water and sanitary means of disposal of excreta;

  - all pregnant women will have access to prenatal care, attendance by trained personnel during childbirth, and referral facilities for high-risk pregnancies and obstetric emergencies;

  - all couples will have access to information and services to prevent pregnancies that are too early, too closely spaced, too late or too many;

  - all people will have access to relevant essential drugs.

- The difference in health status as measured by classical health indicators between socioeconomic groups between and within countries will be reduced by half.

These targets are the minimum that should be achieved by the end of the period covered by the Ninth General Programme of Work. Countries will set more specific national targets in the light of their most

common health problems and/or the problems that have the greatest impact on public health and opportunities for health equity. The setting of such targets by countries reflects that a problem is a priority in the country itself, that effective and affordable technologies exist and that they can be applied in a sustainable way given the skill, knowledge, technical, financial and material resources available.

2.2 Policy directions

2.2.1 Integrating health and human development in public policies

It is well recognized that development - be it economic or social - contributes to health development. This recognition has permeated many international agencies, e.g., the World Bank, UNDP, etc. In recent years, however, there have been instances of narrow economic development which has had adverse effects on the health and social status of the population. Such narrow economic pursuits have led to degradation of the environment and sometimes, through increasing unemployment or recession, to an increase in poor populations which have not profited from the benefits of development. They have too often seen a reduction of their capability to ensure for themselves the prerequisites of health - education, food, clean water, waste disposal, etc. Structural adjustments have sometimes led to decreasing health and social benefits for populations. These consequences of development play against equity, social justice and satisfaction of basic human rights.

The pursuit of economic development alone may obscure the purpose of development, which is to improve the quality of life of all people. Resources to support human and health development are sometimes perceived as expenses. In reality they are investments in the nation's human capital, enhancing people's capability to actively contribute to economic and overall development of societies. Improvement in women's health and well-being is in particular recognized as a necessity for achieving sustainable development. It should also not be forgotten that the health sector is a major employer and generator of economic activities.

WHO will play an important role in drawing attention to the positive and sometimes negative consequences of development not only for health but for the pursuit of social justice of which health equity is a major component. WHO will also be advocating that adequate resources should be allocated to health so that it continues to contribute to development.

Priority will be given to:

- strengthening the capability of the health sector to analyse, comprehend and advocate the interdependence of health and development;
- improving the capability of the health sector to influence the political agenda of all countries with regard to public policies of development and decisions on resource allocations;
- mobilizing resources that exist in countries, within and outside the health sector, as well as international support, to countries most in need and to vulnerable populations.

In cooperating with countries WHO will:

(i) promote policy research to assess the effects of development on health and to evaluate public health actions in terms of socioeconomic development;

(ii) promote the formulation of health and development policies and programmes with particular attention to reducing inequities in health, the important roles and special needs of women, and improving the health status of vulnerable groups;

(iii) support the establishment of national mechanisms for intersectoral policy formulation and implementation in which health supports, and is supported by, human development.

In its international coordinating role, WHO will:

(i) advocate the importance of health in development in international fora and disseminate information about interrelations between health, human development and socioeconomic development;

(ii) cooperate with the United Nations system in all matters related to socioeconomic development;

(iii) mobilize other organizations, especially nongovernmental organizations, to support actions in health and development, particularly for those in greatest need.

2.2.2 Promoting and protecting health

Many of the major health problems both in developing and developed countries are related to life-style and environmental factors. Individual health behaviour can be a matter of personal choice. It is also highly influenced and often determined by social, economic, cultural and physical environments. At one end of the scale is overconsumption, exaggerated risk-taking, abuse of toxic substances, and at the other end is absolute poverty which limits any possibility for a real choice.

Water, air and soil pollution have at all times been threats, especially to those living close to the source. Lately, however, the global dimensions of environmental problems have become clear. The combined effects of pollution, overgrazing and deforestation are felt over the whole globe. They threaten not only the health of the people but also the very survival of the planet as we know it. Uncontrolled fertility is an important cause of ill-health, not only because of the increasing pressure on physical and financial resources, uncontrolled migration to towns and across borders, and social and political instability, but also because of its direct effects on the health of mothers and children.

Nongovernmental organizations and community groups of all kinds at local, national and international levels must be encouraged to act on health matters. Excessive risk-taking should be made socially less acceptable and thereby discouraged. While recognizing the importance of raising people's awareness and motivation for health through information and health education, emphasis should be given to changing the social, economic and environmental factors that make it easier for individuals and people to choose healthy life-styles. It is for example not enough to know about healthy eating: the right food must be easily available at a cost people can afford. An environment must be created that enables people to choose healthy life-styles. Health promotion and protection therefore concerns all sectors of human activity - education, housing, town planning, agriculture, fiscal and price policies, economic policies and legislation.

Priority will be given to:

- developing, in all sectors of human activities, policies which promote safety and improve health, in particular policies which reduce and control health risks, encourage healthy life-styles and make family planning care universally available;

- creating living conditions and environment supportive of health in schools, workplaces, neighbourhoods and homes;

- establishing and reorienting health and health-related policies to enhance people's participation in health and facilitate healthy choices;

- developing and maintaining research capacity on the determinants of health, the factors of social change, the ethical issues, and the economic aspects of health promotion and protection;

- promoting effective prevention and control of environmental health risks, and ensuring ecologically sustainable development.

In cooperating with countries WHO will:

(i) support country programmes aimed at promoting healthy life-styles and behaviour, and at discouraging unhealthy habits such as smoking, and alcohol and drug abuse, through education, information and specific action programmes;

(ii) collaborate in developing programmes within the framework of health care systems, for the promotion and protection of health in vulnerable population groups;

(iii) promote and support programmes for the improvement of the physical environment and the reduction and control of environmental health risks;

(iv) encourage and support the creation of conditions, and networks, for community participation and involvement in health promotion and protection;

(v) collaborate in developing programmes within the health care system to make family planning care available to everyone.

In its international coordinating role WHO will:

(i) advocate the formulation and implementation of international policies, conventions, regulations and programmes which emphasize the promotion and protection of health;

(ii) develop and support research on health promotion approaches and the assessment of health promotive interventions, disseminate scientific and technical information, and ensure international exchange of ideas and experiences;

(iii) validate positive health indicators, data collection methods and information systems for monitoring programme implementation and evaluating health results.

2.2.3 Ensuring equitable access to health services

Globally, there have been significant increases in coverage with some elements of primary health care such as immunization, antenatal care, water supply and excreta disposal facilities. But major inequalities in coverage and in access to care still exist between countries and between communities within countries. Health care systems have not always reached or been accessible to the groups most in need nor addressed priority health problems. Referral mechanisms to ensure access to secondary and tertiary levels of care are often weak or non-existent. This situation has resulted from the lack of integration and coordination, often due to lack of leadership from ministries of health. Quality control of health care has been lacking and the appropriateness of health technologies has often been questionable.

There have been major problems related to the training, distribution and utilization of human resources for health. Too often health workers continue to be trained mainly to implement specific disease-oriented programme activities and to achieve specific targets. Many countries are now reviewing the relevance of the current training of health workers. In some countries, both developed and developing, there is an excess of physicians and a widespread shortage of nurses. It is also not uncommon to encounter a lack of, or underutilization of, health personnel in peripheral institutions, due to lack of incentives to work at district level or to a shortage of equipment, supplies and drugs. At the same time problems in central institutions may arise from gross overstaffing.

Some countries, especially the least-developed, have seen a reduction in their health budgets. However, in all countries there is also less than optimal use of financial, technological and human resources already devoted to the health sector. Priority is not always given to the most important health problems. The activities of the private sector in financing and providing care present a challenge for governments, whose ability to respond properly to the people's needs and to properly manage national resources is now being questioned.

Ministries of health should closely review their responsibilities and their role in providing health care. Promoting health and preventing disease, achieving and maintaining acceptable quality in both public and private health care, strengthening the performance at district level and enabling communities to assume more responsibility in health should all be emphasized.

Enabling communities to assume expanding responsibility for their own health will entail efforts to increase their health management capabilities. Decentralizing intersectoral action to provincial and district levels will require new styles of organization and management. Decision-making and management at various programme levels must emphasize efficiency in administration, accountability to the people, quality and improved performance in service, and should focus on priority problems and vulnerable population groups. A

more comprehensive health information system, relevant to managerial requirements, is needed to support such public health management.

Priority will be given to:

- ensuring access for all communities to health care including the essential elements of primary health care;
- enhancing optimal management of financial and human resources for health;
- ensuring that communities have the capability and opportunity to be actively involved in health development, and that the contribution of sectors other than health and of all potential partners is stimulated and taken into account;
- stimulating the transfer of knowledge about proven, cost-effective technologies and their application where they are most needed and stimulating the sharing of technical and scientific health information.

In cooperating with countries, WHO will:

(i) support the review, further development and implementation of integrated health care at the community level and the necessary referral and support systems (supervision, supplies, etc.), with emphasis on quality and improvement of efficiency;

(ii) strengthen national capacity for mobilization, allocation and use of resources, including adequate measures to improve incentives to work in peripheral health institutions;

(iii) stimulate measures aimed at increasing the development and dissemination of appropriate learning and reference materials, particularly for districts, with emphasis on improving the implementation of primary health care;

(iv) support the redefinition of the roles and responsibilities of the government, private sector and local communities in managing and implementing health care.

In its international coordinating role WHO will:

(i) foster health systems research and facilitate the sharing of findings;

(ii) coordinate the development and implementation of tools for strengthening health and management systems;

(iii) collect and disseminate successful examples of district health systems based on integration of services and community participation;

(iv) advocate the provision of increased resources for health from multilateral and bilateral development agencies;

(v) develop networks of institutions and expertise for the transfer of knowledge to improve the managerial capability at district level.

2.2.4 Preventing and controlling specific health problems

Many countries have shown substantial improvements in coverage with, and access to, affordable, simple and effective technologies for specific health problems. Immunization of children against the six "EPI" diseases is one example. A decade ago the rate of vaccination was about 20%. By 1990, the global average reached 80%. The fall in global prevalence of dracunculiasis from over 10 million in 1985 to three million in 1990 is due to two simple and effective measures: straining all drinking water and preventing contamination of clean water sources. The 50% fall in the number of leprosy cases worldwide during the last seven years is mainly due to multidrug therapy.

Although appropriate preventive, diagnostic, therapeutic or rehabilitative technologies exist to deal with many health problems, many people are still without access to them. Every year, half a million women, almost all of them in developing countries, die from complications of pregnancy and childbirth, although technologies to prevent or treat them exist. Millions of people throughout the world are without access to safe water and basic sanitation. Many neonatal deaths could be prevented by hygienic measures, including clean deliveries and by immunization of mothers against tetanus.

Some age-old diseases continue unabated because existing technologies are not widely available or used. Malaria is an example. Since 1985, the incidence of tuberculosis has increased dramatically, largely because of the AIDS epidemic.

Noncommunicable diseases are responsible for three-quarters of all deaths in the developed countries. In the developing world, as countries enter the middle and final stages of the "epidemiological" transition, these diseases are on the increase. Such countries suffer the double burden of both communicable and noncommunicable diseases, putting added strain on their health system. In both developed and developing countries, injury represents an important cause of disability and death, particularly in the young.

Natural and man-made disasters and emergency situations result in health problems for large numbers of people, often in conjunction with temporary or long-term disruption of health systems.

Priority will be given to:

- preventing and controlling existing and emerging priority health problems for which effective and affordable preventive, therapeutic and rehabilitative technologies exist;

- generating and disseminating information and technology for the prevention and control of important existing and emerging health problems for which effective and affordable means of control are lacking;

- reducing the health consequences of acute and chronic disasters.

In collaboration with countries, WHO will:

(i) strengthen national capacity for health surveillance to enable the analysis of the health situation and trends, monitor the coverage and management of the health system and evaluate the effectiveness of health technology;

(ii) support the development of national health policies to prevent and address priority health problems;

(iii) support the design and implementation of innovative approaches to ensure that effective, affordable and practical interventions are rapidly transferred to and implemented where needed;

(iv) support countries in preparing for and responding to emergencies and disaster situations.

In its international coordinating role, WHO will:

(i) assemble and share information internationally on priority health problems;

(ii) stimulate and support research into the epidemiological transition, causative factors of disease, and programme effectiveness;

(iii) foster and support research on and development of technologies needed for control of current and emerging priority health problems;

(iv) identify and mobilize globally the technical expertise and resources necessary to achieve the major breakthroughs needed in disease control and technology;

(v) undertake the international advocacy needed to raise awareness and action by the international community to support countries in preventing and controlling specific health problems.

2.3 WHO's roles and functions

The two main functions of WHO are technical cooperation with countries and coordinating international health work. In response to changing needs, obstacles and opportunities, WHO has constantly adjusted its understanding of those functions and the ways of fulfilling them. To respond to recent changes, further adjustments are needed for the Ninth General Programme of Work.

2.3.1 Technical cooperation

Technical cooperation in recent general programmes of work has stressed the partnership between the Organization and its Member States needed in order to attain national health goals defined by countries in line with agreed global goals and strategies. It has replaced technical assistance, which was based on a donor-recipient relationship.

The Ninth General Programme of Work will continue to stress true partnership and response to country needs as important elements of technical cooperation. It will put more emphasis on implementing affordable and scientifically proven and effective interventions in order to address national priority health problems, as well as on building up the capability of countries to coordinate, manage and sustain health action. Concerted action to support health development in countries will be ensured through: collaboration among countries themselves, the coordination of the United Nations family and development partners in action for health, and WHO collaboration with countries.

Analysis of experience in previous programmes of work shows that just as there are always problems or obstacles to overcome, so there are opportunities to build upon. In the past, WHO contacts in countries have too often been limited to ministries of health, despite the fact that, according to its Constitution, WHO has direct access to all those who may influence health. During the Ninth General Programme of Work, while keeping ministries of health as its main focal point, the Organization will strengthen its relationship with ministries in other sectors, with levels other than the national level (e.g., regional and local levels), and with public, private and nongovernmental organizations, scientific institutions and professional organizations.

WHO's performance at country level is related to the opportunities and the difficulties in matching the expertise, and social and cultural characteristics of its staff working in countries, to the needs and the political, cultural and social characteristics of countries. It is influenced also by the expectations of countries about what WHO can provide. Too often, the expectations are of funds, supplies and equipment and not technical expertise, which is WHO's mandate and what it can best provide. WHO's planning, resource allocation and management processes do not always provide the flexibility or the authority at country level to reorient its priorities or to reallocate resources in order to address changed national situations or recently emerging problems, or to capitalize on new opportunities for action.

Cooperation with countries is too often poorly integrated. This is due in part to a programme by programme approach in working with countries rather than a country-focused approach integrating the input of all relevant WHO programmes and the different levels of WHO - headquarters, regional and country offices. Countries are also faced with a lack of coordination between the various United Nations specialized agencies and the development funds. Each of them stresses the health problems they identify as priorities and ways to address them without always taking fully into account the country's priorities and needs and internationally agreed policies and strategies.

The Organization will emphasize integrated action at country level within the framework of national health and overall socioeconomic development, with particular focus on local health systems. It will foster mobilization of national and external resources to support national health policy development, programme implementation, and the development of management capabilities at country level. It will support countries in addressing their national health priorities and in coordinating the efforts of external cooperation agencies. It will promote more effective collaboration between countries, and especially among developing countries, to sustain national health development.

In order to make this action more effective WHO will need to review its managerial process.

2.3.2 International coordinating role

WHO's coordinating function in international health work is carried out primarily through the collective action of its Member States. Essentially, it encompasses: the authority to monitor the health situation and trends globally, and to propose norms, standards, conventions and regulations related to health; leadership in establishing international consensus on global priority health problems and ways to intervene, and in stimulating the advancement and application of knowledge and the sharing of information in the field of health; and advocacy with regard to mobilization of international resources and action for health.

During the period of the Ninth General Programme of Work, these functions will continue to be emphasized. Additional weight will be put on: WHO's international conscience role, i.e., in pointing out inequities in health and in stressing the interdependence between health and development, and the Organization's leadership role in building up consensus, especially within the United Nations family and with development partners, on priority health problems and the ways to address them. These responsibilities require WHO to maintain and strengthen its technical expertise and excellence.

An increasing number of United Nations agencies and other international organizations, including nongovernmental organizations, are becoming involved in health. This provides an opportunity to foster action and mobilize resources so as to have greater impact on global health. But it requires a consensus among all partners on the problems to be addressed and on the actions to be taken. It has to be acknowledged that this basic condition does not always exist.

WHO's regular budget has been diminishing in real terms over the past several years. However, the overall level of the WHO budget has been maintained, or even increased, due to voluntary contributions. This provides great opportunity to strengthen WHO action. However, while regular budget resources are used in line with collectively-agreed policies and strategies aimed at meeting countries' priority health problems, extrabudgetary resources may be used more in line with donors' priorities and interests. These sometimes focus on issues popular at a given time, leaving certain crucial issues underfunded or underemphasized. The result may be a dichotomy of priorities and approaches between programmes funded by the regular budget and those funded by extrabudgetary resources. WHO will continue to capitalize on extrabudgetary resources but will at the same time strengthen its capacity to ensure that they are used in line with collectively-agreed priorities and strategies. WHO is accountable to all Member States for the use of these resources.

Priority will be given to providing the leadership in identifying and solving global health problems for which international action is required. This includes the promotion of health research and development and the definition of scientific, technical and managerial bases for health programmes. Mobilization of resources for health and their international transfer will be an important focus. Mechanisms for increasing and coordinating external financing for health from bilateral, multilateral and nongovernmental sources will be developed. Information on health matters and appropriately assessed health technologies, based on an objective assessment, will be generated and transferred.

3. GENERAL PROGRAMME FRAMEWORK

The previous sections have described the major policy directions for accelerating the implementation of Health for All in the period covered by the Ninth General Programme of Work. This section proposes a managerial framework for organizing programmes, activities, services and functions to be developed by WHO at global, regional and country level. The programme framework will be used for grouping WHO activities when preparing the final version of the General Programme of Work, and when preparing the successive programme budgets in the period considered.

3.1 General principles

The programmes developed by the Organization within the Ninth General Programme of Work will comply with the major functions of WHO as defined by Article 2 of its Constitution and elaborated in resolutions concerning WHO functions (WHA23.59, WHA33.17) and the programme budget policy (WHA38.11). Their formulation will be guided by the principles of the Global Strategy for Health for All (WHA34.36) and the Declaration of Alma-Ata.

WHO programmes at all levels will be formulated and implemented in a coordinated manner with a view to providing an integrated response to priority needs at country level, and to facilitate the convergence of other national and international efforts in the field of health.

Programmes will use cost-effective approaches to achieving measurable outputs and outcomes directly relevant to the priority orientations identified in the policy framework.

The processes for WHO programme management will allow for flexibility in the use of the programme classification in order to take into account individual country priorities and regional characteristics, and to make possible adaptations to shifts in priorities during the period considered.

3.2 Criteria for programme formulation

Priorities for WHO programmes are derived both from the policy guidance provided by the governing bodies and from the priority needs identified in each Member State. At each level of the Organization, a proper balance must be achieved between programme activities for technical cooperation and the role of directing and coordinating authority for international health work. The criteria for selecting priorities for WHO action need therefore to be adapted at the different levels, taking into account those endorsed by the Executive Board (EB87.R25). A list of criteria considered as generally applicable is given below.

3.3 Criteria for selecting areas for WHO involvement

(1) The problem is of major public health importance in view of its incidence, prevalence, distribution and severity, or of its adverse sociocultural and economic implications, and cost-effective interventions are available.

(2) The programme is of high social relevance and responds to identified components of national, regional and global strategies for Health for All. In particular, the programme is likely to make a significant contribution to implementing the priority orientations identified in the policy framework.

(3) There is a demonstrable potential for making progress towards solving the problem and for stimulating a multiplier effect at country level, through strategic interventions.

(4) WHO's involvement is required according to its mandate or existing agreements, because WHO is in a unique position to deal with the problem, and/or because international collaboration is required to solve the problem.

(5) WHO is required to maintain technical expertise in the area covered by the programme in order to respond to the needs of Member States, or to act as a technical reference for research on standard setting.

3.4 Criteria for determining the organizational level at which activities should take place

(1) High priority will be given to activities involving all levels of the Organization in a **joint effort** to support health development in countries, particularly countries most in need.

(2) **Country activities** will aim at solving problems of major public health importance in the country concerned, particularly those of underprivileged and high-risk populations; priorities must be identified in consultation between WHO and Member States, and be relevant to the goals of Health for All; activities should benefit sustained implementation of countrywide health programmes within the context of the country's overall health development, and technologies should be cost-effective.

(3) **Intercountry and regional activities** will aim at solving problems which are common to several countries, through the pooling of resources and the sharing of information and experience, facilitating and supporting technical cooperation among countries in the same region, and/or providing specialized technical services to countries.

(4) **Interregional and global activities** will aim at meeting common requirements identified by countries in different regions; facilitating and supporting technical cooperation among countries in different regions; providing specialized support to activities at other levels of the Organization; facilitating international collaboration, coordination and mobilization of resources. The coordinating functions in international health work, e.g., development of international standards, norms, etc., will form a major part. The catalytic support provided by WHO is likely to attract resources from bilateral, multilateral and nongovernmental sources.

3.5 Outline of a WHO programme classification

All WHO's activities should aim at achieving Health for All, according to policy directions described in section 2. In order to facilitate the management of WHO operations, the aggregates of activities and resources used for the attainment of specific objectives have traditionally been organized into groups identified as "programmes".

The experience of the previous general programmes of work has demonstrated the risk of a detailed list of programmes becoming the backbone of all activities in WHO, and sometimes in countries, and leading to a perpetuation of individual programme activities, without further reference to the real priorities of countries and WHO. In order to avoid this risk, it must be made clear that:

(i) the classification of programmes is a managerial tool, subordinated to the four policy directions and the priority orientations given in the policy framework. Programme objectives, approaches and activities should be developed in direct and explicit response to these orientations. Each programme is expected to contribute to more than one policy direction;

(ii) WHO's programme activities must be adaptable to the needs of different countries and regions and responsive to changing priorities. Flexibility must be maintained in order to ensure WHO's ability to respond to changing situations. This can be achieved by using larger groupings than in the Eighth General Programme of Work, and by leaving open the possibility of making different aggregations of programmes when required for ensuring integrated approaches at country level;

(iii) close interaction between programmes will be maintained in order to ensure their complementarity and mutual support in the implementation of the policy orientations, and particularly the support to countries in building up integrated health systems based on primary health care. In particular, each technical programme will show clearly how it contributes to the improvement of capacities within the general health systems.

A proposed draft outline of a WHO programme classification follows.

DRAFT OUTLINE OF WHO PROGRAMME CLASSIFICATION

1. DIRECTION, COORDINATION AND MANAGEMENT

1.1 Governing bodies

1.2 General programme development and management

Executive management; WHO programme development; External coordination (United Nations system, multilateral and bilateral organizations, etc.); WHO management information system ...

2. HEALTH AND HUMAN POLICY DEVELOPMENT

2.1 Public policy and health

Policy analysis; Prerequisites for health; Human rights and ethics; Health legislation; Public information; Leadership for health ...

2.2 Health and socioeconomic development

Intensified support to countries most in need; macro-economic analysis in relation to health; health aspects of sustainable development; women, health and development ...

2.3 Research strategy coordination

2.4 Disaster relief and emergency preparedness

3. HEALTH SYSTEM DEVELOPMENT

3.1 Organization and management of health systems

Health systems based on primary health care (Urban and rural district health systems, Referral systems); Managerial processes; Health systems research ...

3.2 Health situation and trend assessment

3.3 Health care financing

3.4 Human resources for health

3.5 Health care technology

Clinical, laboratory, radiological technology; Drug management; Technology assessment ...

3.6 Health and biomedical information

4. HEALTH PROMOTION AND PROTECTION

4.1 Health promotion

Promotion of healthy life-styles; Health education; Food and nutrition; Mental health; Prevention and control of substance abuse (alcohol, drugs, tobacco) ...

4.2 Family and community health

Maternal and child health; Family planning; Human reproduction research; Adolescent health; Health of the elderly; Workers' health ...

4.3 Environment and health

Water and sanitation; Environmental risk assessment and control; Chemical safety; Environmental health in urban development ...

5. PREVENTION AND CONTROL OF DISEASES AND DISABILITY

5.1 Communicable diseases

Vaccine preventable diseases/immunization; Tropical diseases (Malaria, other parasitic diseases, research on tropical diseases); Diarrhoeal diseases; Acute respiratory infections; AIDS and sexually-transmitted diseases; Tuberculosis; Leprosy ...

5.2 Noncommunicable diseases

Cancer, cardiovascular diseases, other chronic and degenerative diseases ...

5.3 Disability prevention and rehabilitation

Injury prevention; Blindness; Deafness; Rehabilitation ...

6. ADMINISTRATIVE SUPPORT

6.1 Personnel

6.2 General administration and services

6.3 Budget and finance

6.4 Equipment and supplies

4. ELEMENTS FOR CHAPTER ON MANAGEMENT, MONITORING AND EVALUATION

The following suggests that some modifications are needed in the way WHO operates in order to provide appropriate support to countries during the period of the Ninth General Programme of Work. WHO is faced with two important considerations. The first is its commitment to strengthening its performance at country level. The second is the increasing importance of extrabudgetary resources within its overall budget.

At the moment, WHO's programmes of work cover a six-year period. Their development begins five years before the first year of their implementation. Furthermore, the biennial programme budgets plan the allocation of resources to programmes close to three years before they are implemented. This approach to planning and resource allocation does not provide the necessary flexibility to reorient activities at country level, in the light of changing situations, to quickly respond to new or emerging health problems, or to capitalize on new opportunities. Furthermore, at such an early stage, the amount and commitment of extrabudgetary resources are not known.

WHO's managerial process will be reviewed with the following orientations in mind:

1. To be less detailed at the planning stages but to strengthen monitoring and evaluation so as to be accountable to the governing bodies for the use of both regular and extrabudgetary resources.

2. To strengthen accordingly the programme management information system to enable not only the monitoring of the use of all financial resources but also, and mainly, the monitoring and evaluation of programme implementation so that information on past experience and performance can be better used in the planning process.

3. To develop the budgetary and the programme implementation process to allow for greater flexibility and integration of WHO programmes at country level.

This review and any subsequent reorientation will also need to take account of the recommendations of the regional committees, the Working Group of the Executive Board on WHO's Response to Global Change, the Programme Committee of the Executive Board and the Executive Board.

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