MINISTRY OF FOREIGN AFFAIRS OF DENMARK
DANIDA | INTERNATIONAL DEVELOPMENT COOPERATION

Danish Organisation Strategy

for

World Health Organization

2014-2019

July 2014

1. Objective

The World Health Organization (WHO) is the United Nations specialised agency for health, established on 7 April 1948. As set out in the WHO Constitution, the objective of the organisation is to attain the highest possible level of health for all people. Health is defined in the WHO Constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

WHO provides leadership on global health matters and is responsible for shaping the health research agenda by setting norms and standards, articulating evidence-based policy options providing technical support to countries as well as monitoring and assessing health trends.

Danish support to and cooperation with WHO is shared between the Ministry of Health (assessed contribution) and the Ministry of Foreign Affairs (voluntary contribution). This strategy for the cooperation between Denmark and WHO for 2014-2019[1], forms the basis for the Danish voluntary contributions to WHO[2], and is the central platform for the Ministry of Foreign Affairs' dialogue and partnership with the organisation. It sets up Danish priorities for WHO's performance within the overall framework established by WHO's own strategy, the Twelfth General Programme of Work (2014-2019). In addition, it outlines specific goals and results that Denmark will pursue in its cooperation with the organisation. Denmark will work closely with like-minded countries towards the achievement of results through its efforts to pursue specific goals and priorities.

2. The Organisation

2.1 Basic Data and Management Structure

WHO works together with governments, health authorities, civil society, universities and research centres to create greater access to basic health services for the public, including poor and vulnerable population groups. The organisation also works to build up the competencies of developing countries to take care of the health need of their own citizens, and it continues to play an important role in the supervision and control of epidemics.

Established	1948
HQ	Geneva
Director-General	Dr Margaret Chan
Budget for 2014-2015	USD 3.98 bill. (assessed and voluntary)
Danish MFA voluntary contribution in 2014	DKK 30 mill. (appr. USD 5.6 mill.)
Danish Assessed contribution MoH in 2014	USD 3.14 mill. (appr. DKK 17 mill.)
Human Resources	Approx. 8.000
Country offices	150 countries
Denmark member of Executive Board	May 2006 – May 2009
World Health Assembly	May
EB sessions	January & May

WHO is a specialised agency within the United Nations system. WHO is governed by its 194 Member States through the meeting of the World Health Assembly (WHA) held annually in Geneva. The WHA is supported by the Executive Board which comprise 34 individuals qualified in the field of health, and designated by Member States to serve on the Executive Board for three-year terms. The board advises the WHA and facilitates its work.

At global level WHO headquarters based in Geneva is responsible for the overall management and administration of the organisation. At regional level the organisation is divided into six regions with a regional office for each; WHO African Region, WHO Region of the Americas, WHO Eastern Mediterranean Region, WHO European Region (based in Copenhagen), WHO South-East Asia Region and WHO Western Pacific Region. The regional offices are fairly independent and their directors are appointed by the Executive Board in agreement with the Director General. At country level WHO operates in 150 countries, territories and areas.

Through a renewed country focus WHO seeks to improve performance at the country level according to needs. Each country develops a country cooperation strategy to guide its work. The regional offices oversee this work and provide technical assistance to country offices as required.

[1] WHO's twelfth General Programme of Work 2014-2019, Biennial Programme and Budget: 2014-2015, 2016-2017 and 2018-2019.
[2] Under FL §06/Development Cooperation.

2.2 Mandate and Mission

WHO is a leading organisation for the promotion of global health and development. Broadly it has two roles; a normative (e.g. establishing standards) and a developmental (e.g. providing technical assistance to developing countries on health systems). WHO's primary aims are to maintain, secure and improve the state of health in the world.

The core functions of WHO are:

- To provide leadership on matters critical to health and engage in partnerships where joint action is needed
- To shape the research agenda, and stimulate the generation, translation and dissemination of valuable knowledge
- To set norms and standards, as well as promote and monitor their implementation
- To articulate ethical and evidence-based policy options
- To provide technical support, catalyse change and build sustainable institutional capacity
- To monitor the health situation and assess health trends.

The vision and work of WHO are guided by the twelfth general programme of work, supplemented by biennial program budgets, the current covering 2014-2015. The general programme of work and the program budget have goals on both impact and outcome level. Of the six priorities that guide WHO's work five relate to health: Communicable diseases; Noncommunicable diseases (NCDs); Promoting health through the life course; Health systems, and Preparedness, Surveillance and response; and one relates to governance: Corporate services and enabling functions. An overview of the six priorities can be found in annex 1.

The normative and standard setting work of WHO is a prerequisite for the work carried out by the UNFPA, Global Fund, UNAIDS and other multilateral organisations addressing health and equity issues. WHO is both a co-sponsor of UNAIDS and provides technical support for prevention, treatment and medical supplies to the organisation. In May 2014 WHO and Global Fund signed an agreement on WHO technical assistance to the development of Global Fund country concept notes as part of the roll out of the "Global Fund New Funding Model". Furthermore, WHO works closely with other UN agencies and external partners to mobilise political will and material resources. WHO's role in providing technical assistance and guidance to countries is crucial in order to advance sustainable health development at country level.

The two-year budget for 2014-2015 is USD 3.9 billion or at the same level as in 2012-2013. Denmark's joint, assessed and voluntary, contributions amount to approximately 0.22% of the total budget.

2.3 Mode of Operation and Results so far

WHO has contributed to substantial progress in achieving the health related 2015-goals: Reducing child (MDG4) and maternal mortality (MDG5) as well as reducing morbidity and mortality from HIV infection, tuberculosis and malaria[3] (MDG6). More specifically, WHO contributed to; a reduction in the number of under-five deaths from 7.6 million in 2010 to 6.6 million in 2012, a continued fall in Malaria cases setting 50 endemic countries on track to reach targets by 2015, and implementation of a rapid diagnostic test for Tuberculosis in 77 countries ensuring screening for TB in 4.1 million HIV infected. Moreover new AIDS related guidelines have been implemented to reduce partner transmission.

Furthermore, the work towards universal health coverage (UHC)[4] is progressing, thus in 2012 a third of all member states requested technical assistance from WHO on health financing in moving their health systems towards UHC. In discussions on the post-2015 UN development agenda WHO has initially proposed that UHC is included as an overarching health goal to address the global health challenges.

[3] World Health Organization: *WHO Achievements 2012*: http://www.who.int/about/resources_planning/2012achievements.pdf.

[4] *"Universal health coverage (…) combines two fundamental components: Access to the services needed to achieve good health (promotion, prevention, treatment and rehabilitation, including those that address health determinants) with the financial protection that prevents ill health leading to poverty.",* Twelfth General Programme of Work p. 17.

In order to target health inequities WHO focuses on social determinants of health that account for differences in health status within and between countries. Thus in 2012 the World Health Assembly adopted a resolution endorsing the Rio Political Declaration on Social Determinants of Health.

2.4 Effectiveness of the Organisation

The Danish multilateral analysis[5] states that WHO remains highly relevant for overall poverty reduction, advancement of social progress and achievement of health related MDGs. However, in general the continued effectiveness and relevance of WHO will require a successful reform process, with bold steps to focus and strengthen institutional priorities and efficiency at all levels of the organisation (HQ, region and country offices). One of the major challenges arises from the underfunding of some areas (e.g. the Danish priority areas Sexual and Reproductive Health and Rights, and Gender, Equity and Human Rights Mainstreaming) due to earmarked funding from the majority of donors. As a member State-driven organisation, where reform issues will be the subject of inter-governmental processes, it is to be expected that advancing on the reform program will be a long term process. Danish disappointment with the slow progress of the reform, especially underfunding of Danish priority areas and overall misalignment between strategic objectives set and resources, led to the decision to decrease Danish voluntary commitment from 2014. Efforts to improve the alignment have been made, thus, WHO has taken on annual financing dialogues and established a web portal to allow for more transparency and preferably better alignment of funds.

WHO's engagement in and commitment to the 'Delivering as One' agenda has historically not been perceived as strong, and doubts as to the usefulness of the system and of UN coordination has been indicated by WHO. In the Program-Budget for 2014-2015 WHO has now included its share of the joint coordination costs (the Resident Coordinator system). However, continued encouragement to ensure that all tree levels of the organization are fully committed to UN coherence and coordination will be needed.

The 2013 MOPAN assessment of WHO reaffirmed the need for ongoing reforms and points to the not yet fully developed results culture at all levels of the organisation. Overall the MOPAN conclusion is that the limitations in the WHO framework and systems to report on organisation-wide expected results make it challenging to understand WHO's performance story fully and identify its contributions to each of its strategic objectives. The assessment states that WHO's commitment to organisational development is likely to improve the organisations effectiveness and efficiency, although the assessors find that it is too early to conclude on the full effects.

The assessment also finds that on the strategic management level WHO works well towards mainstreaming gender, equity and human rights by launching an approach that establishes performance standards for these areas. Also when it comes to WHO's pragmatic work regarding mainstreaming of gender equality the assessment rates WHO's performance as adequate or above. On an operational management level allocation of funding needs to be made more transparent and consistent. The lowest ranking area in the MOPAN assessment is for results-based budgeting, however, as part of the reform WHO will continue to implement a new results-based budgeting system (RBB) during 2014.

A Norwegian assessment from 2013[6] agrees with the overall positive assessment of WHO, but also points out that the organisation needs to continue the reform process to give more transparency and easily measurable indicators of success. It furthermore states that WHO continues to be the leading coordinating body for health. UK Aid (DFID) undertook a large review of multilateral aid[7] in 2011, which was updated end 2013. The update concluded that WHO now has better information about its use of resources and its programmes, but that further progress is needed on improving performance management systems, particularly for staff and results. The assessment concludes that WHO show weak contributions to results but that the organisation has made reasonable progress in this area. Moreover the assessment states that WHO gives adequate value for money for UK Aid.

[5] Danida 2013: *Danish Multilateral Development Cooperation Analysis*. Copenhagen, April 2013.
[6] Utenriksdepartementet. *Vurdering av 29 multilaterale organisasjoner*. Oslo, October 2013.
[7] DFID 2012: *Multilateral Aid Review* and *Multilateral Aid Review Update: Driving reform to achieve multilateral effectiveness*. December 2013.

3. Key Strategic Challenges and Opportunities

3.1 Summary of Preparatory Analysis

Relevance and Justification of Future Danish Support

Support to WHO is fully in line with *The Right to a Better Life*, the Strategy for Denmark's Development Cooperation, especially the thematic priority area "Social Progress". WHO has a key role in international efforts to strengthen social protection, particular for poor and vulnerable groups and to promote sexual and reproductive health and rights, including the fight against HIV/AIDS.

The basic principles in WHO's Constitution have a strong focus on human rights. It 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". This is echoed in General Programme of Work which also has a clear overarching focus on equity, social justice and gender equality. The Constitution further underlines that Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures. Given WHO's primary role at country level in advising and supporting governments, the main human rights-focus is on the duty bearer perspective. However if part of WHO's dialogue and cooperation with governments includes aspects of increasing accountability, transparency, participation and inclusion, this will help the rights-bearers to claim their rights.

In relation to the broader development agenda incl. green growth, better health is seen as; a precondition for, an outcome of, and an indicator of all three dimensions of sustainable development. WHO emphasises that a healthy environment is a prerequisite for good health. Furthermore, healthy people are better able to learn, be productive and contribute to their communities. Action on the social and environmental determinants of health, both for the poor and the vulnerable and the entire population, is important to create inclusive, equitable, economically productive and healthy societies.

The interdependence between health and peace and security is underlined in WHO's Constitution which states that "The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States".

Major Challenges and Risks

Many of the challenges and opportunities that the world faces have direct implications for global health. In its twelfth Programme of Work, WHO lists the following as central issues; a continuing economic downturn, rapid unplanned urbanization, the demographic dividend, the fragmentation in global health partnerships and actors, as well as the global environment, incl. climate change, under pressure.

Continuing economic downturn with decreases in public spending both nationally and for development aid might have negative impact on basic service, including health, and thus WHO might experience increasing challenges in achieving especially the impact (disease related) goal set for the Global Program.

With the current MDGs, three out of eight goals have focussed on health: Reducing child (MDG4) and maternal mortality (MDG5) as well as reducing morbidity and mortality from HIV infection, tuberculosis and malaria (MDG6). This has created international attention on health on the development agenda and provided a good basis for WHO's work. However, WHO has also been challenged by the often vertical approaches and numerous competing partnerships and initiatives. WHO has been contested in its role as the convening and leading health and development organisation.

From the discussions and papers on the development of the post MDG-framework, so far, it has generally been accepted that health will form part of the new agenda. However, health may become a smaller part of a broader development agenda relatively speaking, at least in regard to the number of goals. WHO has suggested UHC as the overarching health goal, while others have suggested "Ensure healthy lives"[8]. The broader scope of the new goal (and targets) will make it even more obvious that horizontal, integrated

[8] The UN's High Level Panel of Eminent Persons on the Post-2015 Agenda.

health services are key to achieving results, leaving WHO with its focus on health systems strengthening in a possibly stronger positions.

On the other hand, if WHO is not successful in its reform, and especially in ensuring full alignment between agreed strategic objectives and resources, donors and partners might lose faith in WHO and its leadership in global health. Health system strengthening has been one of the constantly underfunded areas in recent years, and even though the budget for 2014-2015 has been increased, full funding is not ensured. Other areas are also at risk for underfunding due to the large amount of earmarked voluntary funding (approx. 75%).

The increasing opposition to the sensitive issues of Sexual and Reproductive Health and Rights might also increasingly hamper WHO's work. Not all countries support the inclusion of people whose sexual practices may be socially unacceptable or even forbidden by national laws. In some countries the opposition to inclusion is vocal, widespread and sometimes violent. Attempts to discuss discrimination in access to health services based on gender identity and sexual orientation have so far not been very successful at WHO board meetings and at WHA.

4. Priority Results of Danish Support

The priority results defined for Denmark's interaction with WHO are determined by the Strategy for Denmark's Development Assistance - The Right to a Better Life. The strategy emphasises that Denmark's overriding aim in international development cooperation is to fight poverty and promote human rights.

In accordance with the strategy, Denmark will place issues of human rights and access to social services higher on the agenda in multilateral forums and be at the forefront of international efforts to promote sexual and reproductive health and rights. Through a stronger multilateral engagement in social sectors, Denmark will contribute to creating synergy, attracting new funding and thereby contributing more effectively to raise the quality of social development and access to social services. Denmark will promote the integration of a human rights-based approach in the multilateral organisations and actively fight the growing political and religious pressure against sexual and reproductive health and rights.

In line with the Paris Declaration it is Denmark's aim to concentrate efforts on furthering those objectives of the organisation that provide the best fit with Denmark's intentions. Within the six categories defined in the General Programme of Work (see Annex 1) Denmark will focus on the following three categories: *Promoting health through the life course; Health systems and Corporate services and enabling functions*. More explicitly, Denmark will concentrate its work in WHO in the following four focus areas:

A. Continued Institutional Reform Process

WHO has taken on an extensive reform process to ensure that the organisation is ready to address the increasingly complex challenges of health. The reform aims at improving the programmatic, governance and management works of WHO, as defined at the 64th World Health Assembly and the Executive Board's 129th session.

Improving strategic planning and resource coordination are key issues for Denmark. So far, approximately 75% of the voluntary contributions to WHO have been earmarked specific programs often not aligned with agreed overall priorities. This is obviously a major challenge for the organisation in the implementation of the agreed strategic objectives, where some areas are constantly underfunded, including Danish priority areas such as sexual and reproductive health, health systems strengthening and the prevention and control of Non-Communicable Diseases (NCDs). It undermines the organisations efficiency, effectiveness and, thus, its ability to achieve the set goals. It also becomes a discouragement for countries like Denmark who has made its voluntary contributions fully flexible (un-earmarked).

Denmark will support WHO's efforts to ensure that income and expenditure are fully aligned with agreed priorities and health needs of Member States, including by continued engagement in the new Financing Dialogue. To facilitate this dialogue, WHO has developed a web portal which displays how the incoming contributions are dedicated to different programme priorities and their according budget lines in 2014-2015. The Web portal which is still being developed is a huge step in the right direction, including when it comes to increasing the transparency. By March 2014, the web portal revealed that in total donors had pledged to cover 75% the 2014-2015 budget (87% incl. projections). However, pledges were still unevenly aligned to the agreed priorities.

B. Sustained Efforts to Fight Corruption and Managing Risks

The management reform also aims at improving transparency, accountability and risk management across the organisation. To this end, WHO has established a new office for Compliance and Risk Management and Ethics. Denmark will follow WHO's efforts towards putting in place an organisation-wide risk management framework, ensuring response plans in place for all corporate risks, developing a new evaluation policy as well as the promotion of ethical behaviour and fairness. While cases of misuse occur, the largest risk is perceived as programmatic risk. This is closely linked to the high ratio of voluntary, earmarked contributions.

C. Strengthening of Health Systems

Strong health systems are the enablers for good health in countries and critical for well-functioning health programmes. WHO has a key role in supporting countries to strengthening their health systems to ensure

increased and better access for the more than one billion people who can currently not obtain the health services they need. All countries should have a comprehensive national health sector strategy with goals and indicators. Furthermore regular reviews and evaluations are needed to ensure plans are successfully implemented or updated if needed. Denmark considers Health System Strengthening the best way to improve health for the poor in a sustainable way, and will support WHO's efforts in this area.

D. Integrating Gender Equity and Human Rights

WHO has embarked on a synergistic approach as the basis for its institutional mainstreaming of gender, equity and human rights. The aim is to increase intersectoral policy coordination and mainstreaming. Denmark will follow WHO's efforts to ensure that all WHO offices and programmes have integrated gender, equity and human rights into routine strategic and operational planning, and put in place evaluation processes to measure gender, equity and human rights in WHO programmes, including by ensuring that more countries provide key health data., Denmark will encourage WHO to further strengthen synergies between sexual and reproductive and other relevant programmes, including by providing integrated policies and packages of interventions with maternal, new-born, child, and adolescent health interventions and other public health programmes as well as by developing evidence based norms, standards, and tools for scaling up equitable access to quality care services within a rights and gender based framework.

Denmark's Participation in the Work of WHO

Denmark will seek to maximise its influence in the above priority results areas also through bilateral discussions with other like-minded members and constituencies. The on-going coordination between the Nordic countries[9] and the EU member states and the EU-Delegation in Geneva will be key avenues for Denmark's efforts to influence the WHO-agenda. To this end, close coordination among national Danish authorities involved in health matters as well as dialogue with Danish CSO and other non-state actors will continuously be pursued.

Monitoring and Reporting

In accordance with the new multilateral guidelines[10], Denmark will use WHO's own monitoring and reporting framework, including the financial reporting, and not produce specific Danish progress reports. The indicator framework that forms part of WHO's twelfth General Programme of Work contains seven health impact goals and 30 outcome goals covering the six categories of the programme (see Annex 2). Within this framework, the Mission will report on developments regarding the key priority results defined in the present Organisation Strategy namely: A. Continued Institutional Reform Process; B. Sustained Efforts to Fight Corruption and Manage Risk; C. Strengthening of Health Systems; and D. Integrating Gender Equity and Human Rights.

This reporting will draw on WHO's Annual Reports to the WHA and Executive Board. In addition, the Mission will continue to report on thematic and other meetings as well as consultations in Geneva with WHO within Danish priority areas and on relevant evaluations and assessments.

The Danish UN Mission in Geneva will carry out a mid-term review to assess progress in pursuing the goals and the key priority results defined in the present organisation strategy as well as challenges, development in risk factors, and possible needs for adjustment. The review should serve as quality assurance of the monitoring of the relationship with WHO rather than an assessment of the performance of the organisation.

WHO will report on their own mid-term review (of 2014-2015 programme and budget) in 2015, thus, the Mission's review will be carried out following this. The review should include input about WHO's work at country level from relevant Danish embassies. It will be distributed widely in the MFA and be sent for information to the Council for Development Policy.

[9] The Nordic countries have an informal constituency; currently none of the Nordic countries hold a seat in the EB.
[10] Ministry of Foreign Affairs: *Guidelines. Management of Danish Multilateral Development Cooperation*. Copenhagen, December 2013.

5. Preliminary budget overview

The budget allocated for the Danish contribution for WHO in the coming four years is shown in the table below:

Table 1 Indicative budget for Denmark's engagement with WHO[11]

Commitments in DKK millions	2014	2015	2016	2017	2018	2019
Core funds	60		60		60	
Earmarked funds						
Totals	60		60		60	

WHO is financed by assessed contributions payable by member states, and voluntary contributions provided by Non-state and State actors, with USA, United Kingdom and Japan being the largest bilateral contributors. Bill and Melinda Gates Foundation is currently the overall second largest contributor to WHO and is expected to become the largest soon.

The Danish commitment amounted to DKK 80 million in 2012-2013, but has been lowered from 2014-2015. Thus, the two-year Danish core commitment to WHO now amounts to DKK 60 million with an annual disbursement of DKK 30 million. WHO's proposed budget for 2014-2015 amounts to USD 3,977 million to be allocated to the six priority categories (Communicable diseases, Non-communicable diseases, Promoting health throughout the life-course, Health systems, Preparedness, surveillance and response plus Corporate services and enabling functions).

As mentioned, WHO's income comes from both assessed contributions and voluntary contributions. The Danish Ministry of Health pays the assessed contribution, currently amounting to 6.3 million USD for 2014-2015, a little less than in 2012-2013.

In 2013, Denmark ranked 19th largest contributor of voluntary funds for all member states and 37th largest voluntary contributor for all contributors (including Foundations, UN Agencies, etc.).

[11] The numbers for 2015-2019 are preliminary and subject to parliamentary approval.

6. Summary Results Matrix

In accordance with the Paris Declaration and subsequent international agreements on aid effectiveness Denmark wishes to monitor the results of WHO's work by using the organisation's own Monitoring and Evaluation Framework. In chapter 4 the priority results of Denmark's support to WHO have been spelled out; the present chapter displays a selection of those WHO indicators that are believed to be the best match with the Danish priority results.

Danish Priority Result A: Continued Institutional Reform Process		
Indicator	**Target**	**Remarks**
Financing and resource allocation aligned with priorities and health needs of the Member States in a results-based management framework	100% alignment of income and expenditure with approved programme budget by category and major office	Baseline: not fully aligned
Greater coherence in global health, with WHO taking the lead in enabling the many different actors to play an active and effective role in contributing to the health of all people	Having at least high level of satisfaction of stakeholders with WHO's leading role in global health issues in stakeholder survey 2015	Baseline: High in 2012 stakeholder survey

Danish Priority Result B: Sustained Efforts to Fight Corruption and Manage Risk		
Indicator	**Target**	**Remarks**
WHO operates in an accountable and transparent manner and has well-functioning risk-management and evaluation frameworks	100% of corporate risks with response plans approved and implemented by 2015	Baseline not applicable

Danish Priority Result C: Strengthened Health Systems		
Indicator	**Target**	**Remarks**
National health policies, strategies and plans	135 countries with a comprehensive national health sector strategy with goals and targets updated within the last 5 years by 2015	Baseline (2013): 115 countries
Health system, information and evidence	112 countries reporting cause of death information using the International Classification of Diseases, 10th revision by 2015	Baseline (2013): 108

Danish Priority Result D: Gender equity and Human Rights		
Indicator	**Target**	**Remarks**
Gender equity and human rights integrated into the Secretariat's and countries' policies and programmes		Evaluation processes are in place to ensure gender, equity and human rights are measured in Secretariat programmes
Reproductive, maternal, new-born, child and adolescent health	320 million women using contraception for family planning in the 69 poorest countries by 2015	Baseline: 260 million

Annex 1

Danish priority results are placed within the categories highlighted in blue.

Table 2: The six priority categories for WHO's Program Budget 2014-2015

Category	Subject	Remarks
1	**Communicable diseases**	**WHO work with countries to increase and sustain access to prevention, treatment and care for HIV, tuberculosis, malaria and neglected tropical disease, and to reduce vaccine-preventable diseases.**
2	**Noncommunicable diseases (NCDs)**	NCDs, violence, and injuries are collectively responsible for more than 70% of deaths worldwide, with the majority occurring in low- and middle-income countries.
3	**Promoting health through the life course**	Cutting across all the work of WHO is the promotion of good health through the life course, which takes into account the need to address environment risks, social determinants, gender equity and human rights.
4	**Health systems**	WHO support countries in the strengthening of health systems, and monitors regional and global health system information. Reliable and updated health information and evidence are crucial in the allocation of health resources. WHO works with countries to improve sharing and use of high-quality knowledge resources.
5	**Preparedness, surveillance and response**	WHO helps countries to strengthen their capacities in prevention, preparedness, response and recovery to achieve health security for all types of hazards, risks and emergencies that pose a threat to human health.
6	**Corporate services and enabling functions**	Corporate services provide the enabling functions, tools and resources that make all of this work possible, thus the funding and management of these services is crucial to the rest of the work done by WHO.

Annex 2

The following show all the impact and outcome goals of WHO's twelfth General Programme of work (2014-2019). Danish priority results are highlighted in blue.

Figure 1 Impact goals, twelfth General Programme of Work

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

Figure 2: Outcome goals, twelfth General Programme of Work: Communicable diseases

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

Figure 3 Outcome goals, twelfth General Programme of Work: Noncommunicable diseases

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

Figure 4 Outcome goals, twelfth General Programme of Work: Promoting health through the life course

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

Figure 5 Outcome goals, twelfth General Programme of Work: Health systems

Category	Programme area	Outcome	Outcome indicator	Baseline	Target
4	National health policies, strategies and plans	All countries have comprehensive national health policies, strategies and plans updated within the last 5 years	Number of countries that have a comprehensive national health sector strategy with goals and targets updated within the last 5 years	115 (2013)	135 (2015)
	Integrated people-centred health services	Policies, financing and human resources are in place to increase access to people-centered integrated health services	Number of countries that are implementing integrated service strategies	50 (2014)	65 (2015)
			Proportion of countries facing critical health workforce shortages	30% (2006)	20% (2014)
	Access to medicines and health technologies and strengthening regulatory capacity	Improved access to and rational use of safe, efficacious and quality medicines and health technologies	Availability of tracer medicines in the public and private sectors	48% (2011)	80% (2015)
	Health systems, information and evidence	All countries have properly functioning civil registration and vital statistics systems	Number of countries that report cause of death information using the International Classification of Diseases, 10th revision	108 (2013)	112 (2015)

Figure 6 Outcome goals, twelfth General Programme of Work: Preparedness, surveillance and response

5	Alert and response capacities	All countries have the minimum core capacities required by the International Health Regulations (2005) for all-hazard alert and response	Number of countries meeting and sustaining International Health Regulations (2005) core capacities	80 (2013)	195 (2016)
	Epidemic- and pandemic-prone diseases	Increased capacity of countries to build resilience and adequate preparedness to mount a rapid, predictable and effective response to major epidemics and pandemics	Percentage of countries with a national strategy in place that covers resilience and preparedness for major epidemics and pandemics	40% (2011)	50% (2015)
	Emergency risk and crisis management	Countries have the capacity to manage public health risks associated with emergencies	Percentage of countries with minimum capacities to manage public health risks associated with emergencies	Not applicable	80% (2019)
	Food safety	All countries are adequately prepared to prevent and mitigate risks to food safety	Number of countries that have adequate mechanisms in place for preventing or mitigating the risks to food safety	116/194 (2013)	136/194 (2015)
	Polio eradication	No cases of paralysis due to wild or type-2 vaccine-related poliovirus globally	Number of countries reporting cases of paralysis due to any wild poliovirus or type-2 vaccine-related poliovirus in the preceding 12 months	8 (2012)	0 (2019)
	Outbreak and crisis response	All countries adequately respond to threats and emergencies with public health consequences	Percentage of countries that demonstrated adequate response to an emergency from any hazard with a coordinated initial assessment and a health sector response plan within five days of onset	Not applicable	100%

Figure 7 Outcome goals, twelfth General Programme of Work: Corporate services and enabling functions

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