



PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION



134th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 21-25 June 2004

Provisional Agenda Item 4.7

CE134/15 (Eng.)

2 June 2004

ORIGINAL: ENGLISH

WHO's 11th GENERAL PROGRAM OF WORK, 2006-2015

1. The current general program of work of the World Health Organization ends in December 2005. It is intended that the 11th General Program of Work (GPW), which will cover the period 2006 to 2015, will present a long-term strategic vision for health and development and provide broad direction to the work of the Organization as the leader in global health and development. The longer time period of this GPW than the previous programs of work is intended to allow for full planning and delivery of the Millennium Development Goals by 2015.
2. The forthcoming WHO General Program of Work (GPW) will be a unique document in several manners. For the first time, it will cover a ten year period. This is significant in that it provides a long-term strategic look at the world and the place of health rather than a short-term status of public health. This is considered necessary as health, either of an individual or of a population, does not exist outside the co-influence of national economies, development, national security, foreign policy, among others.
3. Second, the 2006-15 GPW would use the tools for futures thinking and action, involving forecasting trends, exploring alternative scenarios on the future of health, establishing preferred futures and shared visions, and formulating strategies to achieve the visions in light of the scenarios. It will also revisit the roles various players in global public health, including WHO need to play in response.
4. The GPW may be seen not as a New Vision for achieving health, but rather as a road map laying out different routes toward health. It would however, incorporate the values of other visionary work, such as Health for All and the Millennium Development Goals, as well as concrete issues as documented in the recent World Health Reports, and publications by the World Bank and other partners and academic institutions. Member states, WHO secretariat, NGOs and even corporate sector companies could all see themselves as drivers of vehicles of change as they read and consider the GPW. As each organization plays a distinct role, their path will alter accordingly with each impacting the other.

5. The development of the GPW it is hoped, will involve WHO staff at all levels as well as consultation with partners, member states, and external ‘futures’ and other experts. The preliminary phases of development include information gathering and literature searches to discover what processes and documents exist in public health and other disciplines to provide models for the GPW. Discussions with regional offices are expected to occur early on to learn about similar exercises and consultations and work that have either already taken place or are being planned and examine how they may complement the GPW model and vice-versa. Private organizations that specialize in future modelling will also be researched to assist in the process.

6. After adequate background is ascertained, consultations/workshops with each region will be conducted to gain perspective on issues relevant to the scenario building. These could be dynamic conversations, designed around the premise of creative thinking. To create a GPW that inspires the global community, we hope to be able to depart from our standard ways of thinking and responding to the situation of health and develop ingenious models of action and roles for WHO which influence health. The latter phases of development would aim at converging the previous work into a coherent document. Along with internal consultation and consultation at regional level, global discussions may be held in well positioned strategic groups so that WHO is seen as an open and inclusive organisation, learning from partners.

7. The process of the development of the GPW is seen as being as significant and strategic for WHO as the document itself. The formulation of questions and hypothetical situations, it is hoped, would lead to broader discussions of organization positioning, the relevance of targets, and the synergistic and strategic direction of all contributors to global public health.

8. The GPW should not be viewed simply as a planning document for WHO, even though it would be a Strategic document for WHO, charting out the possible future directions for the Organisation. The questions posed in the GPW could be designed to both ignite ‘out-of-the-box’ planning discussions and serve as a reference/reflection document as the future actually unfolds and WHO’s role in the comprehensive view of health as a global issue evolves. The process to create the GPW would aim at not being ‘business as usual’, so nor would perhaps its utilization —both inside or outside the organization.

9. The outline document (Annex 1) is structured in 3 parts and 6 chapters. Each chapter includes the objective and the rationale for the chapter. It lists main issues to be covered in each chapter and possible issues/questions to be addressed (specific consultations, inputs from other papers/processes or specific reviews). The overall structure of the document will undergo changes as the work progresses.

10. The process paper (Annex 2) provides the main milestones in the development of the GPW.

11. This item has been included on the agenda of the Executive Committee to provide an opportunity for consultation in the Region of the Americas early in the process of the formulation of the 11th GPW. It is intended to continue having this item on the agendas of the Directing Council in September, so the discussion on this topic and the regional inputs of Member States are maximized.

Annexes

Annex 1



11TH GENERAL PROGRAMME OF WORK

DRAFT OUTLINE (1/06/2004)

2006-2015

Options for Working Titles

“Towards a Healthier World”	“Making Health a Priority”
“Choosing Health”	“Influencing Health”
“Transforming Health”	“Achieving the Health related MDG”
“Making the World more Healthy”	“Preparing for Health”
“Putting Health at the top of the Development Agenda”	

Foreword by the Director-General

The foreword will present the GPW and focus on the principle goals of WHO. Making health a priority, with other competing demands is a moral and ethical choice that the world is facing. The forward will focus on the benefits of health for all and on the need to ensure that health development benefits everybody in the world and that health inequalities decrease within and between countries. It will highlight the need for urgency in terms of achieving the MGDs, as internationally agreed goals within a much broader health and development agenda.

Vision of the GPW

Objective: To give an overview of the design and intent of the GPW. This section will be brief, but also contain elements of what the GPW is and is not (e.g. exercise of creating strategy, not implementing it; framework of health for others to consider their role within, rather than a WHO planning document; incorporating other models rather than creating a new vision, etc.); how it should be used and by whom; the wisdom behind and application of the scenarios approach; and, briefly, the development process. This section will also look at how the GPW has been used in the past and how the structure of the 2006-2015 GPW leads to a different *objective* as explained in the cover note.

Part I - Health: a global concern

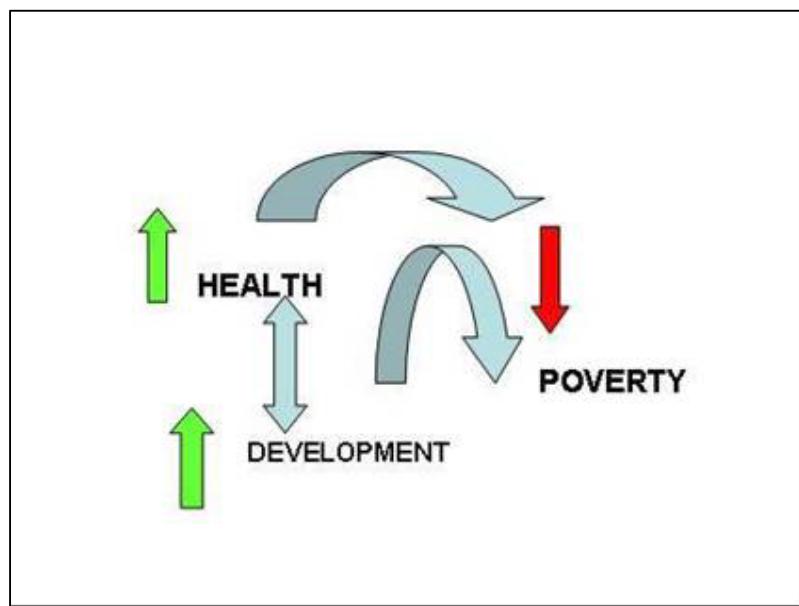
Chapter 1: The Position of Health

Objective of the section: To reaffirm the basic definition of Health (as stated in the WHO constitution) and to clearly position public health within the broad development context.

Rationale: The position of health and our understanding of it have evolved over time. Today different people/groups have a different understanding of the role of health in the present context, and what needs to be done to maintain and to improve it. It is important for WHO to state clearly the role and position of health within the broad development agenda, including poverty reduction, stewardship of the environment, human rights and global security.

What should/may be included in this section:

- (i) Reaffirmation of the main definitions of health as expressed in the WHO Constitution, the Alma Ata Declaration and Health for All.
- (ii) A discussion around health not only as a means but also as an end for development. Health has historically been valued in its own right, but at a population level, it must also be seen as a dynamic instrument for achieving social and economic development, justice and security.
- (iii) The position of health in the broader development context. It will highlight the synergistic relationships between health and other aspects of development (possible evidence) and cross sectoral linkages, including poverty reduction, equity, sustainable development, good governance, stewardship of the environment, human rights, global security, etc. Illustrations will be used to visually represent how health and development co-influence each other.



Some issues are outlined below:

- a) Health and Poverty: poverty means not just low income but the undermining of a whole range of key human capabilities, including health. Ill health disproportionately afflicts poor people, and health shocks push people into greater poverty (medical poverty trap). A major strategy of WHO was to reduce the burden of excess mortality and morbidity suffered by the poor (WHR 1999). However poverty reduction is not enough to decrease health inequalities. Evidence shows that even in the most affluent countries people who are less well off have substantially shorter life expectancies and more illnesses than the rich. These differences are a social injustice, and they also show the sensitivity of health to the social environment and to what is now called “the social determinants of health” (Wilkinson and Marmot). Other important issues are inequities between groups, e.g. gender, between regions, rural/urban, ethnic groups, and legal status (citizenship etc).
- b) Health and Development: Placing health in the context of Development; HIV/AIDS provides a good example of a health problem with important implications on development. Health and Sustainable Development: the role of health as it emerged from Johannesburg/UNCED. Health and Economic growth: the crucial role of health in economic growth. Health is at the same time an input and an output into the growth process, wealth leads to health and health leads to wealth (CMH). Health is an important objective of development, it can be promoted through a process of economic growth which leads to an increasing real national income per capita, but advancement of health is also a goal on its own (A. Sen). Without ignoring the importance of economic growth for health, the report will look well beyond it this aspect and will review the role of public expenditure particularly on health care.
- c) Health and Human Security and Health and Social Justice: (Commission of Human Security, UN Charter: mission of the UN to protect security depends on the establishment of “conditions under which justice can be maintained”; WHR 2003). The WHO constitution identifies the “highest attainable standard of health” as “one of the fundamental rights of every human being without distinction”.
- (iv) Based on (i), (ii) and (iii), a statement on “positioning health”. The role and position of health and the implications of these on health policies and development agendas. The aim will be to challenge stakeholders in terms of the position of health. Most of the broader development processes/perspectives actually aim at improving the well being and health of people. However it should be made more explicit.

Part II – The Future(s) of Health and Development

Chapter 2: Introduction to Key Challenges in Global Health

Objective of the chapter: To introduce the concept of futures and scenarios as a tool to better understand the future, mainly factors that will affect public health, and to assist in "choosing and creating the future".

Rationale: A plethora of factors influence public health. Some, like an increased ageing population are predictable, others, like a new virus are not. Some, like improvement in the status of women or new vaccines, may yield positive influence, while others, like civil war or shortage of fresh water in some parts of the world, can be negative. While certain trends and conditions are not predictable, investigating potential scenarios (in the macro environment and in the health environment) can help to portray these factors and give insight as to how the global health community, and its players, can face the challenges posed by such trends.

What should/may be included in the chapter:

- (i) The rationale for using "health futures" approach: not only as a mean for forecasting the future (plausible futures), but more importantly as a mean for shaping the future (preferred future).
- (ii) The method used (trends, scenarios, vision/approaches, strategy), the difficulties encountered (limits of the method)?
- (iii) Introduction into the following chapter.

Chapter 3: Plausible futures, different broad health scenarios

Objective of the chapter: To present three different pictures of health over the span of ten years. The pictures may include certain diseases and conditions and classic epidemiologic and economic data, but will go further and present health as a co-influence on broader areas of development, such as those mentioned in Part I.

What should/may be included in the chapter:

Topics that may be introduced to illustrate varying scenarios include (in no particular order, and not intended to be an exhaustive list): health systems and health outcomes in sub-Saharan Africa; better health in India and China; health in crises; LDCs; food inequity in access and outcome; reform in transitional economies; research and development; health in OECD countries, impact of accession countries on EU; AIDS, TB and malaria; etc.

The form that scenarios will take need to account for current realities, trends and forecasts that can be made with a fair degree of certainty, threats and opportunities, key drivers of change and the ways they exert their influence, and futures planning of other disciplines that interplay with health, including changes in the macro environment. This would include issues of peace and security scenarios, the impact of different economic determinants, impact of globalisation, good governance. The actors whose roles in health would be explored include: the corporate private sector; global multinational corporations, NGOs; regional multilateral institutions. The scenarios may also take into account the implications of a growing role for civil society; a changing role for the UN; and the growing partnerships in the international scene.

Each scenario picturing what the world may look like through 2016 should/may contain the following components:

- (i) What are the broader trends? What is their impact on the health of the world, specially the less developed countries and the poorest population.

- (ii) Who are dying/disabled/sick? Why are they dying/disabled/sick? Who is healthy, who is not healthy? Why people are healthy or not? What are the key health problems? What are the main risks to Health?
- (iii) What are the ***key challenges***? Among others:
 - a) Impact on the poor and vulnerable. The health needs of ***specific groups***: the poor, the children, the indigenous populations. The poorest people still suffer under an intolerable burden of diseases. Most of this burden is due to a relatively limited set of conditions, most of them amenable to interventions.
 - b) ***Inequalities*** in health and access to health care: Gaps are widening between regions, countries and within countries. Evidence shows a widening gap in adult mortality worldwide.
 - c) Resource levels for making significant changes in the health of populations. This should be examined in terms of financial and human resources, amongst all players. The issue of effective use of resources through a redefining and redistribution of roles and responsibilities for core functions. Decreasing the gap in ***resource*** availability and making better use of resources, including ODA and global initiatives. Inequities in terms of financing.
 - d) The potential of ***Health Systems*** to effectively deliver appropriate health service. The level of political leadership and governance in policy development. The role of private/corporate sector in the stewardship of health.
 - e) The ability to put existing and ***new knowledge*** into practice. The gap between what we know works and have an impact, and what is current policy, and current practice.
 - f) The impact of ***current situations*** on health systems and the larger development community. These would include HIV/AIDS, the double burden of diseases, an ageing population, environmental and other crises and emergencies.
 - g) The need to influence ***other sectors*** to improve the underlying determinants of health.
 - h) Health and ***Globalisation***. Ethical challenges. Information technology and new scenarios for communication. The possible impact of ***trade*** liberalisation on health (impact on access to and cost of medicines; and on health commodities and services) as well as trade in Health

Scenario A: A Stable, Reasonably Predictable Future

Objective: To present a picture of a relatively stable, reasonably predictable future – the future assumed by traditional strategic planning exercises.

Rationale: This model will be an example of current planning processes and primarily serve as a reference model to the other two predictor models that show greater change.

Scenario B: An Uncertain Range of Futures

Objective: To present a picture of a future with greater change than what is typically planned for. The environment is changing and new technologies or new diseases present differing tools and challenges.

Rationale: This model will be an example of a level of change, while not unrealistic, is above what is normally planned for.

Scenario C: Radical Change

Objective: To present a picture of a future of great change and how it may influence health, or more upstream, how health may influence the change.

Rationale: When the health environment radically changes, so must WHO and the global health community. Changes of significant magnitude could be positive, such as a vaccine for HIV/AIDS or negative, such as a new, virulent pandemic. Envisioning such change of radical nature assists in the flexibility of systems to adjust to more minor changes.

Part III – Acting Now for Influencing and Responding the Future of Health

Chapter 4: A Call to Action

Objective of the Chapter: To engage the reader in critical thinking about strategic directions WHO and various players should pursue in health. Using the scenarios, the chapter will explore and identify a range of strategic directions, alternative options or courses of action to achieve "preferable" future (vision) based on WHO values and principles.

Rationale: The scenarios presented will deal with plausible futures (positive or negative), they will allow the reader to understand what is emerging and more importantly to identify what should be done and assess the approaches for moving forward. Each scenario will require action to make it happen and to respond to its occurrence, action by WHO and by other players. However the action should be based on WHO core values and deep purpose. (Vision statement to affect positive change).

What should/may be included in the chapter: visions and strategies linked to trends and scenarios.

Chapter 5: Implications for WHO

Objective of the Chapter: To discuss the implications for WHO of what has emerged in the previous chapter (visions, strategic directions, etc.) and to identify the role WHO should assume in health.

Rationale: Action will be required by WHO in various roles, these roles have to be discussed and defined.

What should/may be included in the chapter:

- (i) *Leadership*: Is there a role for global leadership in health? What form and in what domains should this leadership be expressed? What are likely to be the main challenges/challengers? What capacities need to be developed to exert this leadership more effectively? What are we doing to develop the next generation of leaders at all levels?
- (ii) *Country-level work*: What have we learnt about WHO's role at country level? What is expected of us? Are we doing it? What does it imply in terms of skill development, recruitment, etc?
- (iii) *Positioning Health*: What are the choices we have to make in terms of positioning health? How do we concretely act on choices while maintaining flexibility to respond to the unexpected. How do we define and implement our choices to influence the determinants of health?
- (iv) *Development Policies*: Can we be more effective in influencing development policies? Which policies? In which direction? Are we equipped to do so? How would we know if it happened? Are there hidden consequences of supporting/influencing policies? How to discover them and incorporate them into our decision making process?
- (v) *Relationships with Governments*: How do we work more effectively with governments in different parts of the world? Where do we make our main links? How do we move our current set of relationships? What are there hidden consequences of working with governments? How to discover them and incorporate them into our decision making process?
- (vi) *Setting Priorities*: How does this kind of analysis help us set priorities? What is the practical meaning of priorities? How are these priorities manifested? How do priorities relate to targets? What is the impact of target – the development process, achievement (or not), and evaluation? How does this model fit within the core principles and vice versa?
- (vii) *Monitoring and evaluation*: How do we monitor and evaluate the role (core functions) of WHO and of other partners? What are the core functions to monitor and how? Who should do it and when?

Chapter 6: International Commitments and the International Community

Objective of the chapter: To describe international commitments and how WHO anticipates the role of Member States and other contributors to the status of health to develop.

Rationale: This chapter will assist the reader to better understand the international context and what has already been agreed by governments in the pursuit of health. Because this document is designed for broader influence than just WHO, questions relating to additional partners will be posed.

What should/may be included in the chapter:

- (i) Brief description (including goals and targets, tables) and analysis of the relevance and progress of the various agreements: MDGs, UNGASS, ICPD, TFC, etc.
- (ii) Discussion around roles and responsibilities. The “map” of actors has changed during the last 10 years. What is expected from various partners/actors at the global and local level?
 - Role and responsibilities of Member States.
 - Role and responsibilities of the other partners (UN, Civil Society/NGOs, ODA, and Private sector) based on their comparative advantage.
- (iii) Mandate and overall role of WHO (global health governance, etc.), WHO cannot do everything, what is WHO’s particular role and responsibility for world health. Key functions and what we will deliver.
- (iv) Core principles for how to work effectively together: evidence based and learning from experience, partnership, ownership, harmonisation, primary responsibility for setting priorities, urgency and sustainability, accountability, development is a process and changes take time, etc.
- (v) What is the role for new and non-traditional partners? How are those roles discovered/developed? Should roles be mutually exclusive or over-lap and to what extent?
- (vi) Role and responsibilities of corporate society: a new area for partnerships? What are the consequences (positive/negative) of this?
- (vii) Specific examples of how the document can be used both inside and outside WHO.

Conclusion –

In some aspects, this should be a reiteration of the introduction, yet with a ‘call to action’ tone. It should highlight that while many questions were posed, likely many are without clear answers. We can not precisely predict the next ten years. But we can still strategically influence part of the future and be prepared for those factors we can not influence. The GPW is an attempt to assist us in shaping the future.

Annex 2



11TH GENERAL PROGRAMME OF WORK 2006-2015 THE PROCESS PAPER (1/06/2004)

Conceptual framework for the GPW Process

- The GPW process is conceived as having a divergent opening up process during this year (2004) in order to create and accumulate information. This part of the process would contain different scenarios, inputs from external consultants, academics and other experts. It would also include similar inputs from the regions and countries, including from the Regional Committees.
- Then a convergent process during 2005 which would include using the Executive Board and WHA, etc. The convergent process would necessarily be more participatory than the divergent one. The divergent process is more technical and the convergent may be more political.

Organisational Set Up

The work on the GPW is managed by a small team located in GMG/PRP and led by a Task Manager. The team is assisted by a Task Force, a Coordinating Group and Oversight Groups.

The Task Force is composed of WHO staff. Its mandate is to: assist in managing the process for development of the GPW; to ensure an interactive internal and external consultative process; to monitor progress in consultation with the regional focal points and suggest ways to improve process and contents.

The Coordinating Group is composed of the DPMs from the six regions and chaired by the ADG/GMG. This group is not a new group but is using existing mechanisms of the Meeting of DPMs. Its mandate is the overall management and coordination of the General Programme of Work process, including reviewing and finalizing drafts prepared by the Task Force; ensuring that the GPW is informed by the needs and interests of WHO Member States; proposing ways to ensure that the final product is owned by WHO and all its partners; and recommendations for the attention of the Director-General. The Group works with and benefits from input provided by programme managers at different levels of the organization.

The Oversight Groups will be the Meeting of the Director-General and the Asst. Directors-General and the meeting of the Director -General with the Regional Directors. These groups will periodically review the progress of the development of the GPW and provide strategic oversight.

Roadmap

- Regular meetings of the Task Force and of the Coordinating Group
- Map and compile relevant documents across WHO, including RO and COs to serve as background documentation, and link to existing processes (e.g. MDGs)
- Identify experts on futures to work on scenarios' development (process and content) and
- Hold regional consultations with a limited number of people to check the scenarios and develop strategies/roadmaps for the future before end 2004
- Present the outline and the process to the regional Committees in 2004 for comments and suggestions
- Support case studies in a selected number of countries on plausible future and role of MOH, partners and WHO
- Plan one or more global consultations end of 2004-early 2005 with partners, to be organized in relation with other meetings
- Present latest outline and process paper to the Executive Board for consultation in January 2005
- Organize consultations during 2005 for "ownership building" and developing strategies for the use of GPW
- Review by the Regional Committees fall 2005
- Finalize the document for January 2006.

Some of the Critical Dates in the Development of the 11th GPW	
June 2004	Brief outline of the process and draft outline of the GPW forwarded to regions for distribution to Regional Committees
September 2004	Process and outline of GPW discussed by Regional Committees
October 2004	Partners consultations
October 2004	11-13 October – DPMs review the outline of GPW based on comments from the Regional Committees.
November 2004	1 November – ADGs and RDs review the process and outline of GPW
January 2005	Process and outline of the GPW to be reviewed by the EB 115 via the Programme, Budget and Administration Committee
March 2005	Partners consultations
April 2005	Full Draft of the GPW discussed by ADGs, RDs and DPMs
June 2005	Full Draft of the GPW forwarded to regions for discussions in Regional Committees
September 2005	Draft Proposed GPW commented on by Regional Committees
October 2005	DG revisions of draft Proposed GPW based on comments from the Regional Committees. Mid-October - Director-General approves revised version of Proposed GPW to be reviewed by the EB 117 via the Programme, Budget and Administration Committee.
January 2006	Proposed GPW to be reviewed by the EB 117 via the Programme, Budget and Administration Committee
May 2006	Review and approval of 11 th GPW by the World Health Assembly – WHA59.
June 2006	Subsequent to the review and approval by the World Health Assembly (WHA 59), the approved versions of the GPW document will be published and disseminated.

- - -