



**World Health
Organization**

WHO Results Framework: Delivering a measurable Impact in countries

Fourteenth General Programme of Work

Technical Paper
19 February 2024

Contents

Executive summary	2
Section 1. Improve the WHO Results Framework for GPW 14	5
1. WHO Results Framework	5
2. Impact measurement and updates	6
3. Healthy life expectancy	8
4. Outcome (programmatic) indicators	9
5. Statistical forecasting methods for trajectories of outcome indicators and the Triple Billion targets	10
6. Recalibrating the Triple Billion targets: relative or absolute billions	12
7. Triple Billion and impact measurement for country priority setting	16
Section 2. Accelerate progress in countries using the Delivery for Impact approach	21
1. Operationalize the Delivery for Impact approach	21
2. WHO's contribution to health impact: examples	23
3. An example on health workforce	24
4. Scale up the use of Delivery for Impact approach in countries	25
5. Delivery Dashboard for global accountability	31
Section 3. Improve data, digital and health information systems	33
References	35
Annexes	36
Annex 1. Statistical forecasting method for outcome indicators	36
Annex 2. Achieving SDG targets at the country and regional levels	39
Annex 3. Outcome (programmatic) indicators in GPW 13 and proposals for GPW 14	43
Annex 4. GPW 14 Results Framework: mapping outputs, delivery milestones, to outcomes and impact	52
Annex 5. Global Delivery Milestones: Dashboard	71

Executive summary

In September 2023, the United Nations Heads of State and Government Meeting voiced an urgent need to double the rate of advancement on the Sustainable Development Goals (SDGs). With the 2030 Agenda deadline fast approaching, WHO must address two fundamental and related problems: slow progress and insufficient information.

Transformation of the World Health Organization is succinctly stated by the Director-General, Dr Tedros: "We can only make progress if we measure progress." As such, WHO's strategic plan is predicated on a results-based ethos. Supporting countries to improve data quality and accessibility. Using evidence to drive measurable impact. Aligning biennial budgets with the organization's priorities and with measurable and measured improvements in outcomes.

The draft GPW 14 further builds on the report by the Director-General to extend the GPW 13, 2019–2023 to 2025, with a focus to promote, provide, and protect health, and power the work of the entire global health ecosystem towards the SDGs while enhancing its own organizational performance.

The WHO Results Framework transforms health goals into measurable targets.

The WHO Results Framework is an accountability tool to track the collective contributions of the Secretariat, Member States, and partners towards the Triple Billion targets and health-related SDGs. Anchored in the health-related SDGs, the GPW 13 provided a roadmap to increase healthy lives and well-being for all. The conceptual framework for this was the Triple Billion targets:

- 1 billion more people living with better health and well-being by 2025
- 1 billion more people benefiting from universal health coverage
- 1 billion more people better protected from health emergencies

Impact is measured by the Triple Billion targets and healthy life expectancy (HALE). Outcomes are measured against an agreed set of indicators from the health-related SDG indicators and WHA resolutions. The output measurement evaluates the Secretariat's contributions using leading indicators, the output scorecard, country impact stories/case studies, and delivery dashboards. The latter track accountability against delivery milestones at the global level and support countries to monitor and manage their strategic priorities, ensuring WHO and its partners can effectively promote, provide, and protect the health of the people worldwide.

The world was not on track to reach the Triple Billion targets by 2023 and health-related SDGs before the COVID-19 pandemic. We are further off track now.

WHO's projections reveal that an additional 1.26 billion people are expected to have better health by 2023 compared to 2018. While the target for healthier populations is within reach by 2025, the pace of progress remains insufficient to meet SDG targets by 2030.

Notably, 477 million more people are expected to be covered by essential health services without facing financial hardship. The world must double the pace of progress to achieve the universal health coverage target by 2030. Projections suggest that 690 million more people are expected to be better protected from health emergencies. There is an urgent need to ensure everyone is protected.

There was significant improvement in Healthy Life Expectancy (HALE) at birth at the global level from 2000 to 2019. The forecasted progress is tempered for the next three decades largely due to a slowdown in improvements in mortality. Halving premature mortality and improving quality of life at all ages will put the world back on track by 2050.

WHO is recalibrating the Triple Billion targets for GPW 14 to set ambitious goals with thorough assessments of where there has been progress and where we have more ground to cover. The Triple Billion targets are tentatively recalibrated to absolute targets as follows, with further updates based on the final list of outcome indicators to be included in GPW 14:

- 6 billion people will enjoy healthier lives (promote health)
- 5 billion people will benefit from UHC without financial hardship (provide health)
- 7 billion people will be protected from health emergencies by 2028 (protect health)

The outcome indicators that constitute the indices for each of the Triple Billion targets will be updated to encompass emerging public health concerns, such as climate impact on health, physical activity, and mental health. The Secretariat will work with countries and partners to finalize the outcome indicators for GPW 14, including with baselines and targets. These changes will be reflected in the updated WHO Results Framework for GPW 14.

The Delivery for Impact approach is WHO's response to the slow pace of implementing solutions.

Delivery for Impact uses country-specific, co-developed, quantifiable objectives and a plan, which can result in a country's targets being met, with continuous progress monitoring, evaluations and course correction.

WHO convenes stocktakes and reports on global and country progress using delivery dashboards. At the country level, these dashboards support the Secretariat and our partners to manage and accelerate country priorities. Over 50 WHO country offices have applied delivery approaches including developing acceleration scenarios through application of WHO's normative guidance.

At the global level, delivery dashboards provide accountability and constructive collaboration with UN agencies, multilateral organizations, academia, and civil society, spanning national and international spheres.

WHO will lead collective efforts to accelerate information system and digital transformation at the country level.

The WHO SCORE for Health Data Technical Package, the World Health Data Hub, the WHO Hub for Pandemic and Epidemic Intelligence, the Global Digital Health and AI Strategy and Research for Health are all assets for countries to strengthen health information systems. They better enable countries to monitor existing and new health challenges, analyse real-time data, and update their health targets to improve programmes and policies.

WHO will continue to enhance its accountability to deliver measurable impact in countries.

Especially when faced with needs that increase more rapidly than the resources to address them, maximizing impact requires focus at country, regional and global levels. To better serve countries, WHO will align resources with strategic priorities by integrating the updated WHO Results Framework into GPW 14 strategy. This will in turn cascade to the proposed Programme Budget and the Investment Case.

Prioritizing investments based on maximum health benefits is crucial – it is key to reducing premature deaths and improving quality of life for all at all ages. The GPW 14 HALE target will cascade to recalibrated billions target, which will be directly linked to budget decisions to meet the SDG targets and country and World Health Assembly-decided targets. This strategic alignment is expected to save billions by reducing health costs and boosting productivity.

This technical paper will be updated following feedback from Member States and partners and final paper will be presented to the World Health Assembly along with the GPW 14. We welcome your comments at the following email address: impactmeasurement@who.int

Section 1. Improve the WHO Results Framework for GPW 14

1. WHO Results Framework

Delivering measurable impact in countries is integral to WHO's transformation. The Thirteenth General Programme of Work, 2019-2023 (GPW 13), extended to 2025, enhances WHO's effectiveness in improving global health outcomes. The WHO Results Framework will continue to serve as a tool to improve transparency, efficiency, and accountability for GPW 14.

The WHO Results Framework, established with best-practice methodologies, extensive and transparent consultation, and accountable indicators, provides a comprehensive evaluation of progress. Through this framework, WHO aims to assess and demonstrate its tangible impact improving the health of individuals worldwide.

Measuring and managing impact and outputs are two integral parts of the WHO Results Framework (Figure 1a and 1b). The impact is measured through the Triple Billion targets, focusing on healthy life expectancy (HALE). It encompasses 46 tailored programmatic indicators for countries, and reflects the three areas of WHO's core work: promote, provide, and protect the health of the world's population (Figure 1a).

The output measurement evaluates the Secretariat's contributions using leading indicators, the output scorecard, detailed case studies capturing country experiences and progress ([country impact stories/case studies](#)), and delivery dashboards (Figure 1b).

Figure 1a.

WHO Results Framework: impact measurement

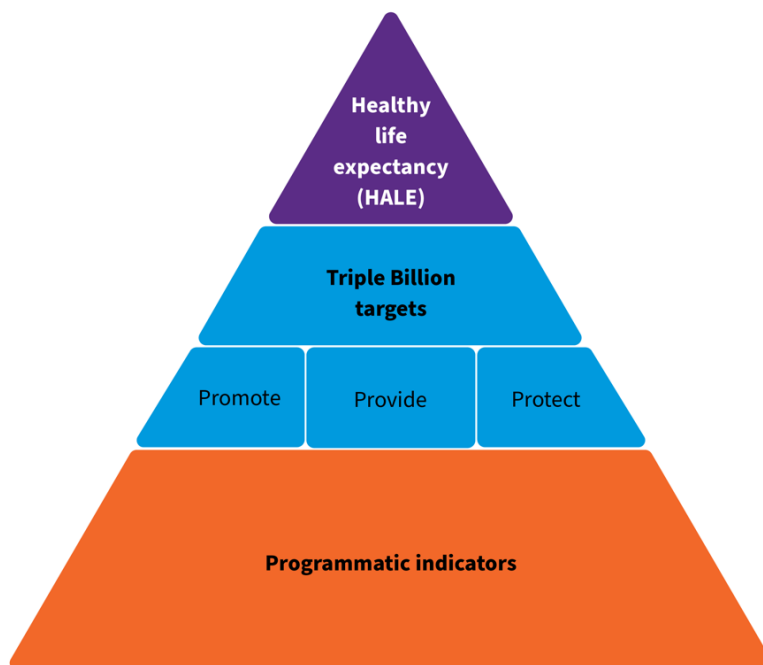
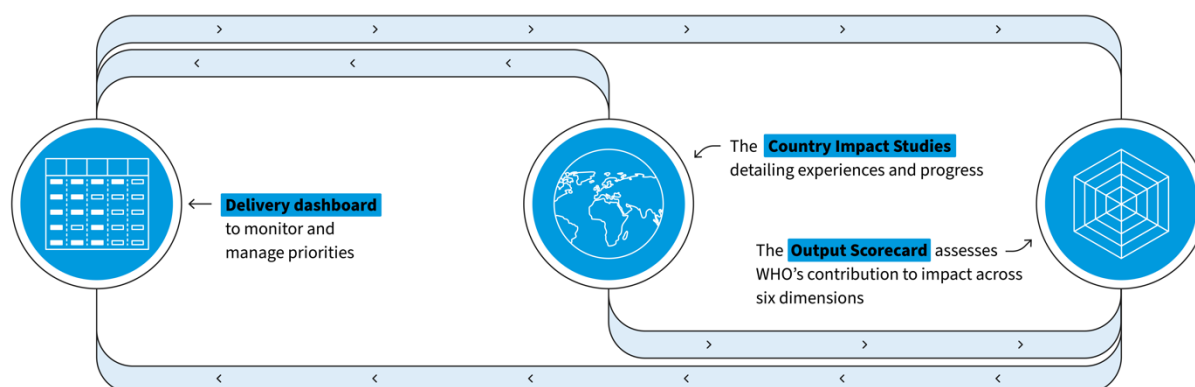


Figure 1b.

WHO Results Framework: Output measurement



2. Impact measurement and updates

Impact measurement assesses and demonstrates tangible improvements in global health and the contributions WHO has made. The framework allows transparent monitoring of progress towards our objectives. Co-developed by the Secretariat and Member States, it tracks joint efforts to meet the Triple Billion targets in GPW 13 and to achieve the health-related SDGs, while measuring the Secretariat's contribution. It underwent a rigorous technical development and review process, followed by consultations and discussions at governing bodies in 2018 and 2019 to finalize its development.¹

The impact measurement assesses progress at three levels, monitoring inequality and improving equity in health at all levels:

1. Healthy life expectancy (HALE), quantifying expected years of life in good health as a measure of the overall health of populations;
2. The Triple Billion targets, to be achieved by 2025:
 - one billion more people benefiting from universal health coverage;
 - one billion more people better protected from health emergencies;
 - one billion more people enjoying better health and well-being.
3. Forty-six health-related outcome (programmatic) indicators (39 indicators are SDG indicators and seven are from WHA resolutions) and their global targets for 2030.

The three components of the impact measurement in WHO's Results Framework are closely connected. They show a clear pathway: from *relevant interventions* to improve population health (outcome indicators) to *relative contribution* in changes in the Triple Billion targets (for example, how many more people have access to essential health services) to *related impact* as measurement by the changes in both morbidity and mortality, which are integrated in the summary index of HALE.

The outcome (programmatic) indicators aim to measure changes in coverage of specific health services as the results of actions taken by both WHO and its Member States. Such changes and efforts are ultimately

¹ Governing bodies documents: [EB144/7](#), [EB146/28 Rev 1](#), [A72/5](#), [A73/16 Rev 1](#), [A76/16](#)

reflected in improvements in mortality and morbidity among populations stratified by age and sex. HALE is a summary metric of such impacts, ultimately reflecting all efforts made in improving population health.

The Triple Billion targets are a comprehensive and coordinated effort by WHO to increase accountability to improve global health outcomes. By strategically focusing on the three specific billions and utilizing existing data sources, WHO aims to bring tangible and measurable improvements to the well-being of billions of people worldwide.

WHO's global health strategy aims to support countries in achieving the health-related SDGs by catalysing progress and accountability through the Triple Billion targets. To streamline data collection and minimize burden on countries, it primarily relies on data from the SDGs.

Counting the Triple Billion targets serves as a powerful tool to measure the impact of interventions and improvements on global health. The Triple Billion targets offer easily understandable concepts and targets, drawing the world's attention and inspiring change.

By packaging the health-related SDGs and a few additional WHA-approved indicators together, the Triple Billion targets drive countries to accelerate their implementation strategies, aiming for maximum impact. Moreover, they reveal data availability, frequency, and quality gaps, urging Member States to address them.

This approach identifies three core areas of health progress: health promotion (Promote), healthcare provision (Provide), and health emergency protection (Protect). This is a strategy focused on delivering ambitious improvements in global health. Member States have approved this approach, signifying a new direction that enhances and welcomes WHO's accountability to the people it serves.

There are several important reasons for implementing the Triple Billion approach:

- a) Matching the global commitment to the SDGs with specific, measurable implementation;
- b) Identifying and closing data gaps;
- c) Increasing accountability through accurate measurement of health outcomes.

The Triple Billion targets are designed to attract the attention of the world in a clear, understandable way. They serve as a catalyst for change. By measuring each of them, we identify data gaps and work towards better data and understanding and towards health protection and improvement. This creates a cycle of progress, leading to clearer choices, more precise actions, and improved lives.

To monitor country progress toward these targets, a counting scheme is necessary. Counting the Triple Billion targets encourages positive changes and accelerates improvements to global health. The Triple Billion methods, including the baseline estimation for outcome (programmatic) indicators and forecasts, will continue to evolve beyond GPW 13, adapting to advancements in data and knowledge.

The methods chosen for monitoring progress in achieving the Triple Billion targets have undergone extensive review and consultations with experts, regions, and countries. In 2017, the Director General empanelled an [Expert Reference Group \(ERG\) and Task Force](#) to rigorously assess means of tracking progress on each of the billions, resulting in an in-depth methodological approach to track GPW 13, published as the '[Methods for impact measurement](#)' report.

The ERG, after intensive review and multiple meetings, summarized its findings as follows:

1. The Task Force believes that the Triple Billion targets for GPW 13 can be measured and provide a very valuable approach to tracking the joint efforts of Member States, the WHO Secretariat, and other partners to achieve the GPW 13 goals and SDGs. The development of the measurement framework is a major step towards accountability and transparency and is a new approach, which is to be appreciated.

2. GPW 13 and the included Triple Billion targets can be measured but will be further improved by Member States' efforts, with the support of WHO, to strengthen measurement systems especially cause of death measurement.
3. It will also require refinement of existing WHO approaches for each of the Triple Billion targets, particularly measuring UHC service coverage.
4. The indicator framework should add the GPW 13 healthy life expectancy (HALE) as an overall integrative measure of population health.

Detailed technical notes on the construction of each of the Triple Billion targets can be found in the [‘Methods for impact measurement’](#) report.

3. Healthy life expectancy

Healthy life expectancy (HALE) serves as a valuable indicator that concisely represents overall population health levels. It quantifies the projected number of years individuals can expect to live in good health. Doing so aligns with the WHO Constitution's commitment to achieving the highest attainable standard of health for all populations.

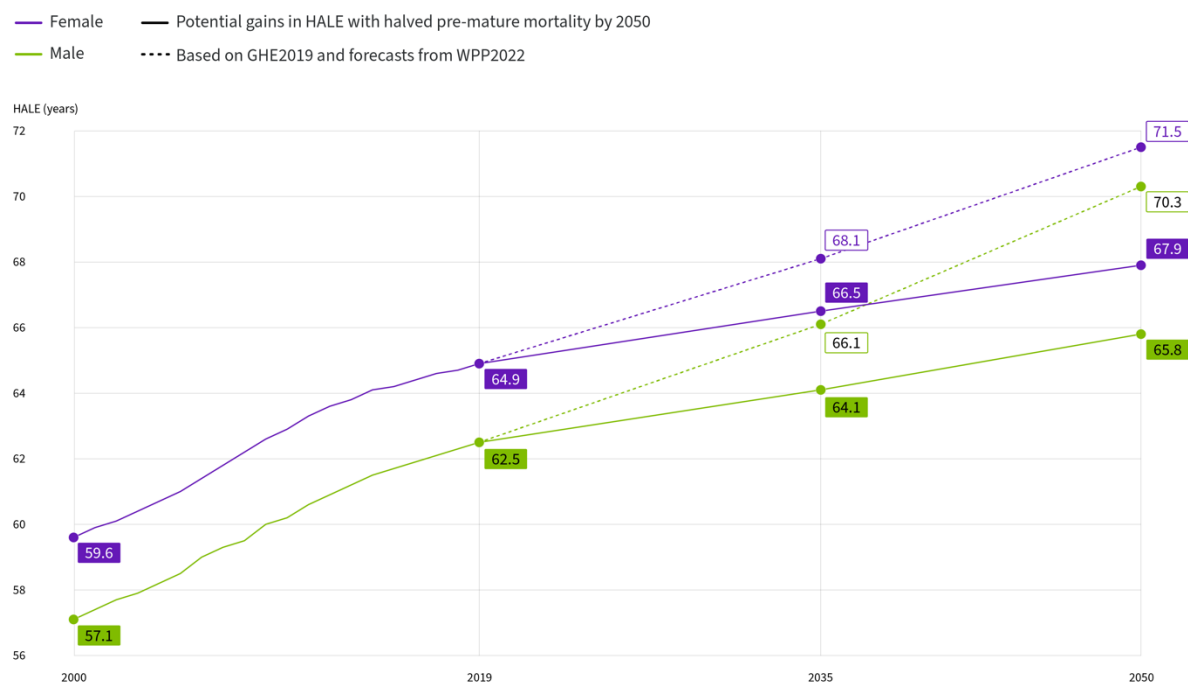
HALE plays a fundamental role in GPW 13 baseline reporting and serves as a monitoring tool to track progress for each Member State. Its utility extends to facilitating cross-country comparisons and allowing for assessments of health changes within countries over time.

As a comprehensive measure for both the length and the quality of life, HALE is calculated using sex and age-specific mortality rates by country, a key input for the calculation of life expectancy, and age and sex-specific proportion of years spent with morbidity, estimated by examining years of life lost due to disability across a spectrum of diseases and injuries after accounting for severity for the sequela of such conditions. The standard life table calculation method is used in calculating HALE after years of life lost due to disability are deducted from each life table age group.

The computation of HALE, and the associated mortality and morbidity estimates, is based on standardized global health estimation methodologies for both input data processing and demographic and statistical estimations that synthesize input data from different data sources and underlying data collection mechanisms to produce comprehensive yet internally comparable estimates among countries and across time for sensible benchmarking and accurate measurement in tracking progress made at both the national and international levels.

It is important to note the various estimation models utilized in the estimation of HALE where data sparsity for certain key inputs such as incidence or prevalence of certain diseases and conditions exists in all countries, even though the level of data sparsity varies. Details on the methodologies used by WHO can be found in the [‘Methods for impact measurement’](#) report and in the [‘methods and data sources for global cause of death and life tables, 1990-2019’](#) report.

Figure 2.
Healthy life expectancy at the global level



Source: Estimates and preliminary forecasts based on Global Health Estimates 2019 and UNPD World Population Prospects 2022.

The world has significantly improved HALE for the past two decades. On average, we observed a five-year increase in HALE for both men and women between 2000 and 2019. However, the latest mortality forecasts from the [United Nations Population Division](#) show much-tempered progress in improving all-cause mortality and life expectancy from 2020 onward. This will slow down the improvement of HALE at the global level between 2019 and 2050.

Yet much could still be done to correct the course. By halving premature mortality and ensuring quality of life for all by 2050, we can put the world back on track. WHO can help achieve such ambitious goals through its GPW 14 and beyond.

HALE will remain as the pinnacle of impact measurement for GPW 14.

4. Outcome (programmatic) indicators

In GPW 13, forty-six outcome indicators covering a wide range of health issues form the basis of the impact measurement and the calculation of the Triple Billion targets. After extensive internal and external consultation, these indicators were approved at the World Health Assembly in May 2019 (WHA72). Among the indicators, 39 were derived from the SDGs (26 from SDG 3; 13 from other SDGs), and seven address priorities identified by Member States, such as antimicrobial resistance, polio, noncommunicable diseases (hypertension, obesity, trans fats policy), and health emergencies (vaccine coverage for epidemic-prone diseases, provision of essential services to vulnerable populations).

While the Triple Billion targets provide succinct summaries of the outcome (programmatic) indicators in each of the three areas, this comprehensive set also allows countries to prioritize indicators based on their national health strategy. Countries will track progress towards the targets for their chosen indicators. Not

every country will necessarily track every indicator. These indicators also form the basis for improving global health and achieving the Triple Billion targets and SDGs.

For GPW 14, WHO technical programmes are evaluating the needs for new and updated outcome indicators to reflect closely the current landscape of global health and the need to track progress made in improving population health at both the national and global levels. A total of 41 outcome indicators have been proposed, covering Promote (14 indicators), Provide (18 indicators), and Protect (9 indicators).

Indicators will be divided into two groups, according to the reliability of their data. Greater focus will be placed on the first group, for which data are readily available and, particularly, where improvements would correlate with substantial improvements in health outcomes. For the second, where estimates are less reliable, the focus will be on improving measurement and/or defining indicators that can be readily tracked and that correlate with improved health outcomes. Where needed, WHO will work to shape the relevant Sustainable Development Goal indicators through the Inter-Agency Expert Group in 2025.

The refresh of the programmatic indicators for GPW 14 serves as a solid foundation for updating the Service Coverage Index of Universal Health Coverage in SDG. The Secretariat is working with WHO technical programmes and Member States closely to ensure maximum consistency.

Table 1 shows a high-level results framework and number of current and proposed indicators by outcome. Details on outcome (programmatic) indicators can be found in Annex 3.

5. Statistical forecasting methods for trajectories of outcome indicators and the Triple Billion targets

As the summary indices of the 46 programmatic indicators, the estimates and forecasts of the Triple Billion targets need to be based on the levels of, and trends in, the programmatic indicators and to account for the impact of COVID-19 when empirical data allows.


Forecasts of the programmatic indicators are produced in a two-step process. A 'baseline' model is fit using 2000-2019 data to capture pre-pandemic trends and project to 2030 what might have occurred without the COVID-19 pandemic. The baseline projections are then adjusted during pandemic years to account for disruption due to the COVID-19 pandemic.

To account for the impact of COVID-19, we also developed a method to adjust baseline forecasts for years during the pandemic based on observed and empirical data and the baseline forecasts based on input data to forecast before the COVID-19 pandemic occurred. The adjustment predicts the difference between the baseline forecast and input estimates given the estimated per capita number of COVID-19 infections. Indicator-specific assumptions are also made about when indicator forecasts will return to baseline forecast trends. Annex 1 comprehensively describes the methods and how they are applied to each outcome indicator.

Table 1.

High level results for GPW 14 with number of current and proposed outcome (programmatic) indicators by six outcomes

 Number of outcome (programmatic) indicators for GPW 13

 Number of proposed outcome (programmatic) indicators for GPW 14

Impact			
More people, everywhere, attain the highest possible standard of health and well-being.			
DRAFT GPW 14 overarching goal:			
To promote, provide and protect health and well-being for all people, everywhere.			
Strategic objectives and major outcomes:			
Respond to climate change , the greatest health threat of the 21 st century.	1.1 More climate-resilient health systems are addressing climate risks and impacts. 1.2 Lower-carbon health systems and societies are advancing health and well-being.	0	0
Address the root causes of ill health by embedding health in key policies across sectors.	2.1 Health inequities reduced by acting on social, economic, environmental, commercial and cultural determinants of health . 2.2 Priority risk factors for noncommunicable and communicable diseases, violence and injury, and mental health reduced through intersectoral approaches. 2.3 Populations empowered to control their health through health promotion programmes and community involvement in decision-making.	21	14
Advance the primary health care approach and essential health system capacities for health equity and gender equality.	3.1 The primary health care approach renewed and strengthened to accelerate universal health coverage. 3.2 Health and care workforce, financing and product availability substantially improved. 3.3 Health information systems strengthened and digital transformation implemented.	2	1
Improve equity and quality in health service coverage and financial protection to advance universal health coverage.	4.1 Equity in access to services for noncommunicable and communicable diseases and mental health conditions improved. 4.2 Equity in access to sexual, reproductive, maternal, newborn, child, adolescent, older and other population-specific health services, and immunization coverage improved. 4.3 Financial protection improved by reducing out-of-pocket health expenditures , especially for the most vulnerable.	20	17
Prevent, mitigate, and prepare for emerging risks to health from all hazards.	5.1 Risks of health emergencies from all hazards, including antimicrobial resistance , reduced and impact mitigated. 5.2 Preparedness, readiness and resilience for health emergencies enhanced.	2	3
Rapidly detect and sustain an effective response to all health emergencies.	6.1 Detection of and response to acute public health threats is rapid and effective. 6.2 Access to essential health services during emergencies is sustained and equitable.	1	6

6. Recalibrating the Triple Billion targets: relative or absolute billions

While considerable progress has been made since 2018, the Triple Billion targets set for GPW 13 will likely not be achieved by 2025 unless significant efforts are made.

At the global level, about 640 million more people are expected to have access to essential health services without incurring financial hardship by 2025.

Significant strides were also made in making about 900 million people better protected from health emergencies.

The healthier populations billion is the bright spot, with 1.55 billion more people expected to have better health by 2025. Yet such progress is still not sufficient to put the world on track to achieve SDG targets by 2030.

Looking ahead, WHO needs a recalibration of the Triple Billion targets to set ambitious goals for the upcoming GPW 14, and such recalibration should also be rooted in realistic assessments of where we have more ground to cover and progress to make by country and programmatic indicator between 2024 and 2028. More importantly, new programmatic indicators will be added and their impact will be reflected in the recalibrated targets.

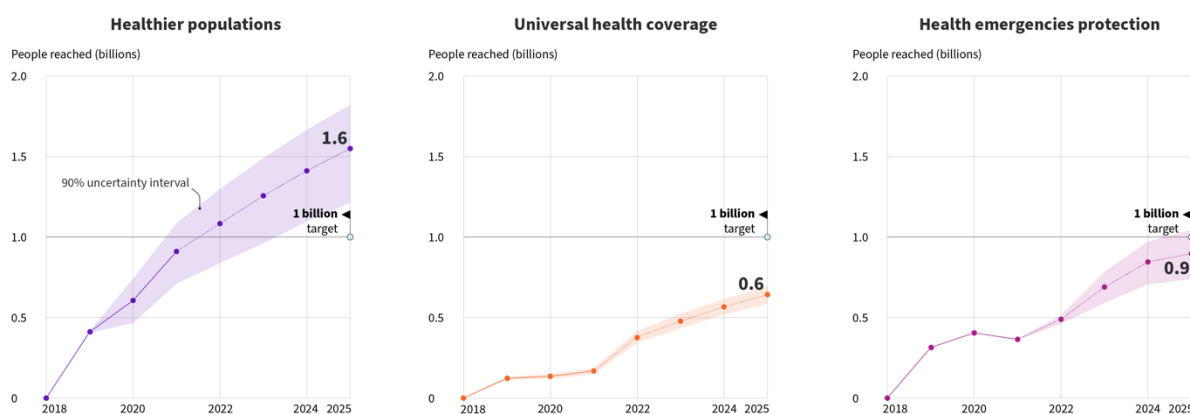
Simply put, the statistical forecasts shown in Figure 3 and Figure 4 provide the "floor" value for recalibration. In other words, values such as 640 million more in 2025 and 856 million more in 2025 for the universal health coverage billion are likely to occur, given the commitment and efforts of the Member States and the global community.

On the other hand, more ground could be gained by setting a more ambitious rate of progress in different scenarios in the coming decade. The final Triple Billion targets should be balanced between projected achievement based on past trends and maximum achievable outcome based on the ambitious rates of improvement.

The scenario-specific exercise is vital to the recalibration of the Triple Billion targets for GPW 14, which will be based on the updated list of outcome indicators. It will also take into account the assessed progress made in achieving the Triple Billion targets in GPW 13 and the likely trajectories for each outcome indicator at country and global levels.

Figure 3.

Progress in achieving the Triple Billion targets



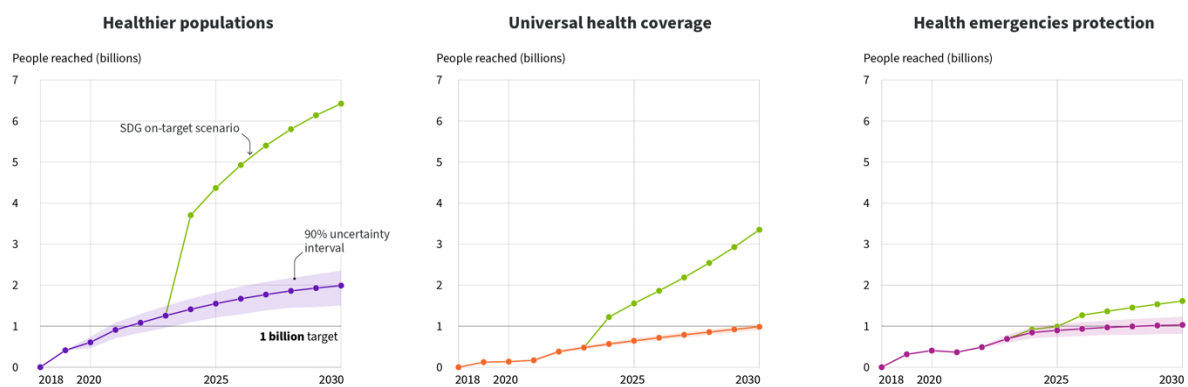
Source: Forecasts based on data from World Health Statistics 2023.

There are significant technical considerations the Secretariat needs to consider for the recalibration of the targets:

- Scenarios analysis based on global targets such as the SDGs and WHO WHA resolutions;
- Achievable health interventions for individual outcome indicators for each region and country;
- Statistical forecasting based on past levels and trends at the indicator and country level;
- Best practice at regional and/or global levels through benchmarking assessment;
- A balance between being realistic and aspirational;
- Account for uncertainty in observed data and forecasts;
- Equity: no one should be left behind and unprotected.

Figure 4.

Triple Billion target projections to 2030 and associated SDG achieving scenarios



Source: Forecasts based on data from World Health Statistics 2023.

WHO's forecast for the coming decade shows promising trends towards a healthier global population, as shown in Figure 4. If current trajectories hold, an additional 1.86 billion people will live healthier lives by 2028 compared to the baseline in 2018. Yet, there's potential for an even more significant impact: if every country meets the health-related SDG targets at the global level by 2030, 2.7 billion more people will live healthier lives by 2028 instead of 1.86 billion projected based on the observed trend so far. Furthermore, meeting these goals could mean an extra 934 million people having access to essential health services without incurring financial hardship by 2028 and an additional 158 million people safeguarded against health emergencies by 2028.

While it is welcome news for the healthier population billion, the progress made so far and the implied trajectories up to 2030 are far from enough to achieve health-related SDG targets by 2030. Table 2 below shows the baseline value 2018 for each outcome indicator, the associated target to achieve by 2030, and the forecasted values 2030 based on the statistical forecasting method described in section 1.5. In addition, we show the annualized rate of change (AROC) between 2018 and 2030, implied AROC to achieve the 2030 target, and the needed acceleration when applicable.

Table 2.

Processes in achieving outcome indicators at the global level, 2018-2030

Category	Indicator	SDG	2030 Target	2018	2030	% Change 2018-2030	Forecast AROC (%)*	Target AROC (%)*	Required times of acceleration
HPOP	Childhood Stunting	SDG 2.2.1	17	25.4	20.2	-20.5	-1.9	-3.3	1.8
HPOP	Childhood Wasting	SDG 2.2.2	3	5.6	7.8	38.8	2.8	-5.2	---
HPOP	Childhood Overweight	SDG 2.2.3	3	5.3	6	13	1	-4.7	---
HPOP	Suicide Mortality	SDG 3.4.2	6	9	7.9	-12.7	-1.1	-3.4	3.1
HPOP	Alcohol Consumption	SDG 3.5.2	5	5.6	6	6	0.6	-0.9	---
HPOP	Road Deaths	SDG 3.6.1	9	17.1	16.4	-4	-0.3	-5.3	15.4
HPOP	Tobacco Use	SDG 3.a.1	18	22.3	17.9	-19.6	-1.8	-1.8	---
HPOP	Developmentally on Track	SDG 4.2.1	0	67.4	67.4	0	0	---	---
HPOP	Intimate Partner Violence (F)	SDG 5.6.1	0	26.7	26.7	0	0	---	---
HPOP	Safely Managed Water	SDG 6.1.1	96	63.5	67.8	6.7	0.5	3.4	6.3
HPOP	Safely Managed Sanitation	SDG 6.2.1	95	54.2	70.9	30.8	2.2	4.7	2.1
HPOP	Clean Household Fuels	SDG 7.1.2	96	65.6	78	19	1.4	3.2	2.2
HPOP	Mean Particulates (PM 2.5)	SDG 11.6.2	5	35.9	30.3	-15.5	-1.4	-16.4	11.6
HPOP	Violence Against Children	SDG 16.2.1	0	79.6	79.6	0	0	---	---
HPOP	Adolescent/ Child Obesity	-	5	6.7	13.9	105.8	6.1	-2.4	---
HPOP	Adult Obesity	-	11	13.2	19.2	45.3	3.1	-1.5	---
HPOP	Trans Fat Policy	-	100	7.1	20.2	185.9	8.7	2.2	2.5
UHC	Family planning	SDG 3.8.1	75	73.7	77.1	4.7	0.4	0.1	---
UHC	Pregnancy and delivery care	SDG 3.8.1	95	77.6	82.2	5.9	0.5	1.7	3.5
UHC	Child immunization	SDG 3.8.1	93	89.5	89.7	0.3	0	0.3	17.2
UHC	Child Health Care Seeking	SDG 3.8.1	85	74.7	79.4	6.3	0.5	1.1	2.1
UHC	TB treatment	SDG 3.8.1	91	74.9	84.2	12.4	1	1.6	1.7
UHC	HIV treatment	SDG 3.8.1	92	56.4	89.2	58	3.8	4.1	1.1
UHC	Malaria prevention	SDG 3.8.1	80	47.8	76.8	60.6	4	4.3	1.1
UHC	Water and sanitation	SDG 3.8.1	96	76.1	84.1	10.5	0.8	1.9	2.3
UHC	Prevention of cardiovascular disease	SDG 3.8.1	80	38.9	42.7	9.8	0.8	6	7.7
UHC	Management of diabetes	SDG 3.8.1	8	9.2	11.5	24.4	1.9	-1.2	---
UHC	Tobacco control	SDG 3.8.1	20	22.8	17.7	-22.1	-2.1	-1.1	---
UHC	Hospital access	SDG 3.8.1	34	26.1	30.7	17.5	1.4	2.2	1.6
UHC	Health workforce	SDG 3.8.1	71	51.5	69.6	35.1	2.5	2.7	1.1
HEP	Preparedness	SDG 3.8.1	80	74.4	80.7	8.5	0.7	0.6	---
HEP	Prevent	-	-	91.2	91.3	0.1	0	---	---
HEP	Time to detect and respond	-	-	59	81.7	38.6	2.7	---	---

Note:

Preliminary estimates subject to changes based on Member State consultation. Do not distribute.

¹ Likely Achieve by 2030

² Acceleration greater than 2X required

³ Reversal of trends required

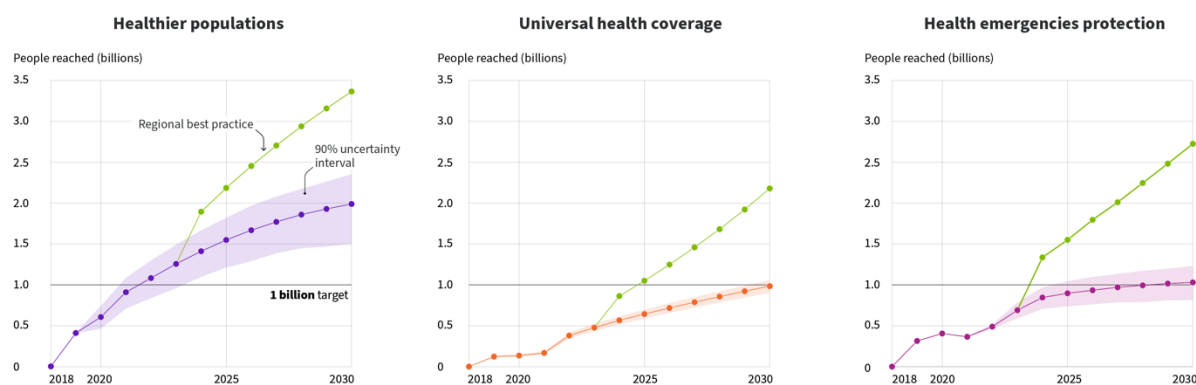
* Annualized rate of change (AROC) = ln(target value / baseline value) / (target year - baseline year)

[†] Required times of acceleration = Target AROC / Forecast AROC

Benchmarking progress made in other countries can be another useful scenario to examine potential gains countries could make in the future. The charts in Figure 5 shows the potential Billions with the red lines, assuming that every country achieves the 80th percentile best rate of improvement in each outcome indicator by WHO region. Similar scenarios can be computed using different assumptions and then used to guide setting the Triple Billion targets up to the year 2028. It is clear that more than 90% of the outcome indicators need a solid plan for acceleration in order to achieve the intended target by 2030.

Figure 5.

Triple Billion target scenario: best regional practice in improvement



Source: Forecasts based on data from World Health Statistics 2023.

The Triple Billion targets for GPW 13 are in relative changes space. In other words, the targets are set for the relative changes in healthier population, universal health coverage, and health emergency protection between the target year in 2023 (or 2025 for GPW 13 extension) and the baseline year in 2018. However, for ease of communication, an alternative would be setting each target in absolute population space: the number of people enjoying healthier lives, the number of people covered by UHC, or the number of people protected from health emergencies globally.

Figures 6 (a and b) below shows statistical forecasts and different scenarios in both the absolute and relative billions contribution spaces for the universal health coverage (UHC) billion between 2018 and 2030. The Triple Billion contributions in relative (right) and absolute (left) correspond for each scenario and the statistical forecast.

Figure 6a.

Global absolute contributions to UHC billion

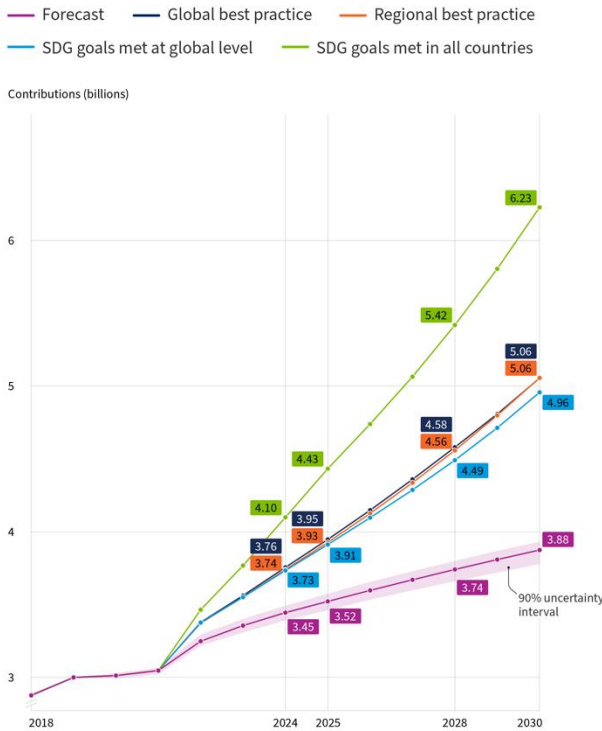
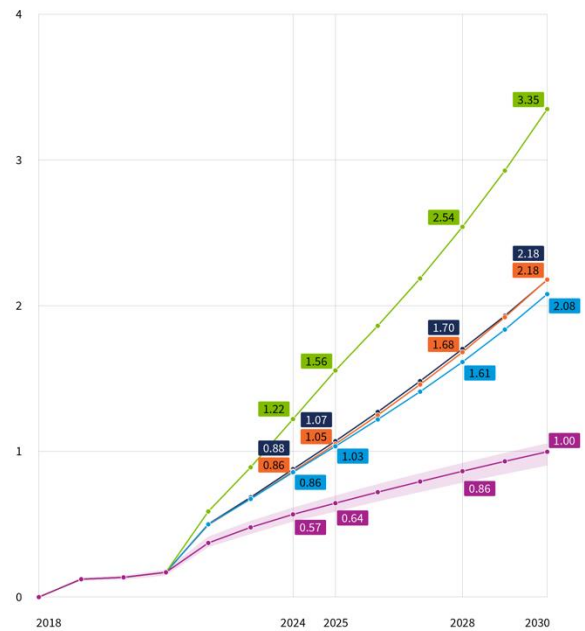


Figure 6b.

Global contributions relative to 2018 to UHC billion



Source: Forecasts based on data from World Health Statistics 2023.

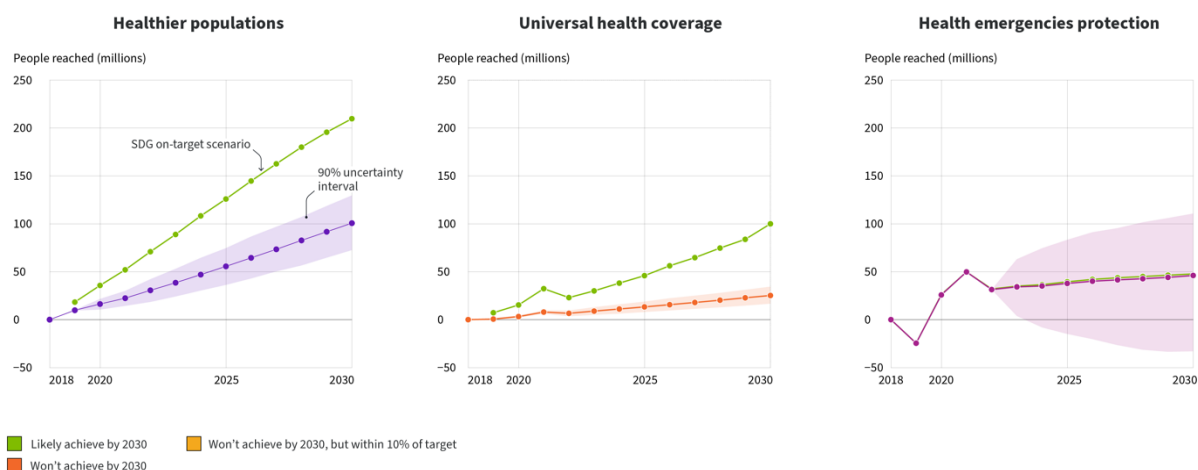
Through the evaluation of potential targets based on different scenarios and the statistical forecast based on empirical data before the baseline in 2018, it is evident that the final target for UHC (Provide) should be between the likely outcome of 3.7 billion in 2028 and the value given by fully achieving SDG targets in every country by the same year, around 5.4 billion. A balance between being realistic and ambitious gives a potential target (absolute population coverage) for UHC at approximately 5 billion in 2028. A similar exercise can be done for the healthier population billion (Promote). A global target for 2028 could be tentatively set at six billion, given the potential gains between 2018 and 2028 based on similar scenario-specific analysis and the above statistical forecasts.

However, it is important to point out that the programmatic indicators remain as the foundation of the GPW 14 impact measurement. The Triple Billion targets for ‘Provide, Promote and Protect’, whether it is in relative or absolute spaces, remains the same summaries of progress for the programmatic indicators at the country and global levels. In addition, as shown in Figure 6 on the UHC billion recalibration, each relative coverage number corresponds to an absolute coverage for the same scenario or statistical forecasts.

The recalibration exercise is in the works and will be updated with an additional list of outcome (programmatic) indicators. The Secretariat will consult with the Member States, expert reference group (ERG), and all three levels of WHO before its finalization.

Figures 8 (a and b).

Country progress: Triple Billion targets and health-related SDGs



Billion	Triple Billion indicator	2030 target	2030 forecast
Healthier populations	Safely managed water	96	67.8
	Childhood wasting	3	7.8
	Trans fat policy	100	20.2
	Suicide mortality	6	7.9
	Childhood stunting	17	20.2
	Road deaths	9	16.4
	Mean particulates (PM 2.5)	5	30.3
	Childhood overweight	3	6.0
	Intimate partner violence (F)	0	26.7
	Tobacco use	18	17.9
	Safely managed sanitation	95	70.9
	Clean household fuels	96	78.0
	Violence against children	0	79.6
	Adolescent/child obesity	5	13.9
	Alcohol consumption	5	6.0
Adult obesity	11	19.2	
Universal health coverage	Tobacco control	20	17.7
	Water and sanitation	96	84.1
	TB treatment	91	84.2
	Child treatment	85	79.4
	Malaria prevention	80	76.8
	Management of diabetes	8	11.5
	Family planning	75	77.1
	Child immunization	93	89.7
	Prevention of cardiovascular disease	80	42.7
	Hospital access	34	30.7
	HIV treatment	92	89.2
	Pregnancy and delivery care	95	82.2
Health emergencies protection	Preparedness	80	80.7

Source: Forecasts based on data from World Health Statistics 2023. Subject to changes based on forthcoming Member States consultation.

The information related to programmatic indicators is not just the cornerstone of the Triple Billion targets; it is also a critical tool for countries to identify and prioritize strategies to enhance the health of their populations. By examining a country's contributions to these three targets, policymakers can gauge progress in improving general health, responding to health emergencies, and achieving the SDGs set by the global community.

Graphical representations, like the heatmaps, clearly show a country's progress benchmarked against other countries. These visual tools allow for an at-a-glance comparison of a country's improvements in various health outcome indicators against set benchmarks, such as the global SDG targets.

Figure 8 above succinctly summarizes a Member State's contribution to achieving the global Triple Billion targets and forecasted trajectories for each outcome (programmatic) indicator by 2030 in terms of achieving the numeric global target, if there is any. In Figure 8, the black lines in healthier population, UHC, and the health emergency protection graphs are the billion contributions from each country based on empirical data and estimates provided by the responsive technical programmes and associated statistical forecasts up to the year 2030.

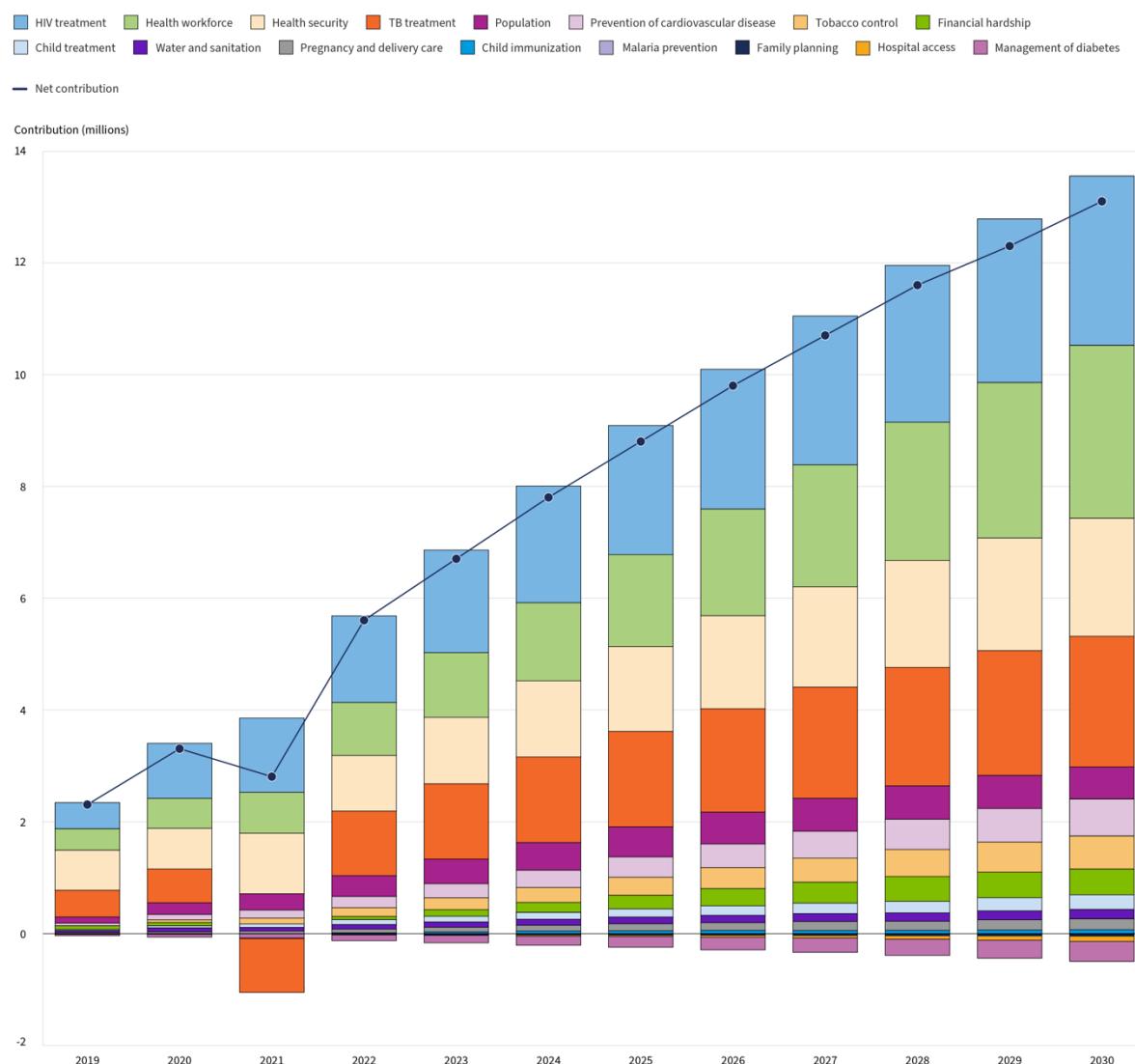
In the same graph, the green lines represent potential contributions to the billions for a Member State if the country achieves a global target for those programmatic indicators with a numeric global target by 2030. The difference between the two lines indicates room for further improving population health at the country level. Similarly, the bottom right heatmap in Figure 8 shows a similar target achievement assessment for a Member State, further illustrating the progress made in each programmatic indicator by the country and its likely trajectory by 2030.

Further analysis can break down a country's specific contributions to the Triple Billion targets by programmatic indicators. For instance, by dissecting the elements contributing to the UHC billion over time, policymakers and the Secretariat can pinpoint significant advancements or identify areas where progress is stagnant or regressing—such as the negative impact of rising adult obesity rates, shown in Figure 9.

This graph's black line over time represents the net contribution the example country made to the global UHC billion between 2019 and 2030. The stacked bar for each year further dissects the net annual billions contribution into positive or negative numeric contributions made by each programmatic/outcome indicator for the same calendar year, represented by different colour blocks as shown in the legend.

For example, the blocks in teal show the negative contributions the programmatic indicator, 'Adult Obesity', made over the period of 2019 to 2030. Such analysis enables the country and the Secretariat to investigate the performances of each outcome indicator further to amplify and show what significant progress was made by the country and the area that lacks progress, or even worse, negative contributions from specific outcome indicators.

Figure 9.
Decomposition of how a specific country has contributed to the Healthier Population billion target



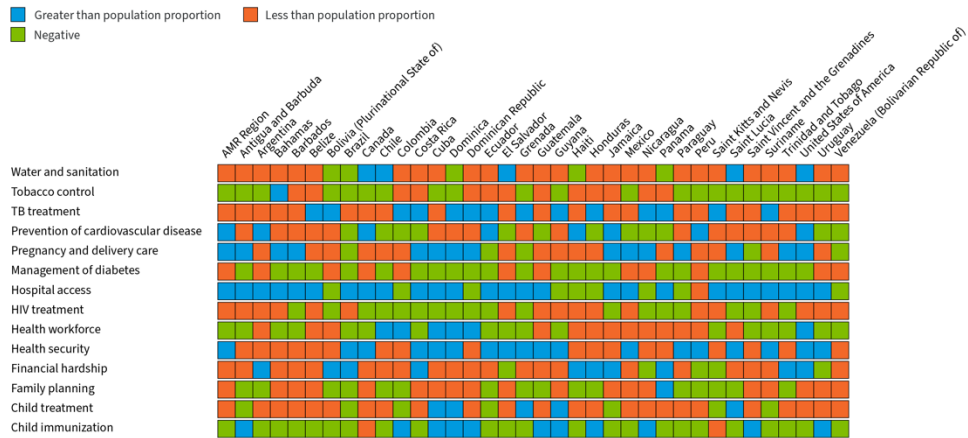
Source: Forecasts based on data from World Health Statistics 2023. Subject to changes based on Member States consultation.

It is also essential to account for population size when assessing a country's contribution to global targets. Countries with larger populations can substantially impact the global billions if they show improvements in health outcomes. This impact can be accounted for by comparing the ratio of a country's contribution to its population size against a global average—allowing for a fair comparison of progress among countries of varying sizes.

For example, Figure 10 illustrates the relative contributions to the UHC billion in the Americas. A green indicator signifies that a country's contribution exceeds the global average, orange indicates below average, and blue denotes a negative contribution.

Moreover, there is a need for similar detailed analyses at the subnational level. Such localized data is vital for designing and implementing targeted and effective health interventions within specific regions or communities.

Figure 10.
Relative contributions to the UHC billion by a WHO region (e.g., PAHO), 2023



Source: Forecasts based on data from World Health Statistics 2023. Subject to changes based on member states consultation.

Section 2. Accelerate progress in countries using the Delivery for Impact approach

As the world stands at the halfway mark of a critical race, the SDG timeline, WHO must catalyse and support accelerated progress in countries. Recognizing the urgent need for progress, WHO adopted the Delivery for Impact approach. This is a commitment to action and to intensified support to countries, harnessing data and delivery, science and innovation, digital technologies and partnerships, and improving the performance of the Secretariat to support countries most effectively.

Introduced in GPW 13, the Delivery for Impact approach strengthens capacities within the WHO Secretariat and Member States to make faster progress on the health-related SDGs and Triple Billion targets. This approach demonstrates measurable impact and supports governments, ministries of health and in-country health programme managers to priorities and make progress on their health priorities.

Align inputs, activities, outputs, outcomes and impact: WHO is intensifying support in countries by improving data quality, accessibility and use to drive policies and programmes. By aligning its Programme Budget with strategic priorities, WHO ensures accountability and credibility towards accelerated health improvements.

WHO has identified four key inputs: secure full and flexible financing, a skilled well-placed workforce, robust planning and budgeting grounded in results-based management, and governance mechanisms that emphasize accountability, transparency, and efficiency.

Outputs are crucial for Programme Budget development and planning, including Member States prioritization, budget costing, Programme Budget implementation, its monitoring and reporting. Outputs encompass the totality of what the Secretariat does and demonstrate a clear logic on how they will contribute to achieving outcomes and impact. More information on the development of outputs and their measurement is available in the White Paper.² For GPW 14, the outputs will demonstrate a clear logic on how they contribute to achieving outcomes and impact. Therefore, the selection of outputs should be based on the maximizing health impact given resource constraints.

WHO Theory of Change: Theory of Change spans functional and management objectives across the five priorities: to promote and protect health, while helping to power the work of the global health ecosystems towards the SDGs and enhance its own organizational performance. Aligned with three strategic shifts, the Organization undertakes activities that produce outputs and outcomes that drive the improvement at country level as explained through the Theory of Change.³

For GPW 14, the results-based management between WHO activities and outputs, and outcomes at the country level is being strengthened. The Theory of Change for GPW 14 is in development and will be updated to reflect its future iterations.

1. Operationalize the Delivery for Impact approach

The pathway from planning to implementation to impact is addressed with the following five questions:

1. What are we trying to achieve? *By using data to identify indicators that are off track to inform prioritization, and setting time-bound acceleration targets for key priorities.*

² WHO. White paper on output development for GPW 14. 12 January 2024.

³ WHO. White paper on output development. Draft 5 January 2024.

2. How are we planning to do it? *Developing a delivery or acceleration plan through prioritized application of WHO guidance on solutions (policies, strategies, interventions) that will most rapidly achieve results.*
3. How will we regularly track progress? *Identifying indicators that are regularly tracked and establishing routines such as stocktakes to track progress on a regular basis.*
4. If we are not on track, what will we do about it? *Identifying bottlenecks and using data and problem solving tools to find solutions and rapidly course correct when progress is not on track.*
5. What can be improved? *Implementing a monitoring, evaluation and learning approach with feedback loops to continually adapt to the environment.*

Delivery stocktakes and delivery milestones are used to set priorities and track progress:

Delivery stocktakes shift the focus from problem identification to the implementation and management of solutions. They help assess the real-world impact of strategies and provide a means for WHO governing bodies to track the Secretariat's programmatic accountability. Strategic leadership sessions are held where WHO assesses its progress towards SDGs and the Triple Billion targets and sets specific, time-bound delivery milestones.

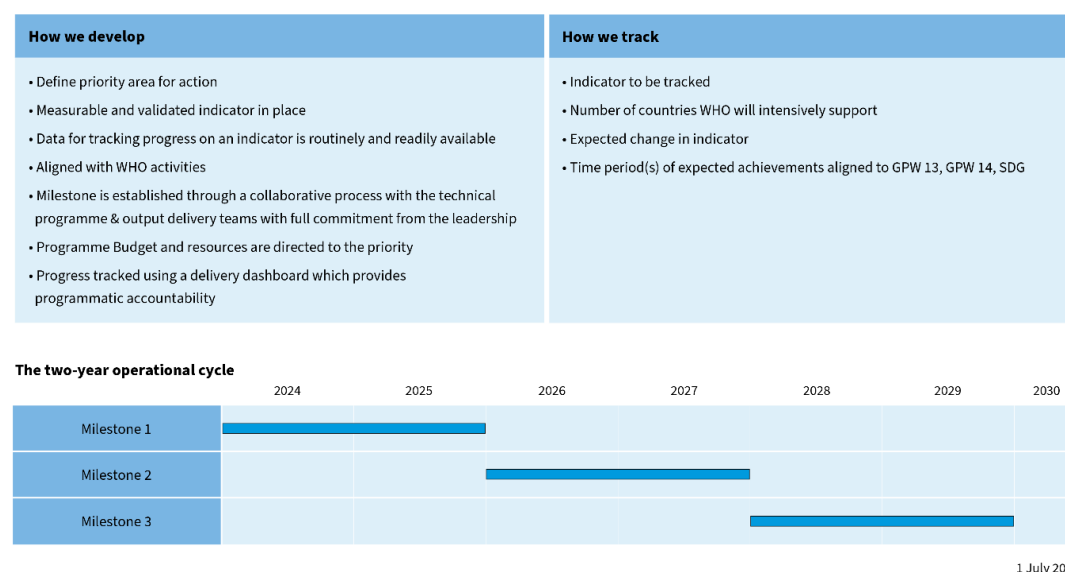
This process is key to align WHO's actions with its overarching goals and boost the confidence of stakeholders in the organization's effectiveness and their investments in global health. Delivery stocktakes have been undertaken to track progress on each of the three billion targets and focusing on several programme areas such as climate and health, obesity, TB, health workforce, health emergency preparedness, primary health care, equity and tobacco control. During these stocktakes, delivery milestones are discussed and agreed across the 3 levels of WHO.

Delivery milestones are priorities established by WHO to direct its resources and efforts towards accelerating progress in a defined area of public health within agreed-upon timelines. Simply, delivery milestones are what WHO will do, where, by when and how. These milestones, designed for a two-year operational cycle, are closely linked to the specific actions WHO undertakes to assist Member States through intensified support to achieve measurable outcomes (Figure 11).

Progress toward these milestones will be tracked using the delivery dashboard. At the global level, the delivery dashboard is used for accountability. At the country level, it facilitates WHO and partner support of national efforts to manage and accelerate progress toward their strategic priorities. Examples of the global and country dashboards are presented in this section.

Figure 11.

Development of delivery milestones



Five steps of the delivery pathway are tracked using the delivery dashboard (Figure 12). This approach has been used in more than 50 countries. The progress towards these milestones is a collaborative effort, with a shared vision to prioritize actions to improve public health, and the details of these milestones are presented in Annex 4.

Figure 12.

Five components of the Delivery for Impact approach tracked using the delivery dashboard (These steps are non-linear and often occur in parallel)

Acceleration scenarios	Communities identified for acceleration	Delivery plan developed	Delivery plan costed and financed	Execution, tracking, and problem solving
Considering current progress toward targets, by how much can progress be accelerated?	Which are the high burden/high-impact countries/communities?	What are the most effective interventions WHO can support to be implemented to accelerate progress in countries?	Is the delivery plan costed? Is a resource mobilization plan developed? Is the resource mobilization plan actioned?	Including accountability routines for regular progress tracking, problem solving, and course-correction.

The 100-day sprint to catalyse progress: To accelerate our transformation, WHO has launched a model of a 100-day delivery sprint to increase collaboration and innovation, accelerate progress, increase integration between teams, and build sustainability and scalability for several transformation initiatives. The 100-day methodology aims to stimulate participants to rethink how government works by introducing a unique model that is built on accelerated results, increased collaboration, and implementing innovative solutions.

The 100-day sprint model works in three phases. In phase one (20 days), the challenge is designed, and stakeholders identified. In phase two (20 days), acceleration targets are set. In phase three (60 days), the results are achieved, sustained, and scaled. Implementation of solutions within the health sector often requires sustained focus and attention. The 100-day sprint model aims to kick-start implementation efforts with a renewed sense of urgency, bringing measurable impact and some quick-wins.

2. WHO's contribution to health impact: examples

As global health challenges evolve, WHO reshapes its operations around three strategic shifts: stepping up leadership, catalysing public health impact across countries, and prioritizing global public goods. WHO plays a multifaceted role in global health. It sets international health standards and provides guidance on best practices. It also conducts vital research and offers technical support to countries. It helps shape health policies worldwide and responds to health emergencies. WHO initiates and enables international health treaties and provides technical support and evidence-based policy options that underpin major decisions by governments and international health agencies.

For example, the leadership function involves negotiating key international treaties and agreements for health such as the Framework Convention on Tobacco Control (FCTC) and the International Health Regulations (IHR 2005). Examples of WHO establishing norms and standards include the MPOWER technical policy package for tobacco control, or WHO's pre-qualification of vaccines and medical products enabling procurement of life-saving products.

Reinforcing technical support, from WHO's guidelines to its in-country experts and operations, plays a significant role in the rapid and effective translation of critical policy actions. Strengthening data systems and using evidence that shapes policy and resource allocation such as how reporting on Pandemic Preparedness and Response capacities drives decisions made by the Pandemic Fund.

Integrating the approach across WHO: The Delivery for Impact approach has become part of WHO's DNA, influencing every level of its operation. It's evident in initiatives like the Health Impact Investment Platform, supported by the Multilateral Development Banks focusing on reinforcing primary health care and health security.

Country Focus: The prioritization within WHO's country offices is influenced by the Programme Budget, the Country Cooperation Strategy, and the Country Support Plan. Together these determine whether countries are receiving adequate support.

For countries lagging on their health goals, WHO offers a suite of Technical Products, outlined in the delivery policy matrix, to help develop targeted plans for rapid progress. WHO collaborates with regions and countries on capacity-building initiatives to tackle implementation hurdles and prioritize impactful planning.

Partnerships: WHO's leadership in the global health arena is critical in aligning efforts of multilateral partners towards the health-related SDGs. By engaging actively with SDG Global Action Plan (SDG GAP) partners, WHO is using the Delivery for Impact approach across various countries and health issues, like increasing vaccinations for 'zero-dose' children. This is not just an expansion; it's a commitment to leaving no one behind.

In summary, WHO's Delivery for Impact approach is multifaceted and addresses the complexities of global health. By addressing challenges head-on, measuring and amplifying impact, and collaborating globally, WHO aims not just to catch up but to leap forward in the race towards the SDGs.

3. An example on health workforce

Incorporating the concept of a delivery milestones, an example is the focused analysis on the role of the health workforce (HWF) in advancing the Triple Billion targets. Analysis undertaken for the global stocktake show that the health workforce is critical for accelerating progress towards the health-related SDGs and progress throughout the Triple Billion targets, particularly influencing progress toward the UHC and Health Emergencies Protection Billions. Even with a growing workforce it is still expected that by 2030, the world will have a shortfall of 10 million workers.

Glaring inequalities are evident in health workforce density across WHO regions. The AFRO and EMRO regions will bear 72% of the workforce shortage by 2030, an increase from 37% in 2020. AFRO is expected to double its share of the total shortage by 2030.

The Support and Safeguard list highlights those countries with the biggest challenges facing their health workforce and is complemented by the Small Island Developing States (SIDS) with some francophone African countries showing a relatively high gap in HWF. Beyond inequalities across WHO regions and between countries, there are also inequalities within countries that need to be tackled.

Proposed actions to reduce the HWF shortage are built on the 5th Global Forum on HRH, with a specific target to double HWF in the LMICs with greatest shortages over the next 10 years.

Following on from the global stocktake, WHO has intensified its work across the three levels to prioritize investment in health workforce, by committing to achieving the time-bound delivery milestones (Figure 13). In practice, this means Country Offices will receive additional support to define acceleration scenarios, develop delivery plans, and establish routines to ensure progress is on track.

Figure 13.

Delivery stocktake commitments (milestones) to double health workforce in LMIC by 2030

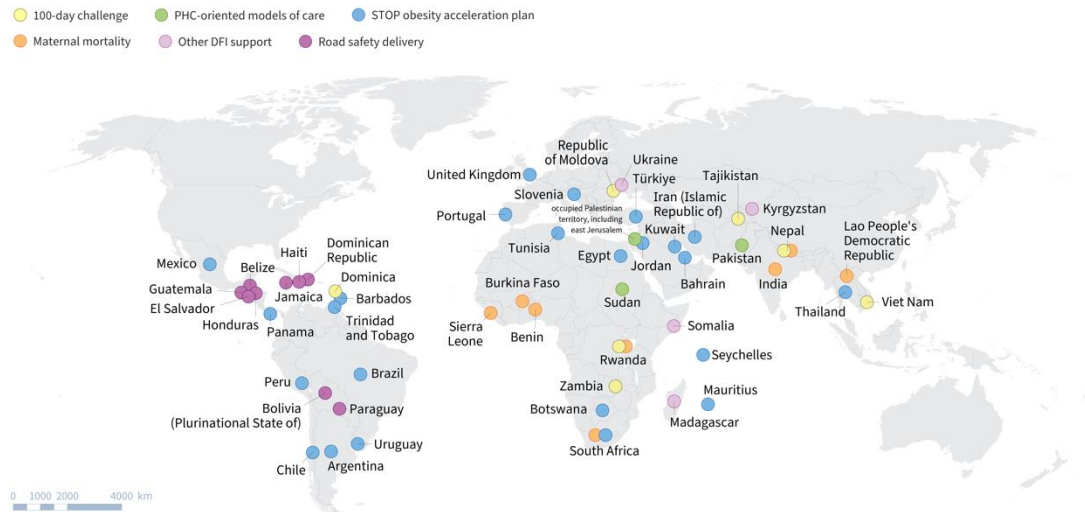
Countries	Commitments
40 safeguard and support list countries (AFRO, EMRO)	Intensified support to countries to double workforce by 2030
7 Francophone countries (Benin, Cameroon, Central African Republic, Chad, Madagascar, Mali, and Niger)	Investment in training and employment focused on primary health and public health in rural areas
Small Island Developing States (SIDS)	Initiate actions on retention, employment and implementation of the WHO Global Code of Practice
100 countries	Strengthen public health and emergency workforce
10 HIC (Australia, Belgium, Canada, France, Germany, Saudi Arabia, Switzerland, United Arab Emirates, UK, and the USA)	Adopt domestic and international policies on self-sufficiency

4. Scale up the use of Delivery for Impact approach in countries

At the country level, the delivery dashboard supports WHO and our partners to manage and accelerate country priorities. Over 50 WHO country offices have embraced this approach, developing policy-sensitive proposals to accelerate impact amenable to change through application of WHO's normative guidance (Figure 15). Integral to this approach is the constructive collaboration with UN agencies, multilateral organizations, academia, and civil society, spanning national and international spheres.

Figure 16.

Delivery for Impact applications . These include diverse hybrid and online supports, in-person workshops, tailored-country supports applying the delivery approach, distinct from technical team priority countries.



- 10 countries have completed an end-to-end process
- 52 WHO country offices are using delivery approach for at least 1 priority area
- More than 400 colleagues and MoH staff trained on the delivery approach
- Active collaboration with over 20 technical teams in HQ and regional offices

Country examples showing acceleration scenarios across the healthier populations (promote), universal health coverage (provide) and health emergencies protection (protect) billions are shown in Figures 17-19.

As can be seen in Figures 17 through 19, each of the three countries have nine indicators on track to achieving global targets by 2030, and varying targets projected to be within 10% of the goal. Based on this analysis, countries can prioritize areas for accelerated action.

Figure 17a.

Viet Nam: progress toward SDGs and Triple Billion targets

■ Likely achieve by 2030
 ■ Won't achieve by 2030, but within 10% of target
 ■ Won't achieve by 2030

Billion	Triple Billion indicator	2030 target	2030 forecast
Healthier populations	Childhood wasting	3	■
	Suicide mortality	6	■
	Childhood stunting	17	■
	Road deaths	9	■
	Mean particulates (PM 2.5)	5	■
	Childhood overweight	3	■
	Intimate partner violence (F)	0	■
	Tobacco use	18	■
	Clean household fuels	96	■
	Violence against children	0	■
	Adolescent/child obesity	5	■
	Alcohol consumption	5	■
	Adult obesity	11	■
Universal health coverage	Tobacco control	20	■
	Water and sanitation	96	■
	TB treatment	91	■
	Child treatment	85	■
	Management of diabetes	8	■
	Family planning	75	■
	Child immunization	93	■
	Prevention of cardiovascular disease	80	■
	Hospital access	34	■
	HIV treatment	92	■
Pregnancy and delivery care	95	■	
Health emergencies protection	Preparedness	80	■

Figure 17b.

Viet Nam: adult male tobacco use prevalence current trend and target

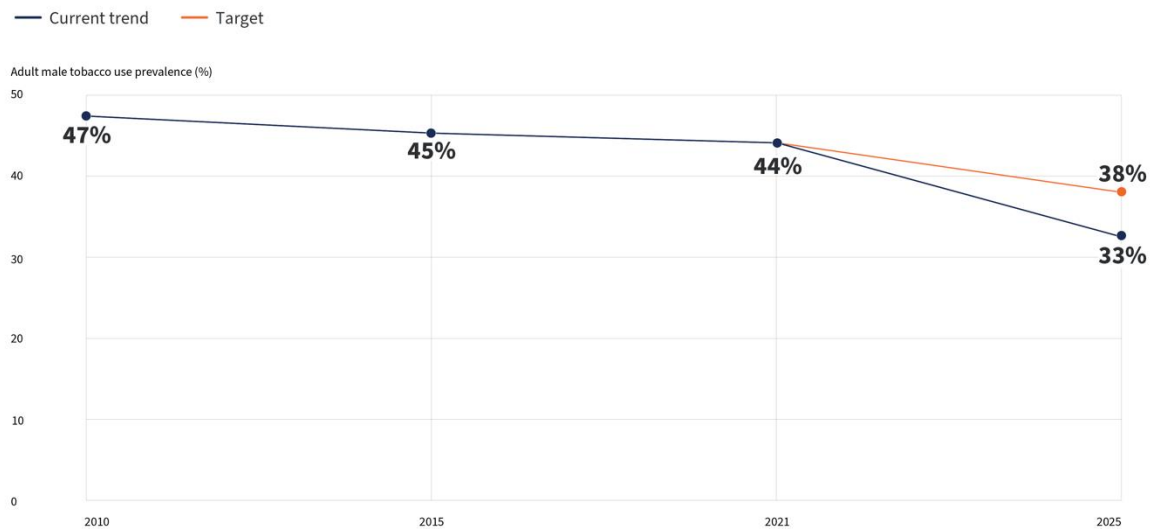


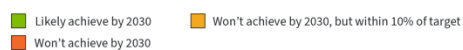
Figure 17c.

Viet Nam: country delivery dashboard



Figure 18a.

Tajikistan: progress toward SDGs and Triple Billion targets



Billion	Triple Billion indicator	2030 target	2030 forecast
Healthier populations	Safely managed water	96	■
	Childhood wasting	3	■
	Trans fat policy	100	■
	Suicide mortality	6	■
	Childhood stunting	17	■
	Road deaths	9	■
	Mean particulates (PM 2.5)	5	■
	Childhood overweight	3	■
	Intimate partner violence (F)	0	■
	Clean household fuels	96	■
	Violence against children	0	■
	Adolescent/child obesity	5	■
	Alcohol consumption	5	■
Adult obesity	11	■	
Universal health coverage	Tobacco control	20	■
	Water and sanitation	96	■
	TB treatment	91	■
	Child treatment	85	■
	Management of diabetes	8	■
	Family planning	75	■
	Child immunization	93	■
	Prevention of cardiovascular disease	80	■
	Hospital access	34	■
	HIV treatment	92	■
Pregnancy and delivery care	95	■	
Health emergencies protection	Preparedness	80	■

Figure 18b.

Tajikistan: acceleration needed to achieve HIV 95-95-95 global targets

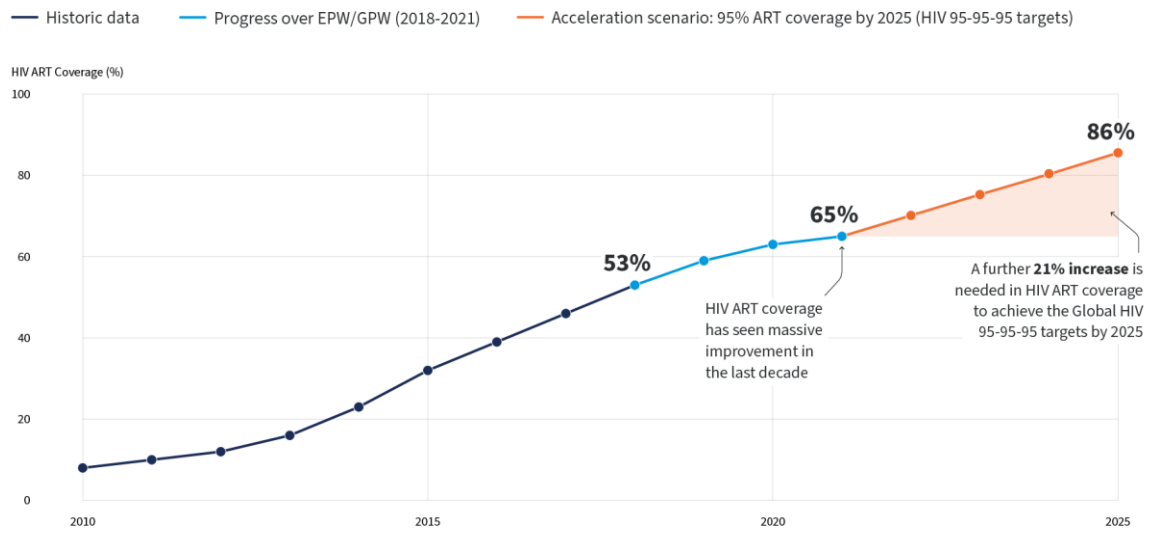


Figure 18c.

Tajikistan: country delivery dashboard

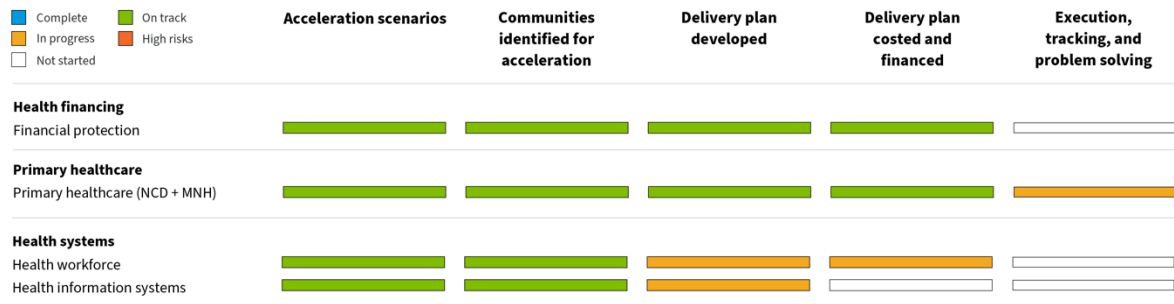


Figure 19a.
Nepal: progress toward SDGs and Triple Billion targets

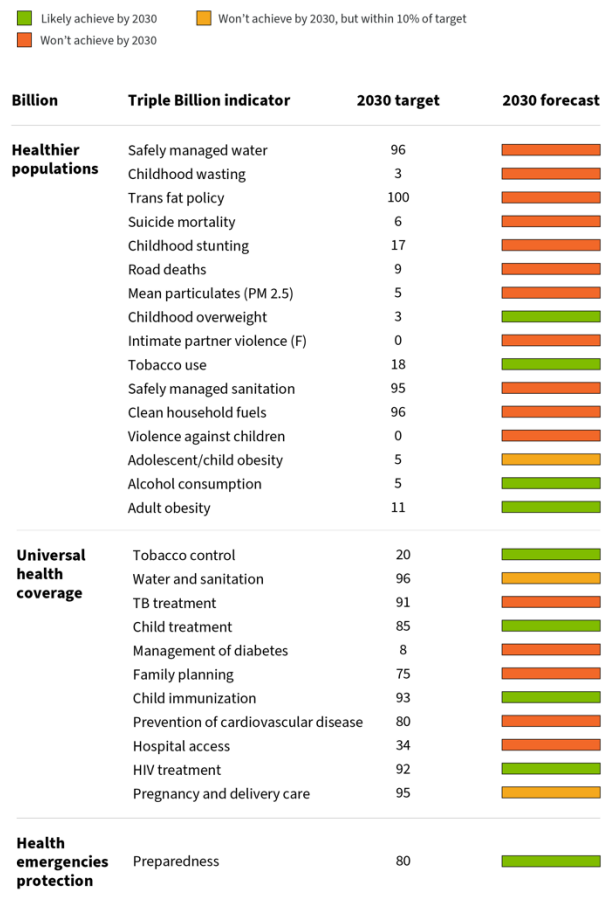


Figure 19b.
Nepal: IHR core capacity score acceleration compared to global and regional averages

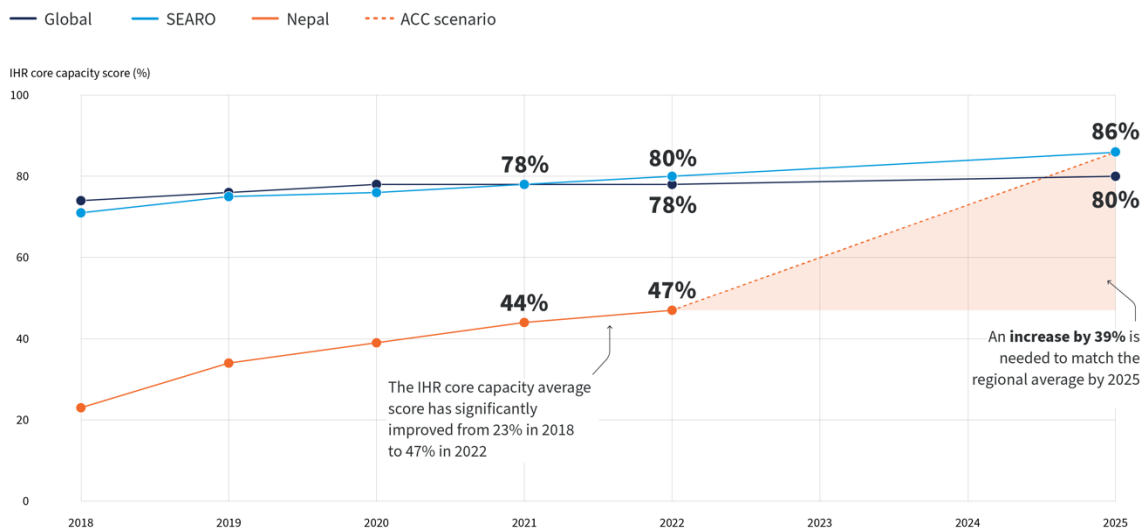
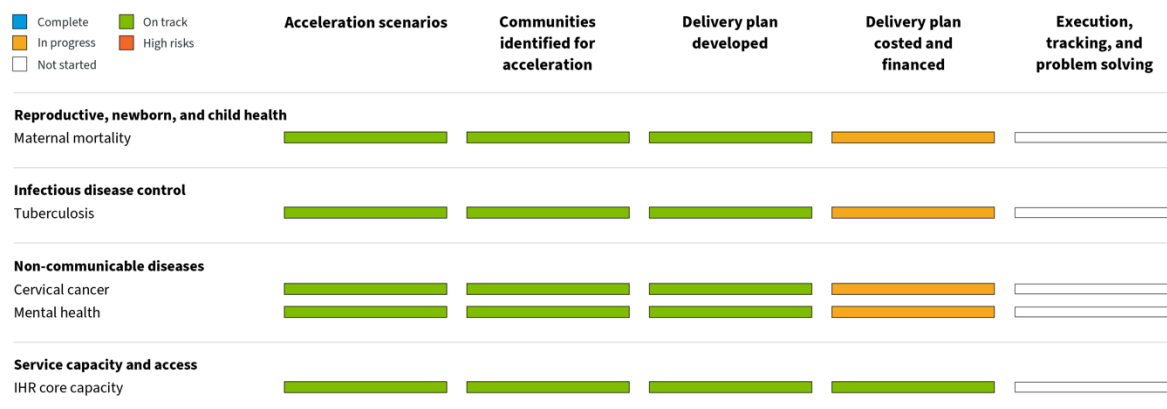


Figure 19c.

Nepal: country delivery dashboard

The delivery end to end planning process identifies priorities and targets, and is consistently applied across workstreams. Using the DFI approach brings a sustained focus on achieving impact, when used as a routine tracking mechanism updated quarterly. Following the 100 days Challenge, priorities selected with the Nepal country office are being implemented and tracked in this delivery dashboard.



5. Delivery Dashboard for global accountability

The delivery dashboard (Figure 20) tracks the progress of global delivery milestones identified through the stocktaking process. Countries can use the delivery dashboard to monitor their progress on selected milestones that are most relevant to their specific challenges, as depicted on the previous pages.

This tool not only promotes accountability within the WHO Secretariat but also supports Member States in their governance reform efforts in alignment with recommendations from the Agile Member States Task Group (AMSTG).

The delivery dashboard provides a snapshot on accountability in response to the recent evaluation of the WHO's Results-Based Management (RBM) approach which identified areas for improvement, including the need for more cohesive RBM practices and addressing the previously noted disconnection between outputs and outcomes. Institutionalizing the Delivery for Impact approach is a response to these findings, realigning WHO's RBM components, and strengthening the causal link between the organization's outputs and the health outcomes observed in Member States.

This also responds to the inception report of the GPW 13 evaluation which also highlights the lack of an explicit link between outputs and outcomes. Delivery for Impact provides an explicit link between outputs and outcomes at the Member State level.

Figure 20.
Global delivery dashboard



Despite knowing how to tackle global health issues, implementation can be impeded by limited data analysis, insufficient political will, and inadequate resource distribution. The Delivery for Impact approach overcomes these barriers by fostering accountability, pushing for the adoption of evidence-based solutions, and enabling effective execution for real-world outcomes.

WHO is committed to ensure responsive problem-solving and strategic adjustments throughout the implementation process.

Section 3. Improve data, digital and health information systems

In today's rapidly evolving landscape of global health, the ability to clearly comprehend our current standing and make informed decisions has never been more important.

To this end, WHO harnesses the power of data, digital and cutting-edge technologies to ensure timely, reliable, and actionable data is readily available. Data is not only about monitoring health challenges but also about closing the inequality gap through provision of disaggregated data.

WHO, along with partners, provides countries with advanced tools and resources to upgrade their health data and digital systems, ensuring they can effectively monitor emerging health challenges, analyse fresh data, and update their health targets accordingly. These efforts are essential in a world where health dynamics are constantly shifting and investments in improving health information systems need to be prioritised.

At the core of this effort is the [WHO SCORE for Health Data Technical Package](#), a comprehensive suite of validated strategies for strengthening health information systems. The SCORE Package encompasses a wide array of functions, including surveying population health risks, tracking births, deaths, and causes of death, optimizing health service data, reviewing progress and performance, and enabling data use for policy and action. This multifaceted approach covers diverse sources of health data, ranging from public and disease surveillance systems to civil registration and vital statistics (CRVS), hospital records, and health facility data.

Continuous improvements are made to key statistical reports and tools to accurately reflect the ever-changing global health landscape. Notable examples include the World Health Statistics Report, Global Health Estimates, and the UHC Global Monitoring Report. WHO is fostering collaboration to expand the implementation of interoperable digital solutions, such as the 11th International Classification of Diseases ([ICD-11](#)) in countries.

The [World Health Data Hub](#), the [WHO Hub for Pandemic and Epidemic Intelligence](#), the [Global Digital Health Strategy](#), and the Geographic Information System (GIS) [Center for Health](#), and Research for Health are platforms pivotal to facilitate access and use of health data, empower public health experts and policymakers worldwide with the tools necessary to predict, detect, and assess epidemic and pandemic risks. These tools enable swift decision-making to prevent and respond to future public health emergencies, and enhance the relevance of data to real-time scenarios, bolstering predictive capabilities.

WHO remains committed to forging multi-sectoral partnerships that extend the reach and impact of its health content while concurrently combating the proliferation and impact of misinformation.

A contemporary data architecture underpins these efforts, ensuring data digitization and secure storage. Comprehensive data governance is a priority for WHO, safeguarding the reliability and confidentiality of health information. This governance allows for a seamless flow of primary and secondary data, facilitating its use across various health sectors. Access to complete and accurate data paints a clearer picture of population health trends, enabling more precise and effective public health interventions.

These collective efforts serve to accelerate the digital transformation at the country level, thereby propelling progress towards achieving the Triple Billion targets and the SDGs, paving the way for a healthier and safe future for all. Investments in improving these systems need to be prioritized.

As requested by Member States, the Secretariat is working with health ministries, ministries of information and technology, national statistics offices and registrar generals' offices to improve public health surveillance, civil registration and vital statistics, routine health information systems and digital health. The Secretariat will convene a global technical consultation to review the components of the Results Framework

and accelerate efforts to strengthen data and health information systems in countries, and is prioritizing the provision of technical support to least developed countries and Small Island Developing States.

Moving Forward: A WHO the world can depend on – maximizing WHO’s impact protecting and improving health

Faced with needs that increase more rapidly than resources to address them, maximizing impact requires focus at country, regional and global levels. The WHO Results Framework proposes to increase the real-time monitoring of and accountability for progress. Based on maximum health impact for the investment, focusing on priority areas will be important to support countries and partners to prevent premature deaths and improve the quality of life at all ages, while saving tens of billions of dollars through reduced health cost and increased productivity.

This technical paper will be updated following feedback from Member States, partners and WHO technical programmes in February and March 2024. The final paper will be presented to the World Health Assembly along with the GPW 14. The Results Framework will be fully integrated into the draft GPW 14, which in turn will cascade into the Programme Budget and frame the Investment Case.

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Annexes

Annex 1. Statistical forecasting method for outcome indicators

Statistical forecasting methods for trajectories of the Triple Billion targets

The Triple Billion indices are calculated as a function of 46 outcome indicators. To forecast the Triple Billion to 2030 each tracer indicator must be forecast to 2030. For the few indicators where data is available the forecast captures the impact of the COVID-19 pandemic.

Forecasts are generally produced in a two-step process:

1. A "baseline" model is fit using 2000-2019 data to capture pre-pandemic trends and project to 2030 what might have occurred without the COVID-19 pandemic.
2. The baseline projections are then adjusted during pandemic years to account for disruption due to the COVID-19 pandemic.

a. Baseline Projections

For each of the tracer indicators one of the following modelling strategies is used to produce baseline projections to 2030. Table 2 lists the modelling strategy used for each indicator.

1. Constant: The latest data point is held constant until 2030 and all draws are equal to this constant value.
2. Auto Regressive Integrated Moving Average (ARIMA): ARIMA time series models are fit for each indicator-location to project to 2030.

b. Auto Regressive Integrated Moving Average (ARIMA)

Without shocks like the COVID-19 pandemic, each tracer indicator in each country should follow previous time trends. One of the most common time series forecasting methods is the Auto Regressive Integrated Moving Average (ARIMA) model. ARIMA models can be used to forecast each indicator for each country to 2030.

See Chapter 9 of 'Forecasting: Principles and Practice' for a brief description of ARIMA time series models. A basic subtype of ARIMA models is the random walk model with drift, also known as $ARIMA(0,1,0)$. This can be written as

$$y_t = c + y_{t-1} + \epsilon_t$$

where y_t is the sum of the previous data point y_{t-1} , the average trend or drift c , and random noise ϵ_t .

A non-seasonal ARIMA model can generally be defined by three parameters p , d , and q where:

p = the autoregressive order d = the order of differencing q = the moving average order

The non-seasonal ARIMA model can then be written as:

$$y_t' = c + \phi_1 y_{t-1}' + \dots + \phi_p y_{t-p}' + \theta_1 \epsilon_{t-1} + \dots + \theta_q \epsilon_{t-q} \epsilon_t$$

where y_t' is the series of values differenced by order d . Differencing a time series is simply calculating the difference between consecutive observations.

Another common method for time series modelling is exponential smoothing models (ETS). ETS (., ., .) models can be classified by the error (E), trend (T) and seasonal (S) components. For this work we only consider additive error and non-seasonal ETS models which can also be written as ARIMA models. Chapter 8 of 'Forecasting: Principles and Practice' again provides descriptions of ETS models and Table 9.4 from the

textbook is reproduced below to show equivalency between additive errors and non-seasonal ETS models and ARIMA models.

Table 3.1: 'Equivalence relationships between ETS and ARIMA models'. From Table 9.4 of 'Forecasting: Principles and Practice'.

ETS model	ARIMA model	Description
ETS(A,N,N)	ARIMA(0,1,1)	Simple exponential smoothing
ETS(A,A,N)	ARIMA(0,2,2)	Holt's linear trend method
ETS(A,Ad,N)	ARIMA(1,1,2)	Damped trend method

The *fable R package* provides functions to fit ARIMA and ETS models and does model selection and validation for each model class. *fable* uses the Hyndman-Khandakar algorithm to automatically iterate through the space of possible ARIMA models and uses corrected Akaike's Information Criterion (AIC) to select the best $ARIMA(p, d, q)$. For ETS models the *fable* package also uses AIC to select the best ETS model. This procedure as implemented in the *fable* package is described in more detail at the following links for *ARIMA* and *ETS* models.

Most tracer indicators are bounded between a minimum and maximum value. For indicators measured as percentages the logit transformation is used to constrain values between 0 and 100. For indicators that are positively constrained the scaled logit transformation is used to constrain values between 0 and twice the maximum observed value in the time series across all countries.

The general algorithm used to produce a baseline time series forecast for each indicator-location is:

- For most indicators only data points in 2019 and before are used to fit the ARIMA models. See Table 3 for a list of indicators where all available data is used.
- Fit the random walk model with drift $ARIMA(0,1,0)$.
- In specific cases, the forecasts from the random walk model with drift are inconsistent with prior expectations about future trends. For all locations *fable* is also used to fit and select a best:
 - i. non-seasonal ARIMA model.
 - ii. additive and non-seasonal ETS model.
- By default, the random walk model with drift is used to make final baseline projections to 2030. Visual review is used to select for which indicator-locations the automatically selected model from *fable* should be used instead. In total 96.5% of indicator-locations did not use the default random walk model with drift $ARIMA(0,1,0)$ or the default constant model. Table 2 shows this percentage separately for each indicator.
- 1000 draws of the baseline forecast are then sampled from the selected model to feed into the next covid adjustment step.

c. COVID-19 Pandemic Adjustment

A subset of Triple Billion tracer indicators account for the COVID-19 Pandemic in input estimates for the year 2020 and 2021.

There are three different scenarios for whether or not a tracer indicator has been adjusted for the impacts of the COVID-19 Pandemic.

- 1) The tracer indicator does not include any estimates after 2019. In this case we do not attempt to predict the impact of the COVID-19 Pandemic in forecasts. Table 3 column '2020-2021' shows the percentage of location-years with data.

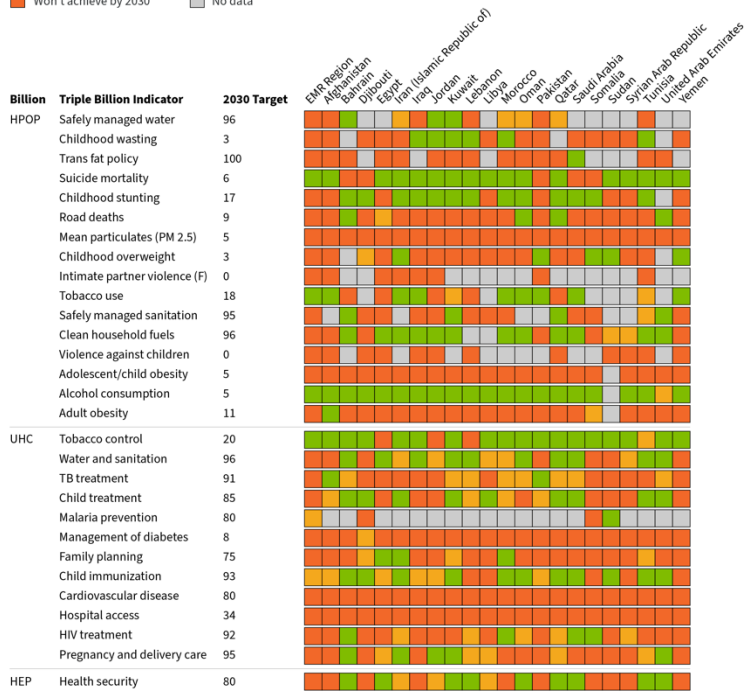
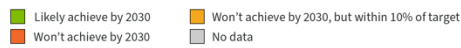
- 2) The tracer indicator accounts for the COVID-19 Pandemic in a small subset of locations. For example, the anc4 tracer indicator included data points for 2.8% of location-years in 2020 and 2021. In these cases, we adjust forecasts to exactly match input estimates in 2020 and 2021 where they are available but do not attempt to predict the impact of the COVID-19 Pandemic in other locations.
- 3) The tracer indicator accounts for the COVID-19 Pandemic in a substantial number of locations that allows us to predict potential impacts of the COVID-19 Pandemic in other locations where input estimates are not included. Table 3 column 'COVID Adjustment' shows for which indicators this adjustment is applied.

This adjustment predicts the difference between the baseline forecast and input estimates given the estimated per capita number of covid infections.

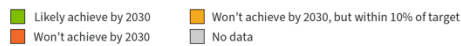
$$\begin{aligned} \delta_{l,t} &= \hat{y}_{c,t} - y_{c,t} \text{ where: } \hat{y}_{c,t} \\ &= \text{baseline prediction of indicator in transformed space in country } c \text{ and time } t \\ y_{c,t} &= \text{input estimate of indicator in transformed space in country } c \text{ and time } t \\ \delta_{l,t} &= \text{residual difference between baseline prediction and input estimate in transformed space in country } c \text{ and time } t \\ &= \alpha_0 + \beta X_{c,t} + \epsilon_{c,t} \quad \epsilon_{c,t} \sim \text{Normal}(0, \sigma) \end{aligned}$$

In scenario 3 the predicted difference from the baseline forecast is used for location-years where data does not exist for 2020 or 2021. Where input data does exist for 2020 or 2021 the forecasts are adjusted to exactly match the input data point. Indicator specific assumptions are then made about when indicator forecasts will return to baseline forecast trends. The 'Return to Baseline Year' column in Table 3 shows the year that each covid adjusted indicator is assumed to return to baseline forecast trends after 2021 data points or predicted 2021 covid adjusted estimates. In cases where it is assumed that the indicator will return to baseline levels in 2024, 2022 and 2023 are filled in using linear interpolation between 2021 and 2024 estimates.

Eastern Mediterranean Region (EMRO)



South-East Asia Region (SEARO)



Western Pacific Region (WPRO)

■ Likely achieve by 2030 ■ Won't achieve by 2030, but within 10% of target
■ Won't achieve by 2030 ■ No data



Annex 3. Outcome (programmatic) indicators in GPW 13 and proposals for GPW 14

Where possible and feasible, programmatic indicator data will align to SDG target 17.18 to include disaggregation by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts.

Strategic objective	Outcome	GPW 13 outcome (programmatic) indicator METADATA	Proposed outcome (programmatic) indicators for GPW 14 (in addition to existing outcome indicators) METADATA
GPW 14 priority: PROMOTE HEALTH Progress is measured by the healthier populations billion (target will be recalibrated for GPW 14)			
1. Respond to climate change, the greatest health threat of the 21 st century	1.1 More climate-resilient health systems are addressing climate risks and impacts.	[No indicator matched]	
	1.2 Lower- carbon health systems and societies are advancing health and well-being	[No indicator matched]	
2. Address the root causes of ill health by embedding health and wellbeing in key policies	2.1 Health inequities reduced by acting on social, economic, environmental, commercial and cultural determinants of health.	SDG 3.a.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older	SDG 5.1.1 Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex
		SDG 3.6.1 Death rate due to road traffic injuries	SDG Target 17.18 Proportion of GPW outcome indicators with data disaggregation, weighted by the proportion of countries with data available
		SDG 3.5.2 Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol	SDG Target 17.18 Proportion of countries that feature data disaggregation in their national health statistics reports
		SDG 4.2.1 Proportion of children aged 24–59 months who are developmentally on track in health, learning, and psychosocial well-being, by sex	SDG Target 17.18 Number of datasets available in the WHO Health Inequality Data Repository

		WHA 66.10 (2013) Best practice policy implemented for industrially produced trans-fatty acids (Y/N)	SDG 5.1 / 3.8 Gender equality advanced in and through health
2.2 Priority risk factors for noncommunicable and communicable diseases, violence and injury, and mental health reduced through intersectoral approaches	SDG 2.2.1 Prevalence of stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age		
	SDG 2.2.2 Prevalence of overweight (weight for height more than +2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age	WHA 69.9 Exclusive breastfeeding under six months	
	SDG 2.2.2 Prevalence of wasting (weight for height more than -2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age	WHA75(11) Proportion of population aged 15+ with healthy dietary pattern	
	SDG 2.2.3 Prevalence of anaemia in women aged 15 to 49 years, by pregnancy status (percentage)		
	SDG 3.9.1 Mortality rate attributed to household and ambient air pollution		
	SDG 3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation, and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All [WASH] services)	WHA73.5 Proportion of people who have suffered a foodborne diarrheal episode of non-typhoidal salmonellosis	
	SDG 3.9.3 Mortality rate attributed to unintentional poisoning		
	SDG 6.1.1 Proportion of population using safely managed drinking water services		

		SDG 6.2.1a Proportion of population using safely managed sanitation services	
		SDG 6.2.1b Proportion of population using a hand-washing facility with soap and water	
		SDG 7.1.2 Proportion of population with primary reliance on clean fuels and technology	
		SDG 11.6.2 Annual mean levels of fine particulate matter (e.g., PM2.5 and PM10) in cities (population weighted)	
		WHA 66.10 (2013) Prevalence of obesity among children and adolescents (aged 5–19 years) (%)	WHA71 (6) Prevalence of insufficiently physically active adolescents
		WHA 66.10 (2013) Prevalence of obesity among adults aged ≥18 years	WHA71 (6) Prevalence of insufficiently physically active adults
	2.3. Populations empowered to control their health through health promotion programmes and community involvement in decision-making	SDG 5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual, or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age	SDG 5.3.2 Proportion of girls and women aged 15 – 49 who have undergone female genital mutilation
		SDG 5.6.1 Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care.	SDG 3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group
		SDG 16.2.1 Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month	SDG 10.3.1 / 16.b.1 Proportion of population reporting having personally experienced discrimination against or harassed in the previous 12 months on the basis of a ground of discrimination prohibited under international law

GPW 14 priority: PROVIDE HEALTH

Progress is measured by the universal health coverage billion (target will be recalibrated for GPW 14)

<p>3. Advance the primary health care approach and essential health system capacities for health equity and gender equality</p>	<p>3.1 The primary health care approach renewed and strengthened to accelerate universal health coverage</p>	<p>[No indicator matched]</p>	<p>Existence of national strategy, policies and plans oriented to PHC and UHC meeting criteria</p> <p>Existence of health sector coordination mechanisms for multistakeholder participation, including communities and civil society (meeting criteria)</p> <p>Package of services for UHC (UHC package) is developed and meeting criteria</p> <p>Institutional capacity for essential public health functions meeting criteria</p> <p>Health facility density & distribution (by type & level of care)</p> <p>% of population reporting perceived barriers to care (geographic, socio-cultural, financial)</p> <p>Service utilization rate (primary care visits, emergency care visits, hospital admissions)</p> <p>Service availability (% of facilities with availability of services as per UHC package) (sub-set of countries only)</p> <p>Service readiness (% of facilities with service capacities & readiness to deliver UHC package) (sub-set of countries only)</p> <p>People centredness of primary care (patient experiences, perceptions, trust) (sub-set of countries only)</p>
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	3.2 Health and care workforce, financing and product availability substantially improved	SDG 3.c.1 Health worker density and distribution	Government domestic spending on health as a share of general government expenditure
		SDG 3.b.3 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis	Government domestic spending on health per capita Government domestic spending on PHC as a share of total PHC health expenditure Improved regulatory systems for medicines & health products Highly performing regulatory systems for medicines & health products Availability of essential medicines as per national list, by type/level (sub-set of countries only) Availability of vaccines as per national list, by type/level (sub-set of countries only) Availability of essential in vitro diagnostics as per national list, by type/level (sub-set of countries only) Availability of priority medical devices as per national list, by type/level (sub-set of countries only) Availability of priority assistive products as per national list, by type/level (sub-set of countries only)
	3.3 Health information systems strengthened and digital transformation implemented	[No indicator matched]	Completeness of birth and death registration Completeness of reporting by facilities System of regular and comprehensive population

			<p>health surveys that meets international standards</p> <p>Regular surveys of patient-reported experiences</p> <p>Existence of national digital health strategy, costed implementation plan, and legal frameworks to support safe, secure and responsible use of digital technologies for health</p> <p>% of health facilities using point of service digital tools that can exchange data through use of national registry and directory services (by type) (sub-set of countries only)</p>
<p>4. Improve equity and quality in health service coverage and financial protection to advance universal health coverage.</p>	<p>4.1 Equity in access to services for noncommunicable and communicable diseases and mental health conditions improved</p>	SDG 3.8.1 Coverage of essential health services	SDG 10.7.2 Does the government provide non-national equal access to essential healthcare?
		SDG 3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age, and key populations	
		SDG 3.3.2 Tuberculosis incidence per 100,000 population	
		SDG 3.3.3 Malaria incidence per 1,000 population	Vector-borne disease incidence
		SDG 3.3.4 Hepatitis B incidence per 100,000 population	Hepatitis C incidence per 100,000 population
		SDG 3.3.5 Number of people requiring interventions against neglected tropical diseases	Prevalence of active syphilis in individuals 15 to 49 years of age (%)
		SDG 3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes, or chronic respiratory disease	WHA75(11) Prevalence of controlled diabetes in adults aged 30-79 years
		SDG 3.4.2 Suicide mortality rate	WHA 73(12) Percentage of older people receiving long-term care at a residential care facility and home

		SDG 3.5.1 Coverage of treatment interventions (pharmacological, psychosocial, and rehabilitation and aftercare services) for substance use disorders	WHA72/2019/REC/1 Service coverage for people with mental health and neurological conditions
		SDG 3.d.2 Percentage of bloodstream infections due to selected antimicrobial-resistant organisms	Effective refractive error coverage (eREC)
		WHA68.7 (2015) Patterns of antibiotic consumption at national level	SDG 16.6.2 Proportion of population satisfied with their last experience of public health services
		WHA 66.10 (2013) Prevalence of raised blood pressure in adults aged ≥18 years	WHA66 (10) Prevalence of controlled hypertension, among adults aged 30-79 years
	4.2 Equity in access to sexual, reproductive, maternal, newborn, child, adolescent, older and other population-specific health services and immunization coverage improved	SDG 3.1.1 Maternal mortality ratio	WHA 67.15 Proportion of health facilities that provide comprehensive post-rape care as per WHO guidelines
		SDG 3.1.2 Proportion of births attended by skilled health personnel	WHA 67.10 Postnatal Care Coverage (newborn)
		SDG 3.2.1 Under-5 mortality rate	WHA69/16 Postnatal Care Coverage (woman)
		SDG 3.2.2 Neonatal mortality rate	WHA 67.10 Stillbirth rate (per 1000 total births)
		SDG 3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods	WHA73(2) Cervical cancer screening coverage in women aged 30 - 49 years, at least once in lifetime
		SDG 3.b.1 Proportion of the target population covered by all vaccines included in their national programme	Obstetric and gynaecological admissions owing to abortion
			SDG 5.6.2 Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and

			reproductive health care, information and education
	4.3 Financial protection improved by reducing out-of-pocket health expenditures , especially for the most vulnerable	SDG 1.a.2 Proportion of total government spending on essential services (education, health, and social protection)	Proportion of population with large household out-of-pocket expenditures on health as share of total HH expenditure or income Proportion of population with impoverishing population due to out-of-pocket expenditures on health payment OOP payments as a share of current spending on health
		SDG 3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income	Prevalence of foregone care (not seeking medical care when needed) ⁴
GPW 14 priority: PROTECT HEALTH			
Progress is measured by the health emergencies protection billion (target will be recalibrated for GPW 14)			
5. Prevent, mitigate, and prepare for emerging risks to health from all hazards	5.1 Risks of health emergencies from all hazards, including antimicrobial resistance , reduced and impact mitigated	Vaccine coverage for epidemic prone diseases	Identification of hazard and prevention indications incl. WASH, Infection Prevention and Control, and risk of zoonotic spillover
		Number of cases of poliomyelitis caused by wild poliovirus	
	5.2 Preparedness, readiness and resilience for health emergencies enhanced.	SDG 3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness	Identification of vulnerability and capacity indicators (IHR++)
			Adjustment of assessments based on full range of IHR monitoring and evaluation framework (JEE, AAR, IAR, SimEx)
6. Rapidly detect and sustain an effective response to all health emergencies	6.1 Detection of and response to acute public health threats is rapid and effective		Broaden the type of events which are measured
			Refine response activation indicator for the first 7 days

⁴ Metadata not available yet.

			Expand to include performance measure for the first 28 days of an emergency response
	6.2 Access to essential health services during emergencies is sustained and equitable.	Proportion of vulnerable people in fragile settings provided with essential health services (%)	Quality and effectiveness of essential health services during emergencies
			SDG 10.7.2 Does the government provide non-national equal access to emergency healthcare?
			Timeliness of development and equitable distribution of medical countermeasures
			Disruption to essential health services and systems in emergencies

Annex 4. GPW 14 Results Framework: mapping outputs, delivery milestones, to outcomes and impact

Mapping 3 priorities (promote, provide, protect), 6 strategic objectives, 15 outcomes, 46 outcome (programmatic) indicators⁵, 41 proposed outcome indicators, 24 delivery milestones⁶ (TBD), and 45 indicative outputs⁷

Outcomes	Outcome indicators	Proposed outcome (programmatic) indicators for GPW 14	Indicative delivery milestones	Indicative outputs
	SDG and WHA res. based	(in addition to existing outcome indicators)	Used to drive outcome indicators and focus indicative outputs	
GPW 14 priority: PROMOTE HEALTH				
Progress is measured by the healthier populations billion (target will be recalibrated for GPW 14)				
Strategic objective 1				
Respond to climate change, the greatest health threat of the 21 st century				
1.1 More climate-resilient health systems are addressing climate risks and impacts	[No indicator matched]		Stabilize and then reduce carbon emissions from the global healthcare sector on a path to halve emissions by 2030	<ol style="list-style-type: none"> 1. WHO supports the development of vulnerability and adaptation assessments, and national adaptation plans, to protect health from climate shocks and stresses 2. WHO strengthens capacity and provides guidance to countries to enhance the climate resilience of health systems, and reduce the burden of climate-sensitive diseases, including through a

⁵ Proposed outcome indicators will be reviewed and incorporated in consultation with Member States

⁶ Delivery milestones are priorities established by WHO to direct its resources and efforts towards accelerating progress in a defined area of public health within agreed-upon timelines. Simply, delivery milestones are what WHO will do, where, by when and how. These milestones, designed for a two-year operational cycle, are closely linked to the specific actions WHO undertakes to assist Member States through intensified support to achieve measurable outcomes. Placeholders from Programme Budget 2022-23 following delivery stocktakes. Final numbers of countries receiving intensified support will be developed during Operational Planning processes.

⁷ As outlined in the draft GPW 14 (EB154/28), White Paper on output development, and Technical Paper on WHO Results Framework: Delivering a measurable impact in countries

				multisectoral One Health approach
1.2 Lower-carbon health systems and societies are advancing health and well-being	[No indicator matched]			<ol style="list-style-type: none"> 1. WHO develops norms and standards, provides guidance and builds capacity in countries, to stabilize and then reduce carbon emissions from the health sector 2. WHO develops norms, standards, and policy guidance, supporting countries to enhance health while cutting carbon emissions in key systems outside of the health sector (energy, transport, food, urban)
Strategic objective 2 Address the root causes of ill health by embedding health in key policies across sectors				
2.1. Health inequities reduced by acting on social, economic, environmental, commercial and cultural determinants of health	SDG 3.a.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older		Strengthen tobacco control policies, at the highest level, in at least XX countries, to reduce tobacco use	<ol style="list-style-type: none"> 1. WHO develops metrics, tools, and guidance and supports countries in designing policies and shaping resource allocation and investment and in establishing partnerships (within and beyond the health sector) to address social and economic determinants and reduce health inequities 2. WHO supports countries in developing and implementing regulations to safeguard public health from adverse interests of commercial and other stakeholders, and in
	SDG 3.6.1 Death rate due to road traffic injuries		Stabilize and then reduce road traffic death rates in at least XX priority countries by 2025 through implementation of the Global Plan for the Decade of Action for Road Safety 2021-2030	

	SDG 3.5.2 Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol		Further reduce the alcohol consumption by 20% in at least 20 priority countries by 2025	<p>leveraging the potential contribution of the commercial sector to improve health and health equity</p> <p>3. WHO supports the development of evidence-informed policies across sectors, and at all levels of government, and adapt public health measures to meet and mainstream the social, health and wider needs of populations in situations of vulnerability, including migrants and displaced people</p>
	SDG 4.2.1 Proportion of children aged 24–59 months who are developmentally on track in health, learning, and psychosocial well-being, by sex			
	WHA 66.10 (2013) Best practice policy implemented for industrially produced trans-fatty acids (Y/N)			
		SDG Target 17.18 Proportion of GPW outcome indicators with data disaggregation, weighted by the proportion of countries with data available		
		SDG Target 17.18 Proportion of countries that feature data disaggregation in their national health statistics reports		
		SDG Target 17.18 Number of datasets available in the WHO Health		

		Inequality Data Repository		
		SDG 5.1 / 3.8 Gender equality advanced in and through health		
		SDG 5.1.1 Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex		
2.2. Priority risk factors for noncommunicable and communicable diseases, violence and injury, and mental health reduced through intersectoral approaches	SDG 2.2.1 Prevalence of stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age			<ol style="list-style-type: none"> 1. WHO develops technical packages, norms and standards, and supports countries in their implementation, including through regulation and legislation, that address risk factors, and builds capacities through whole of government and society approaches 2. WHO provides countries with comprehensive access to appropriate promotion and preventive health services to populations (such as tobacco cessation services, diet and physical activity, breastfeeding) including for those in situations of vulnerability, migrants and displaced people, as well as victims of violence
	SDG 2.2.2 Prevalence of overweight (weight for height more than +2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age	WHA 69.9 Exclusive breastfeeding under six months		
	SDG 2.2.2 Prevalence of wasting (weight for height more than -2 standard deviation from	WHA75(11) Proportion of population aged 15+ with healthy dietary pattern		

	the median of the WHO Child Growth Standards) among children under 5 years of age		3. WHO develops tools and platforms and supports countries in implementing and maintaining data systems, including harnessing the use of digital technologies, to monitor the conditions of living, risk factors and the barriers and drivers of health to inform policy and decision-making
	SDG 2.2.3 Prevalence of anaemia in women aged 15 to 49 years, by pregnancy status (percentage)		
	SDG 3.9.1 Mortality rate attributed to household and ambient air pollution		
	SDG 3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation, and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All [WASH] services)	WHA73.5 Proportion of people who have suffered a foodborne diarrheal episode of non-typhoidal salmonellosis	
	SDG 3.9.3 Mortality rate attributed to unintentional poisoning		
	SDG 6.1.1 Proportion of population using safely managed drinking water services		
	SDG 6.2.1a Proportion of population using safely managed		

	sanitation services			
	SDG 6.2.1b Proportion of population using a hand-washing facility with soap and water			
	SDG 7.1.2 Proportion of population with primary reliance on clean fuels and technology			
	SDG 11.6.2 Annual mean levels of fine particulate matter (e.g., PM2.5 and PM10) in cities (population weighted)		Improve air quality and other environmental risk factors in at least six countries by 2025	
	WHA 66.10 (2013) Prevalence of obesity among children and adolescents (aged 5–19 years) (%)	WHA71 (6) Prevalence of insufficiently physically active adolescents	Stop the rise in obesity rates in at least 24 high-burden countries through the Obesity Accelerated Action Plan by 2025	
	WHA 66.10 (2013) Prevalence of obesity among adults aged ≥18 years	WHA71 (6) Prevalence of insufficiently physically active adults		
2.3. Populations empowered to control their health through health promotion programmes and community involvement in decision-making	SDG 5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual, or psychological violence by a current or former intimate partner	SDG 5.3.2 Proportion of girls and women aged 15 – 49 who have undergone female genital mutilation		1. WHO develops guidance and supports countries to strengthen their capacity to engage with and empower communities, including through increased health literacy and support for creating healthy settings and healthy living environments

	in the previous 12 months, by form of violence and by age			2. WHO develops guidance and supports countries to strengthen capacity and improve governance for health through engagement with other sectors, at all levels of government, to advance co-benefits, and implement policies that protect and promote health
	SDG 16.2.1 Proportion of children aged 1-17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month	SDG 10.3.1 / 16.b.1 Proportion of population reporting having personally experienced discrimination against or harassed in the previous 12 months on the basis of a ground of discrimination prohibited under international law		
			A milestone on physical activity is under development	

GPW 14 priority: PROVIDE HEALTH

Progress is measured by the universal health coverage billion (target will be recalibrated for GPW 14)

Strategic objective 3

Advance the primary health care approach and essential health system capacities for health equity and gender equality

3.1. The primary health care approach renewed and strengthened to accelerate universal health coverage	[No indicator matched]	WHA 72.2 Percent of countries with a national health policy oriented to PHC		<ol style="list-style-type: none"> 1. WHO strengthens capacity and provides guidance to reorient and improve the delivery of quality, people-centred comprehensive, integrated individual and population-based services 2. WHO strengthens the capacity of national public health institutions to deliver essential public health functions and improve the
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				<p>resilience of health systems</p> <p>3. WHO facilitates dialogues and provides guidance to strengthen health governance capacity within and across sectors, including engagement with communities and the private sector</p>
<p>3.2. Health and care workforce, financing and product availability substantially improved</p>	<p>SDG 3.c.1 Health worker density and distribution</p>		<p>Support at least 60 countries on improving availability, equity and quality of their health and care workforce by 2028</p>	<p>1. WHO strengthens capacity and provides guidance to countries to strengthen their health and care workforce for integrated services, emergency preparedness and response, and improved health and well-being</p>
	<p>SDG 3.b.3 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis</p>			<p>2. WHO guides design and supports the implementation of evidence-based health financing policies to improve equitable access to efficiently delivered individual and population services and products</p> <p>3. WHO produces norms and standards and supports implementation of measures for better access to and use of safe, effective, affordable and quality-assured medicines and other health products</p>

3.3. Health information systems strengthened and digital transformation implemented	[No indicator matched]			<ol style="list-style-type: none"> 1. WHO develops tools and platforms to support countries in improving their health information systems to guide decision making and accelerate impact 2. WHO develops guidance and support countries to harness digital transformation of health and health systems to expand coverage and equity to accelerate impact
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Strategic objective 4

Improve equity and quality in health service coverage and financial protection to advance universal health coverage

4.1. Equity in access to services for noncommunicable and communicable diseases and mental health conditions improved	SDG 3.8.1 Coverage of essential health services	SDG 10.7.2 Does the government provide non-national equal access to i) essential and/or ii) emergency healthcare?		1. WHO develops evidence-based policies and supports the implementation of “best buys” and other actions to strengthen prevention and control of non-communicable diseases
	SDG 3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age, and key populations		In 21 priority countries fill the gaps in universal access to HIV, viral hepatitis, and STIs (namely gaps in HIV 95, 95, 95 targets, HCV and HBV treatment, and syphilis treatment targets, by 2025	2. WHO supports the design, scale up, implementation, and the measurement of coverage of people-centred, rights-based services for key mental health, neurological and substance use conditions
	SDG 3.3.2 Tuberculosis incidence per		Support the 16 countries most disrupted by COVID-19 to get	3. WHO develops evidence-based guidance and standards, builds capacity, and supports implementing people-centred services to reduce incidence,

	100,000 population		on track for the End TB Strategy targets by 2025	<p>morbidity, mortality, and, where applicable, control, eliminate, or eradicate communicable diseases</p> <p>4. WHO provides guidance and standards to monitor and respond to antimicrobial resistance to improve quality of care and health outcomes</p>
	SDG 3.3.3 Malaria incidence per 1,000 population	Vector-borne disease incidence	Support 26 high burden malaria countries to be on track for achieving the SDG targets by 2025	
	SDG 3.3.4 Hepatitis B incidence per 100,000 population	Hepatitis C incidence per 100,000 population	In 21 priority countries fill the gaps in universal access to HIV, viral hepatitis, and STIs namely gaps in HIV 95, 95, 95 targets, HCV and HBV treatment, and syphilis treatment targets, by 2025	
		Prevalence of active syphilis in individuals 15 to 49 years of age (%)		
	SDG 3.3.5 Number of people requiring interventions against neglected tropical diseases		Reduce the number of people requiring interventions against neglected tropical diseases to 1.2 billion by 2025	
	SDG 3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes, or chronic respiratory disease	WHA75(11) Prevalence of controlled diabetes in adults aged 30-79 years		

	WHA 66.10 (2013) Prevalence of raised blood pressure in adults aged ≥18 years	WHA66 (10) Prevalence of controlled hypertension, among adults aged 30-79 years		
	SDG 3.4.2 Suicide mortality rate			
	SDG 3.5.1 Coverage of treatment interventions (pharmacological, psychosocial, and rehabilitation and aftercare services) for substance use disorders	WHA72/2019/REC /1 Service coverage for people with mental health and neurological conditions	Support at least 24 low- and middle-income countries to measure and report service coverage for mental, neurological, and substance use tracer conditions (psychosis, depression, epilepsy, alcohol use disorder)	
	SDG 3.d.2 Percentage of bloodstream infections due to selected antimicrobial-resistant organisms	Effective refractive error coverage (eREC)		
	WHA68.7 (2015) Patterns of antibiotic consumption at national level	SDG 16.6.2 Proportion of population satisfied with their last experience of public health services		
		WHA 73(12) Percentage of older people receiving long-term care at a		

		residential care facility and home		
4.2. Equity in access to sexual, reproductive, maternal, newborn, child, adolescent, older and other population- specific health services and immunization coverage improved	SDG 3.1.1 Maternal mortality ratio	WHA 67.15 Proportion of health facilities that provide comprehensive post-rape care as per WHO guidelines	Support up to 27 countries BOTH projected as not currently on-track to meet their EPMM target AND as of the most recent year available (2020), had an MMR that was either high, very high, or extremely high (high = 300-499; very high = 500-999; extremely high = >=1000) to reduce maternal mortality levels in line with SDG	<ol style="list-style-type: none"> 1. WHO sets norms and standards, provides guidance and builds country capacity to improve sexual, reproductive, newborn, child, adolescent, and older person health services across the life course 2. WHO sets norms and standards, provides guidance and builds country capacity to strengthen and sustain immunization services across the life course, with specific attention on polio
	SDG 3.1.2 Proportion of births attended by skilled health personnel	WHA 67.10 Postnatal Care Coverage (newborn)		
		WHA69/16 Postnatal Care Coverage (woman)		
	SDG 3.2.1 Under-5 mortality rate		Support countries off-track to achieve SDG 3.2.1 (under 5 mortality) target to accelerate the reduction of child mortality rates to reach under-5 mortality rate to at least as low as 25 per 1,000 live births by 2030 (based on 2022 data this is 59 countries)	

	SDG 3.2.2 Neonatal mortality rate	WHA 67.10 Stillbirth rate (per 1000 total births)		
	SDG 3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods		Support at least 20 countries scale up interventions to increase the proportion of women of reproductive age (aged 15-49 years) who have their need for contraception satisfied with modern methods (SDG Indicator 3.7.1)	
	SDG 3.b.1 Proportion of the target population covered by all vaccines included in their national programme		Restore DTP3 and MCV2 immunization coverage rates to pre-COVID-19 levels	
		SDG 5.6.2 Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education		
		Obstetric and gynaecological admissions		

		owing to abortion		
		WHA73(2) Cervical cancer screening coverage in women aged 30 - 49 years, at least once in lifetime		
4.3. Financial protection improved by reducing out-of-pocket health expenditures , especially for the most vulnerable	SDG 1.a.2 Proportion of total government spending on essential services (education, health, and social protection)			<ol style="list-style-type: none"> 1. WHO provides guidance and strengthens capacity to address financial barriers and hardship associated with seeking health and care services, especially for the most vulnerable 2. WHO provides guidance and strengthens capacity for countries to collect, track and analyzes disaggregated data on out-of-pocket expenditures, financial hardship, financial barriers to identify inequities, inefficiencies, inform decision-making, and track progress
	SDG 3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income	Prevalence of foregone care (not seeking medical care when needed) ⁸	Halt the rise in financial hardship in at least 25 countries by 2025	
GPW 14 priority: PROTECT HEALTH				
Progress is measured by the health emergencies protection billion (target will be recalibrated for GPW 14)				
Strategic objective 5				
Prevent, mitigate, and prepare for emerging risks to health from all hazards				

⁸ Metadata not available yet.

<p>5.1. Risks of health emergencies from all hazards, including antimicrobial resistance, reduced and impact mitigated</p>	<p>Vaccine coverage for epidemic prone diseases</p>		<p>Restore vaccine coverage of at-risk groups for epidemic and pandemic prone diseases to pre-COVID-19 levels</p>	<ol style="list-style-type: none"> 1. WHO conducts risk, threat, and vulnerability assessments at the country level, and aids countries in developing, financing and monitoring prevention and mitigation strategies tailored to specific contexts and hazards 2. WHO develops guidelines and assists countries in effectively communicating risks and managing infodemics, thereby enabling and empowering individuals and communities to make informed decisions to protect their health during emergencies 3. WHO establishes norms and standards, and supports countries in designing and implementing preventive public health and social measures at the community level across all hazards, utilizing a One Health Approach 4. WHO produces norms and standards, offer guidance, and builds country capacity to enhance infection prevention and control measures, as well as to protect health workers and patients in emergency contexts
	<p>Number of cases of poliomyelitis caused by wild poliovirus</p>	<p>Identification of hazard and prevention indications incl. WASH, Infection Prevention and Control, and risk of zoonotic spillover</p>		

5.2. Preparedness, readiness and resilience for health emergencies enhanced	SDG 3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness		Increase preparedness for emergencies in all countries, as measured through IHR States Parties self-assessment annual reporting	<ol style="list-style-type: none"> 1. WHO coordinates capacity assessments and assists countries in developing, financing and monitoring national action plans for health security and readiness 2. WHO builds capacity, provides guidance, and offers tailored support to improve national and international integrated surveillance systems for effective monitoring of diseases 3. WHO builds capacity, provides guidance, and offers tailored support to enhance national and international diagnostics and laboratory capacities, including pathogen detection, genomic surveillance, and biosafety 4. WHO leads network of networks across research and development, scalable manufacturing, and
		Adjustment of assessments based on full range of IHR monitoring and evaluation framework (JEE, AAR, IAR, SimEx)		

		Identification of vulnerability and capacity indicators (IHR++)		<p>supply chain systems to ensure the timely and equitable deployment of medical countermeasures during emergencies</p> <p>5. WHO develops guidance and supports the strengthening of national public health institutions and the health emergency workforce</p> <p>6. WHO enhances the readiness and resilience of clinical care services and systems against health emergencies through country capacity building</p>
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Strategic objective 6

Rapidly detect and sustain an effective response to all health emergencies

6.1. Detection of and response to acute public health threats is rapid and effective		Broaden the type of events which are measured	Detect suspected outbreaks within seven days, notify public health authorities to start an investigation within 1 day, and investigate and establish an initial response within seven days	<p>1. WHO establishes and strengthens national and international early warning and alert systems for public health threats, including the verification of signals, risk assessment, and grading of public health events</p> <p>2. WHO leads emergency responses that require international coordination, provides</p>
		Refine response activation indicator for the first 7 days		

		Expand to include performance measure for the first 28 days of an emergency response		<p>technical guidance, and supports the development, financing and monitoring of strategic and operational plans</p> <p>3. WHO develops and deploys multisectoral rapid response capacities and expertise; provides surge emergency supplies and logistics; and allocates contingency financing for rapid and effective health emergency response operations</p>
6.2. Access to essential health services during emergencies is sustained and equitable	Proportion of vulnerable people in fragile settings provided with essential health services (%)	Quality and effectiveness of essential health services during emergencies		<p>1. WHO coordinates the assessment of public health needs in protracted emergencies, supports countries in developing, financing and monitoring health emergency response plans, and leads health clusters for a coordinated health response</p> <p>2. WHO works with countries and partners to ensure the provision of lifesaving care during health emergencies</p> <p>3. WHO collaborates with countries and partners to ensure equitable and</p>
		Timeliness of development and equitable distribution of medical countermeasures		

		Disruption to essential health services and systems in emergencies		<p>timely access to medical countermeasures during health emergencies</p> <p>4. WHO develops norms and standards and provides technical expertise to countries in developing, implementing, and monitoring plans to sustain or improve routine essential health services and systems during emergencies</p>
<p>GPW 14 priority: POWER HEALTH</p> <p>Power health to accelerate progress (data and digital health, science and innovation, delivery for impact and partnerships)</p>				
TBD				
<p>GPW 14 priority: PERFORM</p> <p>Optimizing WHO's performance</p>				
TBD				

Annex 5. Global Delivery Milestones: Dashboard

	Complete	In progress	On track	High risks	Not started
	Complete	In progress	On track	High risks	Not started
PROMOTE (ex HPOP)					
Climate change (1.0)					
Reduce carbon emissions HCF*					
Address root causes (2.1)					
Tobacco use					
Alcohol use					
Road safety					
Priority risk factors (2.2)					
Obesity and overweight					
Air pollution					
Health promotion programmes (2.3)					
Physical activity					
PROVIDE (ex UHC)					
Health and care workforce, financing and product availability (3.2)					
Health workforce density					
Equity in access to NCD, communicable and mental health services (4.1)					
HIV treatment (ART) coverage					
Tuberculosis treatment coverage					
Malaria prevention (ITN use)					
Hepatitis B (Links with HIV)					
Neglected tropical diseases*					
Hypertension					
Mental health, neurological, substance use*					
Equity in access to population specific health services & immunization (4.2)					
Maternal mortality (Antenatal care)					
Under-5 mortality (Treatment of childhood pneumonia)					
Family planning					
Immunization coverage					
Financial protection (4.3)					
Financial hardship					
PROTECT (ex HEP)					
Prevent, mitigate and prepare (5.0)					
Mitigate risks – vaccination (5.1)					
Prepare (5.2)					
Rapid detect and sustain response (6.0)					
Notify and respond (6.1)					

Note: All indicators marked ‘**’ are not included in the billion calculations. All data as of November 2022. Data will be regularly updated as implementation progresses. Suicide mortality is included in the healthier population billion calculation, but is grouped with NCD care within this dashboard