

## **Progress reports**

### **Report by the Secretariat**

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## **A. POLIOMYELITIS: MECHANISM FOR MANAGEMENT OF POTENTIAL RISKS TO ERADICATION**

1. In 1988, the Health Assembly adopted resolution WHA41.28 on global eradication of poliomyelitis by the year 2000. By 2008, all but four countries had interrupted indigenous transmission of wild polioviruses (Afghanistan, India, Nigeria and Pakistan), and the annual number of cases had declined by more than 99%. However, case numbers were still fluctuating between 1000 and 2000 per year and 12 to 23 additional countries were experiencing cases of poliomyelitis due to imported polioviruses each year. In at least two of these latter countries (Angola and Chad) and possibly the Democratic Republic of the Congo and Sudan, the imported virus persisted for more than 12 months and led to further international spread. In 2008, the Health Assembly in resolution WHA61.1 called for a new strategy to eradicate poliomyelitis from the remaining affected countries. The Programme of Work 2009 of the Global Polio Eradication Initiative was constructed in order to inform this new strategy by evaluating new tactical innovations in each disease-endemic area, conducting clinical trials of new oral poliovirus vaccine formulations and facilitating an independent evaluation of major barriers to interrupting poliovirus transmission.

2. In India, new tactics increased oral poliovirus vaccination campaign coverage in 2009 among migrant and mobile populations, and enhanced campaign operations being undertaken in the disease-endemic districts of central Bihar and western Uttar Pradesh, raising the proportion of very young children with antibodies to type 1 poliovirus in the latter area from 85% in late 2007 to 96% in late 2009. In Nigeria, comparing the last six months (May–October 2009) with the same period in 2008, the proportion of children who had never been immunized in the 10 endemic northern states (high-risk states) fell from close to 20% (19.5%) to less than 10% (9.6%) in 2009, after state governors signed the Abuja Commitments to Polio Eradication in February 2009 and traditional leaders formed a polio eradication committee in June 2009. Both of these actions have resulted in greater accountability at the local level for the performance of the poliomyelitis campaigns. In Pakistan, the Prime Minister launched a Polio Action Plan in February 2009 that enhanced multisectoral support for the oral poliovirus vaccination campaigns in many areas, although coverage remained less than 80% in the disease-endemic districts in the north of both the North West Frontier Province and the Federally Administered Tribal Areas, Baluchistan and the greater Karachi area of Sindh. In the two remaining disease-endemic provinces in Afghanistan (Kandahar and Helmand in the Southern Region), access to children improved in key security-compromised districts during recent oral poliovirus vaccination campaigns through the use of new tactics, which included an enhanced role for nongovernmental organizations, the recruitment of local “access negotiators”, and negotiations with the International Security Assistance Force and the Taliban for days of tranquillity. Although access in the Southern Region continues to fluctuate, the proportion of inaccessible children was reduced for the first time to 5% during the oral poliovirus vaccination campaigns in July and September 2009, down from more than 20% at the start of the year.

3. To improve the efficiency and impact of oral poliovirus vaccination campaigns against the last two remaining serotypes of wild poliovirus, clinical trial lots of a bivalent oral poliovirus vaccine, containing type 1 and type 3 viruses, were produced. In 2009, the results of the clinical trial demonstrated that the protection conferred against disease due to both serotypes by this bivalent vaccine was superior to that provided by the trivalent oral poliovirus vaccine and “non-inferior” to the respective monovalent oral poliovirus vaccines.<sup>1</sup> The Advisory Committee on Poliomyelitis

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<sup>1</sup> Advisory Committee on Poliomyelitis Eradication: recommendations on the use of bivalent oral poliovirus vaccine types 1 and 3. *Weekly Epidemiological Record*, 2009, **29**(84):289-300.

Eradication concluded that “the use of bivalent oral poliovirus vaccine in supplementary immunization activities constitutes an important new tool for the Global Polio Eradication Initiative” and made recommendations for its use.<sup>1</sup> This product will first be used in the Global Polio Eradication Initiative in December 2009 with subsequent rapid scale up in order to meet full demand by mid-2010.

4. An independent evaluation of major barriers to interrupting poliovirus transmission was chaired by Dr A.J. Mohamed (Oman), a vice-chairman of the Executive Board, and comprised five subteams with a total of 28 experts in relevant disciplines including public health, immunization programmes, vaccinology, social mobilization and security. These subteams collectively spent 24 person-months working on the evaluation in Afghanistan, Angola, India, Nigeria, Pakistan, Sudan, the WHO regional offices for Africa and the Eastern Mediterranean and WHO headquarters, with wide consultation with Global Polio Eradication Initiative partners and stakeholders in each country. The evaluation team submitted its report to the Director-General on 22 October 2009.

5. In India, the evaluation team verified very high coverage during oral poliovirus vaccination campaigns and recommended an aggressive research agenda and multipronged approach to overcome the unique challenge posed by incomplete gut mucosal immunity to polioviruses in the setting of northern India. In Nigeria, the team recommended building on the improvements in oral poliovirus vaccination campaign coverage made in 2009, in particular by establishing specific mechanisms to hold leaders of local government areas accountable for programme performance as management issues at this level were now the most critical barriers to success. Finding that insecurity is now one of the most significant barriers to eradication in Afghanistan and Pakistan, the team highlighted the need for plans and solutions specific to districts and subdistricts in such areas, based on the local culture, local partners and the nature of the civil conflict. In Pakistan, the team also recommended monitoring the coverage achieved through the oral poliovirus vaccination campaign at the subdistrict level in order to be able to rectify the “non-accountability and political interference” of local district leaders, especially in the infected areas of Sindh and Baluchistan.<sup>2</sup>

6. The evaluation team found that the persistent transmission of imported polioviruses in Angola and Chad, and possibly in the Democratic Republic of the Congo and Sudan, was the result of incomplete implementation of guidelines on the responses to poliomyelitis outbreaks. The team recommended that poliovirus transmission be considered to have been re-established in such areas, reflecting the increased risk they pose to the global eradication effort. To limit further international spread of polioviruses, the evaluation team urged a bolstering of routine oral poliovirus vaccination coverage in districts neighbouring poliomyelitis-affected areas and the focusing of such vaccination campaigns on areas where the virus had been reintroduced and routine oral poliovirus vaccination coverage was poor. The team recommended the vaccination of travellers at land crossing points between poliomyelitis-affected and poliomyelitis-free countries in sub-Saharan Africa, and supported the vaccination of other travellers, wherever appropriate, in order to reduce further the risk of international spread, as has been implemented during the hajj.

7. In order to enhance the Global Polio Eradication Initiative’s support to poliomyelitis-affected countries, the team recommended that research be continued and promising advances (such as bivalent

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<sup>1</sup> Advisory Committee on Poliomyelitis Eradication: recommendations on the use of bivalent oral poliovirus vaccine types 1 and 3. *Weekly Epidemiological Record*, 2009, **29**(84):289-300.

<sup>2</sup> Independent evaluation of major barriers to interrupting poliovirus transmission – Executive Summary. 20 October 2009. Available at [http://www.polioeradication.org/content/general/Polio\\_Evaluation\\_CON.pdf](http://www.polioeradication.org/content/general/Polio_Evaluation_CON.pdf) (accessed 26 November 2009).

oral poliovirus vaccine) be rapidly introduced and extended on a wider scale; that the level of technical assistance provided by the Global Polio Eradication Initiative in countries where poliovirus was persisting after importation be aligned with that in areas where the disease is endemic; and that the Global Polio Eradication Initiative's work be linked more closely with that on strengthening immunization systems. The evaluation team recommended the consideration of further mechanisms to address poorly performing local entities.

8. As at 17 November 2009, a total of 1387 cases of poliomyelitis had been reported from 23 countries in 2009: 1082 from the four disease-endemic countries (Afghanistan, India, Nigeria and Pakistan); 122 from the four countries where poliovirus transmission was known or suspected to have been re-established (Angola, Chad, the Democratic Republic of the Congo, and Sudan); and 183 in a further 15 countries in western and central Africa and the Horn of Africa due to new importations. In Nigeria, the improvements in oral poliovirus vaccination coverage resulted in a 50% decline in the overall number of poliomyelitis cases and a 90% decline in cases due to type 1 poliovirus compared with 2008. Although case numbers in India were similar to those of 2008, the new tactics that were introduced in 2009 reduced both the genetic diversity and geographical extent of the remaining viruses. In Pakistan the overall number of cases was 20% lower than at the same time in 2008, with many being reported from, or genetically linked to, areas affected by insecurity. In Afghanistan, endemic poliomyelitis was primarily persisting in just 10 districts in the Southern Region, out of 329 districts in the country. By late 2009 no new case had been reported for more than three months in the Horn of Africa, although the outbreaks in Angola, Chad, central Africa and western Africa were continuing.

9. The results and impact of the Global Polio Eradication Initiative's Programme of Work 2009 were reviewed by WHO's Strategic Advisory Group of Experts on immunization on 29 October 2009, and by the Advisory Committee on Poliomyelitis Eradication on 18 and 19 November 2009 at a special consultation of this Group with poliomyelitis-affected countries and Global Polio Management Team Partners. The Strategic Advisory Group of Experts on immunization urged the Global Polio Eradication Initiative rapidly to consider the findings of the independent evaluation; it also supported an enhanced research agenda and agreed that bivalent oral poliovirus vaccination constituted an important new tool. The Group recommended that the Global Polio Eradication Initiative's major indicators be internationally monitored with influential oversight by senior management in partner agencies and polio-affected countries. The Advisory Committee on Poliomyelitis Eradication stated that the challenges faced by the Global Polio Eradication Initiative in 2009 should not be allowed to overshadow significant achievements, particularly in Nigeria, India and Afghanistan. Participants in the Advisory Committee on Poliomyelitis Eradication's consultation concurred that the Global Polio Eradication Initiative should establish a new three-year programme of work that focused on stopping transmission of wild poliovirus globally, based on the findings of the independent evaluation, and developed in a consultative process with countries and partners.

#### **D. RAPID SCALING UP OF HEALTH WORKFORCE PRODUCTION**

10. Several regions and countries have made commitments to augmenting the health workforce, and many have introduced innovative solutions. The need to expand the health workforce has also been recognized by multilateral and bilateral organizations, special initiatives, civil society, the private sector and philanthropic organizations.

11. The Secretariat is working to fulfil the Health Assembly's requests to the Director-General in the resolution at global, regional, and national levels. In the context of renewed focus on primary

health care, it has identified three main strategic directions: providing strategic information on human resources for health; promoting strategic investments for developing human resources for health; and promoting innovative approaches to harmonize policies and programmes for providing health care to individuals throughout the life-course and to communities. The Secretariat has identified three main streams of work: advocacy; normative work; and capacity building in regions and countries.

12. Through advocacy, WHO has worked with major stakeholders to set goals for scaling up the workforce. For instance, the Japan International Cooperation Agency has committed itself to support the training of 100 000 new health workers in sub-Saharan Africa and the United States of America's President's Emergency Plan for AIDS Relief has made a similar commitment to train 140 000 new health workers. WHO has also advocated that health workforce production be a critical area for the High-Level Taskforce on Innovative Financing for Health Systems to invest in and provided support for estimating the costs of scaling up human resources for health. The need to scale up the health workforce towards the WHO threshold of 2.3 health workers per 1000 people was also recognized by the G8 members in 2008 and reinforced in the Summit leaders declaration in 2009.<sup>1</sup>

13. WHO co-organized with the Global Health Workforce Alliance the First Global Forum on Human Resources for Health (Kampala, Uganda, 2–7 March 2008), at which participants adopted the Kampala Declaration and Agenda for Global Action.<sup>2</sup>

14. In accordance with WHO's mandate, and pursuant to resolution WHA57.19 on international migration of health personnel, the Secretariat is working with Member States on a code of practice on the international recruitment of health personnel. Related to this, in July 2009, leaders of the G8 countries, in the Summit Leaders' declaration, called for WHO to complete the voluntary code of practice on ethical recruitment of health workers and for countries to endorse it.

15. The Secretariat has worked with global health initiatives, such as the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria, to develop recommendations, to channel as much funding as possible towards long-term and sustainable solutions for human resources for health.<sup>3</sup>

16. WHO, in collaboration with President's Emergency Plan for AIDS Relief and UNAIDS, has issued global recommendations and guidelines on task shifting.<sup>4</sup> These also cover the production of mid-level cadres and community health workers. The guidelines have now been implemented in 15 sub-Saharan African countries.

17. WHO and the President's Emergency Plan for AIDS Relief are partners in a new initiative to expand medical and nursing education in support of attaining sustainable human resources for health in countries.

18. The Secretariat is also contributing to work on increasing the number of midwives in order to make progress towards Millennium Development Goal 5 (Improve maternal health).

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<sup>1</sup> [http://www.g8italia2009.it/G8/Home/Summit/G8-G8\\_Layout\\_locale-1199882116809\\_Atti.htm](http://www.g8italia2009.it/G8/Home/Summit/G8-G8_Layout_locale-1199882116809_Atti.htm)

<sup>2</sup> <http://www.who.int/workforcealliance/forum/2011/en/index.html>

<sup>3</sup> <http://www.who.int/healthsystems/publications/positivesynergiesdocs/en/index.html>

<sup>4</sup> WHO, President's Emergency Plan for AIDS Relief, UNAIDS. *Task shifting: rational redistribution of tasks among health workforce teams. Global recommendations and guidelines on task shifting*. Geneva, World Health Organization, 2008.

19. WHO, the Global Health Workforce Alliance, United States Agency for International Development and other partners have collaboratively developed the Human Resources for Health Action Framework in order to streamline work at country level and to design operational tools for use by countries in scaling up the health workforce.

20. The Secretariat provides technical assistance to Member States for implementing the recommendations of the Global Health Workforce Alliance's Task Force for Scaling Up Education and Training for Health Workers, in the elaboration of which WHO participated.<sup>1</sup> The recommendations include preparation of a 10-year plan to increase the production of health workers.

21. The Secretariat provided support to countries in developing proposals for the Global Fund to Fight AIDS, Tuberculosis and Malaria that included interventions to scale up the health workforce. The Global Fund allocated 23% of the overall funding to human resources for health in Global Fund Round 2–7 proposals.

22. The Secretariat provided support to two educational networks in Africa in order to establish academic programmes focused on health workforce development and is the lead moderator on an online forum of more than 500 interested parties to exchange information for expanding the health workforce.

23. Several countries have expanded the health workforce with technical support from WHO and partners. Brazil trained and deployed 30 000 family health teams which, by 2008, reached 70% of the population. In the past three years Ethiopia has trained and deployed more than 25 000 health extension workers, with some 6800 more in training; intake of medical students has been increased from 200 per year in 2006 to 1500 in 2008 and a strategy for four-year innovative medical education is being explored. In Malawi, output of medical doctors from training institutions increased from 17 in 2002 to 59 in 2008; of clinical officers from 66 to 103; medical assistants from none to 192; and nurses and midwives from 168 to 322.

## **E. STRENGTHENING NURSING AND MIDWIFERY**

24. In response to resolution WHA59.27, the Secretariat, in collaboration with international, regional and national partners, is working with Member States at regional level in order to strengthen national capacities for nursing and midwifery. This report highlights progress made in the areas of developing human resources for health, strengthening health systems within the context of primary health care and optimizing the contribution of nurses and midwives to the achievement of the health-related Millennium Development Goals.

### **Developing human resources for health**

25. In collaboration with 45 bodies representing health professionals, WHO has developed a framework for interprofessional collaboration in education and practice, as a strategy for effective health workforce utilization. The framework is currently being piloted in two countries in the Caribbean region.

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<sup>1</sup> World Health Organization, Global Health Workforce Alliance. *Scaling Up, Saving Lives: summary and recommendations*. Task Force for Scaling Up Education and Training for Health Workers. Geneva, World Health Organization, 2008.

26. In 2008, a global programme of work, supported by dedicated tools and standards, was developed by the Secretariat in collaboration with partners and representative Member States.<sup>1</sup> In line with the global programme, one country in each of the six WHO regions is implementing the following activities: strengthening education in nursing and midwifery, improving health service provision, promoting supportive workplace environments, building capacity for leadership and management, and enhancing partnerships.

27. The Regional Office for the Western Pacific has developed a model with 15 baseline indicators for projecting needs in the area of human resources for health. Five countries from three WHO regions are using the model to inform their health workforce planning in order to maintain adequate numbers of competent nursing and midwifery personnel.

### **Strengthening health systems within the context of primary health care**

28. All WHO regions have begun reorienting nursing and midwifery programmes to support the renewal of primary health care. In 2009, the Regional Office for the Eastern Mediterranean has been supporting the establishment of national family health nursing programmes. An evaluation report on the applicability of the programmes to current population health needs will be produced by the Regional Office for Europe.

29. WHO and key partners have advocated regulatory reform to support health system strengthening. Twenty countries in the Region of the Americas are updating nursing regulations based on the findings of a study carried out by the Regional Office for the Americas. In 2009, eight francophone countries in the African Region have assessed the roles and functions of regulatory bodies, and 21 countries have developed national action plans.

30. A compendium has been issued of 38 case studies of successful primary health care models, involving 29 countries.<sup>2</sup> Lessons learnt will be used to strengthen the role of nurses and midwives in efforts to renew primary health care.

### **Optimizing the contribution of nurses and midwives**

31. In 2008, policy advice issued by the Global Advisory Group on Nursing and Midwifery Development covered, inter alia, the establishment of a multidisciplinary high-level group on the renewal of primary health care. WHO is providing technical support to the work of the group in reviewing related policies and health care models.

32. WHO has drafted a strategy for accelerating work in the area of human resources for health in support of the achievement by 2015 of Millennium Development Goal 5. The Regional Office for South-East Asia is supporting Member States in strengthening educational programmes and in reforming pre- and in-service education on maternal and child health.

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<sup>1</sup> *Scaling up the capacity of nursing and midwifery services to contribute to the Millennium Development Goals: Programme of Work, 2008–2009*. Geneva, World Health Organization, 2008.

<sup>2</sup> *Now more than ever: the contribution of nurses and midwives to primary health care. A compendium of primary care case studies*. Geneva, World Health Organization, 2009 (document WHO/HRH/HPN/09.2).

33. As part of the continuing collaboration between the Secretariat and different stakeholders, two capacity-building workshops were conducted using the training package on infection prevention and control of acute respiratory disease;<sup>1</sup> an article on the contribution of nurses and midwives in the eradication of poliomyelitis and the control of measles was also published;<sup>2</sup> and an Asia–Pacific network in disaster preparedness and management came into operation in response to the recommendation of the global consultation meeting on nursing and midwifery, held in Geneva in 2008.

34. WHO has supported 14 countries in the Region of the Americas in mounting hepatitis B vaccination campaigns in order to tackle occupational transmission of bloodborne pathogens among health workers; 500 000 health workers have been vaccinated as a result. A new global workplan on occupational health has been developed for the period 2009–2012. In addition, agreement was reached on recommendations and policy options for health workers' access to services for HIV and tuberculosis at a WHO-organized international consultation (Geneva, 14–16 September 2009).

### **Future directions for strengthening nursing and midwifery**

35. The publication *Strategic directions for strengthening nursing and midwifery services (2002–2008)* is being updated in line with current global health priorities and the Eleventh General Programme of Work.

36. WHO will continue to work towards increased investment in the nursing and midwifery workforce at all levels and will strive to enhance interprofessional collaboration for the achievement of the Millennium Development Goals and the renewal of primary health care.

## **I. CLIMATE CHANGE AND HEALTH**

37. In January 2009 the Executive Board at its 124th session adopted resolution EB124.R5, which endorsed the Secretariat's workplan for climate change and health and requested the Director-General, inter alia, to implement the actions contained in the workplan. In May 2009 the Sixty-second World Health Assembly noted the resolution and workplan. The relevant activities undertaken to date are presented according to the four objectives of the workplan.

38. **Advocacy and awareness raising.** A comprehensive toolkit of audiovisual material – including posters, slide shows, public service announcements, brochures and fact sheets – has been developed in order to provide support to countries and health professionals in responding to and preventing the health impacts of climate change. In collaboration with professional and nongovernmental organizations, a web-based initiative has been launched in order to catalyse action on the “greening” of the health sector and to share stakeholders' experiences. In May 2009, WHO and the nongovernmental organization Health Care Without Harm jointly prepared and issued a paper that begins to define a framework for analysing and dealing with the health sector's impact on the environment. WHO's climate and health web site has also been redesigned and updated.

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<sup>1</sup> Infection prevention and control of epidemic- and pandemic-prone acute respiratory diseases in health care. WHO interim guidelines. Geneva, World Health Organization, 2007 (document WHO/CDS/EPR/2007.6).

<sup>2</sup> Nkowane A et al., The role of nurses and midwives in polio eradication and measles control activities: a survey in Sudan and Zambia. *Human Resources for Health*, 2009, 7:78.



**39. Partnerships with other organizations of the United Nations system and other sectors.**

WHO has actively contributed to the United Nations System Chief Executives Board for Coordination and related mechanisms. This has increased recognition of the health implications of climate change within the relevant United Nations documents, such as the Secretary General's report to the sixty-fourth General Assembly on climate change and its possible security implications.<sup>1</sup> WHO has also contributed to the negotiation process of the United Nations Framework Convention on Climate Change in support of a clear reference to the impact of climate change on health in the new climate agreement, scheduled to be negotiated at the 15th Conference of the Parties to the Framework Convention in Copenhagen in December 2009. The Organization's involvement has included organizing events during the preparatory sessions for the Conference, and at the preparatory meeting held in Bangkok, WHO discussed with a number of Parties to the Framework Convention the best means of reflecting health concerns within the text of the new agreement. WHO has also been assigned the responsibility of leading an event on protecting health from climate change during the high-level segment of the 15th Conference of the Parties. The Organization also participated in WMO's World Climate Conference-3, leading the technical working session on climate and human health.

40. In response to the United Nations Secretary General's drive towards a "carbon neutral" United Nations system, a comprehensive analysis of the carbon footprint of WHO headquarters and other offices has been carried out. The Secretariat is reviewing policy options and developing an action plan to reduce its emissions of carbon dioxide.

**41. Promote and support the generation of scientific evidence.** WHO has published the results of a global consultation to define an applied research agenda in this field. An international collaborative project to improve estimates of the global burden of disease attributable to climate change has also been initiated. In November 2009, an international consortium, including WHO, will publish a first assessment of the health implications of actions to reduce greenhouse gas emissions. One example of these outcomes, which are generally positive, would be the reduction of health impacts due to air pollution.

**42. Strengthen health systems to protect populations from the threats posed by climate change.** The activities in support of this objective are being integrated into the relevant regional policy frameworks, such as the Libreville Declaration on Health and Environment in Africa (2008).

43. Guidance for assessing the threat posed by climate change to the health of local populations and for selecting the necessary adaptation measures has been updated by the Regional Office for the Americas, and is now being piloted in several countries. In August 2009, the WHO Regional Office for South-East Asia issued a set of lectures to provide training on climate change and health. In September 2009, a technical meeting was held on improving early warning systems in support of malaria control. During 2009, WHO and national governments have co-organized capacity-building workshops in Albania, Bhutan, Maldives, Oman, Russian Federation, The former Yugoslav Republic of Macedonia and Uzbekistan.

44. WHO has initiated country projects on climate change and health. The projects have involved seven countries in eastern Europe (with support received from the Government of Germany), China and Jordan (with support received from the Government of Spain). Funding from the Global

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<sup>1</sup> Document A/64/350.

Environmental Facility is expected by the end of 2009 for an additional seven-country global project to be undertaken in collaboration with UNDP.

45. The present report concerns one year of activities to implement resolution WHA61.19. However, the Executive Board may wish to consider a two-year reporting cycle as suggested during the relevant discussion at the Sixty-second World Health Assembly in May 2009.<sup>1</sup>

## **J. PRIMARY HEALTH CARE, INCLUDING HEALTH SYSTEM STRENGTHENING**

46. This report summarizes progress made with planning support for the renewal of primary health care, through the involvement of WHO's headquarters and regional and country offices.

47. Each region has reported numerous instances of countries engaging in often comprehensive reforms in order to renew primary health care, with universal coverage and people-centred primary care featuring prominently. The findings of the Commission on Social Determinants of Health are shaping efforts to establish multisectoral action as a central feature. Recurring themes include:

- moving towards universal coverage through efforts to extend the supply of services, remove barriers to access and extend social health protection through pooled prepayment mechanisms;
- transforming conventional health-care delivery into people-centred primary care networks, with frequent references to comprehensiveness, integration and continuity of care and a redistribution of roles between close-to-client primary care teams and hospitals;
- raising awareness about health inequalities, bolstering capacity for public health interventions and rapid responses, and introduction of health-in-all-policies approaches;
- policy dialogue on overarching national strategies for health development, and striving for a political consensus about the responsibilities and the level of engagement of the state in the health sector, with participation and involvement of civil society.

48. Each region is drawing up plans for supporting renewal of primary health care. In the African Region these are guided by the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa (2008); in the Region of the Americas by the amended Strategic Plan 2008–2012 for the Pan American Sanitary Bureau; in the European Region by the Tallinn Charter: Health Systems for Health and Wealth (27 June 2008); in the South-East Asia Region by the strategic framework developed through the Regional Meeting on Health Care Reform (Bangkok, 20–22 October 2009); and in the Eastern Mediterranean Region by the Doha Charter and Declaration on Primary Health Care (November 2008). The Western Pacific Region started planning its work, which focuses largely on universal coverage, at an intercountry Meeting on WHO Action in Primary Health Care and Health Systems Strengthening (Manila, 14–15 April 2009). Regional task forces and technical working groups provide oversight and guidance to the translation of commitments into country cooperation strategy documents and the planning exercises for the biennium 2010–2011.

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<sup>1</sup> See document WHA62/2009/REC/3, summary record of the seventh meeting.

49. In order to ensure that the organizational efforts across all levels of the Organization contribute to the renewal of primary health care, the Secretariat has begun to provide support to Member States by:

- developing national health strategy and planning processes that respond to the country's health problems, health system challenges and expectations for renewal of primary health care;
- creating the institutional and managerial arrangements for implementing these strategies and plans;
- using these national strategies and plans as base for negotiating adequate resources with country and global stakeholders.

50. WHO is reprioritizing its work accordingly, and:

- has started linking all its programmes and country-cooperation strategies to national planning and strategy-building processes;
- is formulating a multiyear Organization-wide plan to bolster its capacities for supporting policy dialogue, at country and global levels, on the renewal of primary health care;
- has started using the preparation of *The world health report 2010* on financing for universal coverage and other corporate initiatives as a means to address issues that have previously received insufficient attention, such as investment in health-care infrastructure, including hospitals, and the inclusion of civil society in the policy dialogue on national health strategies and plans;
- is working towards creating a technical advisory committee on primary care and health systems strengthening;
- has stepped up its efforts to align global interventions with national health plans by, among other actions: providing, together with the World Bank, the secretariat functions of the International Health Partnership; facilitating the attempts of the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance and the World Bank to move towards more harmonized funding mechanisms; and intensifying collaboration with partners, particularly UNICEF.

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