

Implementation of resolutions: progress reports

Report by the Secretariat

CONTENTS

	Page
A. Strengthening active and healthy ageing (resolution WHA58.16)	2
B. Commission on Social Determinants of Health ¹	3
C. Public-health problems caused by harmful use of alcohol (resolution WHA58.26)	4
D. Emergency preparedness and response (resolution WHA59.22).....	5
E. Implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors	7
F. Public health, innovation, and intellectual property: towards a global strategy and plan of action ²	
G. <i>World report on violence and health</i> : implementation of recommendations	8
H. Health metric networks	10
I. Cancer prevention and control (resolution WHA58.22): cervical cancer ²	
J. Reducing global measles mortality ²	
Action by the Executive Board	11

¹ Subsection on empowering local communities contained in document EB120/35 Add.1.

² Contained in document EB120/35 Add.1.

A. STRENGTHENING ACTIVE AND HEALTHY AGEING

1. In resolution WHA58.16, the Health Assembly requested the Director-General to initiate and provide support to a number of activities in order to strengthen the Organization's work on active, healthy ageing and to report to the Sixtieth World Health Assembly, through the Executive Board, on progress made.

2. The Secretariat developed initiatives involving Member States, and professional, academic and nongovernmental organizations in order to raise awareness worldwide of the public-health challenges of ageing. For example, the intersectoral project "age-friendly cities", in which 27 cities in 18 countries are participating,¹ uses a common qualitative research protocol within which older people define priority interventions that could make their urban environment more age friendly.

3. WHO contributes to implementation of the Madrid International Plan of Action on Ageing, 2002, by using the active ageing policy framework which defines active ageing as "the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age".² The principles and recommendations for action contained in this document have been adopted globally by Member States and leading academic, professional and nongovernmental organizations. The framework rests on a life-course approach, focusing on ageing at all stages of life, rather than compartmentalizing older people. The inclusion of ageing throughout WHO's activities and programmes has been strengthened accordingly.

4. WHO is collaborating with academic institutions and government agencies from Australia, Brazil, Canada, Costa Rica, Jamaica, Singapore, Spain and Turkey adapting primary health care capacity to meet the needs of older people. Results include widely circulated documents enunciating principles and calling for action in the areas of core competencies, physical environment and administrative procedures. A tool kit on ways to make primary health care centres more age friendly is being piloted in five of the above-mentioned countries.

5. WHO conducted a multistage, qualitative and quantitative research project entitled "Integrated Health Systems' Response to Rapid Population Ageing in Developing Countries" in 18 countries, with a focus on capacity building, south-south exchange of models and experiences, adoption of "bottom-up" approaches and policy development and implementation.

6. The WHO Study on Global Ageing and Adult Health was designed in order to develop valid, reliable and comparable survey methods to examine patterns of health and well-being among older persons in six countries.³ The study was the first multidimensional and community-based international survey on ageing and it is expected that its instruments will be used for other studies worldwide.

7. In order to make optimal use of scarce resources, the Secretariat, including staff in regional and country offices, has focused on a few projects in priority, yet neglected, areas. Work is carried out in collaboration with other specialized agencies of the United Nations system and international

¹ Argentina, Australia, Brazil, Canada, China, Costa Rica, Germany, India, Ireland, Jamaica, Japan, Mexico, Pakistan, Russian Federation, Spain, Switzerland, Turkey and United Kingdom of Great Britain and Northern Ireland.

² Document WHO/NMH/NPH/02.8.

³ China, Ghana, India, Mexico, Russian Federation and South Africa.

nongovernmental organizations, thus ensuring intersectoral action. Areas include older people in emergency situations; prevention of falls in older age; women, ageing and health from a gender perspective; minimum curriculum content on ageing for health professionals; and older persons as carers in the context of the AIDS epidemic in Africa.

B. COMMISSION ON SOCIAL DETERMINANTS OF HEALTH

Introduction

8. The Commission on Social Determinants of Health was launched in March 2005 and will function until May 2008. It supports countries and global institutions, including WHO, in designing and implementing health policies that address the social factors leading to ill-health and health inequities.

9. Its 20 Members are outstanding innovators in science, public health, policy-making and social change. The Commission collaborates with civil society to support policy change and monitor results.

10. The Commission's goals are to support health policy change in countries by promoting models and practices that effectively address the social determinants of health; to support countries in placing health as a shared goal to which many government departments and sectors of society contribute; and to help build a sustainable global movement for action on health equity and social determinants, linking governments, international organizations, research institutions, civil society and communities.

Summary of progress

11. Since its inception, the Commission has met six times, in Brazil, Chile, Egypt, India, Iran and Kenya. Five regional consultations have taken place: in the African Region, the Region of the Americas, the South-East Asia Region, the Eastern Mediterranean Region and the Western Pacific Region. A consultation in the European Region will be held in February 2007.

12. There are nine global knowledge networks together comprising some 300 leading scientists, policy-makers, and representatives of global institutions, civil society and nongovernmental organizations. Each network is responsible for compiling and consolidating knowledge on globalization, early child development, urban settings, employment conditions, women and gender equity, social exclusion, health systems, measurement and evidence, and priority public health conditions. The knowledge network on priority public health conditions is based within headquarters and aims to enhance the effectiveness of key health programmes in incorporating the social determinants of health. The networks will submit to the Commission recommendations on the best practices for action on the social determinants of health.¹

13. An important part of the Commission's work with Member States² is aimed at bringing a contextual understanding of local approaches to health policies that address social determinants of health. The Commission aims in particular to draw lessons from intersectoral action and participatory approaches that promote health equity within countries.

¹ Analytical and Strategic Review papers and scoping papers can be found at http://www.who.int/social_determinants/en/.

² In particular Bolivia, Brazil, Canada, Chile, Congo, Egypt, India, Iran, Jordan, Kenya, Malawi, Mauritania, Mauritius, Morocco, Mozambique, Pakistan, Senegal, Sri Lanka, Sweden, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, Zambia and Zimbabwe.

14. Civil society organizations in four geographical regions, covering sub-Saharan Africa, the Americas, Asia and the Eastern Mediterranean, work closely with the Commission to advocate the use of the social determinants of health approach within their constituencies. They will report on grass roots practices for the Commission's final report and verify the applicability of the overall work of the knowledge networks.

15. During the first half of 2006, the Commission analysed the global health and development policy environment and selected four key target audiences for its global advocacy work, namely, the World Bank, the United Nations Economic and Social Council, the G8, and the CEB. Over the coming year, the Commission will prepare an analysis of and strategic plan for working with each of these institutions to ensure that equity and social determinants of health feature prominently on their policy agendas, and in their institutional priorities and plans.

16. Within WHO: steps have been taken to ensure that the social determinant of health approach is interpreted as one of the five priorities in the Eleventh General Programme of Work and as one of the 15 strategic objectives in the draft Medium-Term Strategic Plan to improve health equity. The knowledge network on priority public health conditions has been established to identify facilitators of and barriers to access to health care and to introduce pro-equity interventions within health programmes, particularly in low- and middle-income countries.

17. The Commission's seventh meeting will take place in January 2007 at WHO headquarters. Members will review the preliminary findings and progress of the streams of work, and discuss the Commission's interim statement, which will be disseminated in early July 2007 for review and comment. The final report will be issued in May 2008. The Sixty-second World Health Assembly is expected to consider a global strategy and resolution for addressing the social determinants of health and health equity.

C. PUBLIC-HEALTH PROBLEMS CAUSED BY HARMFUL USE OF ALCOHOL

18. In order to implement resolution WHA58.26, the Secretariat strengthened its capacity and has implemented a range of activities at the global and regional levels. It has given priority to a comprehensive assessment of public-health problems caused by harmful use of alcohol, reviewing evidence and making recommendations for policies and interventions, reinforcing global and regional systems of information about alcohol, and collaborating with relevant stakeholders.

19. Regional activities have been intensified through assessments of public-health problems caused by harmful use of alcohol and design of appropriate regional responses and programmes. Technical consultations were organized in the African (Brazzaville, May 2006), Eastern Mediterranean (Cairo, June 2006) and Western Pacific regions (Manila, March 2006). Resolutions on the subject were adopted by the regional committees for South-East Asia and for the Eastern Mediterranean. A Regional Strategy to Reduce Alcohol-Related Harm was endorsed by the Regional Committee for the Western Pacific.¹

20. The Secretariat has updated the estimated global burden of disease attributable to alcohol and prevalence of alcohol-use disorders. The methods used for the estimations, the new figures on the burden attributable to alcohol, and data-collection procedures and their improvement were discussed at a meeting of a technical advisory group on alcohol epidemiology (Geneva, 13–15 September 2006).

¹ Resolution WPR/RC57.R5.

21. The process of drawing up recommendations on policies and interventions to reduce alcohol-related harm included a series of technical consultations and a web-based survey of the view and opinions of academic institutions, professional associations, nongovernmental organizations and representatives of the alcoholic-beverage industry and trade and agricultural sectors. The WHO Expert Committee on Problems Related to Alcohol Consumption (Geneva, 10–13 October 2006) reviewed available evidence and made technical recommendations. Further consultations are needed to draft global recommendations and construct an appropriate framework for global activities to reduce alcohol-related harm that accommodates regional examples such as the European Alcohol Action Plan 2000-2005, the Framework for Alcohol Policy in the WHO European Region and the Regional Strategy to Reduce Alcohol-Related Harm in the Western Pacific Region.

22. In order to enhance the global information system on alcohol consumption and its health and social consequences, the Secretariat has revised and expanded the Global Alcohol Database, and transferred most of it to a web site. Global monitoring of both harmful use of alcohol and national policy responses need to be strengthened through the establishment or better functioning of regional information systems and effective linking with country-based monitoring and surveillance activities. The technical tool to support data collection and analysis, the International Guide for Monitoring Alcohol Consumption and Related Harm,¹ is being revised. Work on the development of a composite indicator for monitoring harmful use of alcohol at national and subnational levels is in progress.

23. Collaboration with nongovernmental organizations was enhanced through a global consultation (Geneva, 24–25 April 2006) and by facilitating networking between such organizations and professional associations working directly with alcohol-related problems or in associated areas.

24. An open global consultation with representatives of the alcoholic-beverage industry in order to exchange views on appropriate corporate initiatives was organized in WHO headquarters (Geneva, 8 March 2006). A similar consultation was held in the Western Pacific Region (Manila, 8 June 2006). Further interaction with representatives of the industry and the agricultural and trade sectors is being planned in the context of their potential contribution to reducing alcohol-related harm as commercial producers, distributors and marketers of alcoholic beverages.

D EMERGENCY PREPAREDNESS AND RESPONSE

25. In resolution WHA59.22 the Health Assembly requested the Director-General to support Member States in building their health-sector emergency preparedness and response programmes at national and local levels, working in collaboration with relevant organizations of the United Nations system and other partners, and to inform the Sixtieth World Health Assembly, through the Executive Board, of progress made.

26. A WHO five-year emergency preparedness and risk reduction strategy, focusing on the health sector and on community capacity building, has been finalized. Four priority areas have been identified; (1) institutionalization of emergency preparedness programmes within health ministries; (2) human resource development; (3) national capacity building for immediate medical and health care following major emergencies and sudden onset disasters; and (4) support to community-based initiatives.

¹ Document WHO/MSD/MSB/00.4.

27. In order to enable Member States to deal with existing emergency response gaps, WHO is preparing managerial and technical guidelines on mass casualty management, following input from an expert consultation in September 2006. Other initiatives include the preparation of guidance on chronic disease management and maternal and newborn health in emergencies.

28. A global assessment of the level of emergency preparedness in Member States has been launched. Phase I, involving 60 countries, has been completed; phase II was initiated in November 2006 and is due for completion by the end of 2006. The full report will be available in January 2007.

29. The Safe Hospitals Initiative is being developed jointly with the United Nations International Strategy for Disaster Reduction and the World Bank as part of the Hyogo Framework¹ in preparation for the 2008–2009 Campaign for Safe Hospitals.

30. WHO is an active member of the United Nations Inter-Agency Standing Committee and the Executive Committee on Humanitarian Affairs, an active partner of the United Nations Office for the Coordination of Humanitarian Affairs and participates in the humanitarian reform process. It is the lead agency for the Inter-Agency Standing Committee Health Cluster, co-chairs its Task Force on Gender and Humanitarian Assistance, its Task Force on Mental Health and Psychosocial Support, and participates in its Ad Hoc Working Group on Strengthening the Humanitarian Coordinator System. An action plan for the global health cluster is being implemented in coordination with other partners. The plan covers training, common health needs assessments, a coordinated response and health management tool kit, and the health and nutrition tracking service.

31. The tracking service has been the subject of a lengthy consultation with the main stakeholders. The final project proposal has been endorsed by the Inter-Agency Standing Committee's Health and Nutrition Clusters and welcomed officially by its Working Group. Extensive discussions have since been held with other potential partners. Implementation will start as soon as funds are available.

32. The health cluster approach has been implemented in Lebanon and is currently being introduced in Democratic Republic of Congo, Liberia, Somalia and Uganda.

33. WHO collaborated with the International Federation of Red Cross and Red Crescent Societies in establishing a Tsunami Recovery Impact Assessment and Monitoring System in South-east Asia.

34. In the Horn of Africa, WHO was instrumental in making the health sector a major beneficiary of the new Central Emergency Response Fund in order to meet the humanitarian needs of the most vulnerable communities in Djibouti, Eritrea, Ethiopia, Kenya and Somalia. The successful implementation of grants in those situations enabled the Fund to provide aid to a total of 20 countries worldwide, including 13 in the African Region, through its rapid response and under-funded emergency grants.

¹ Hyogo Framework for Action 2005–2015: Building the Resilience of Nations and Communities to Disasters, adopted by the World Conference on Disaster Reduction (Kobe, Japan, 18–22 January 2005).

Participation in United Nations system-wide mechanisms for logistics and supply management

35. WHO is participating in United Nations system-wide mechanisms for logistics and supplies. Work in this area is carried out through the Organization's involvement in the Inter-Agency Standing Committee's Logistics Cluster, the United Nations Joint Logistics Centre and in the development of the Logistical Supply System. In 2006, focused negotiations with WFP resulted in bilateral agreements on privileged access to WFP's logistic capacities for WHO's surge response in emergencies, and on the common use of the five regional logistics hubs for health purposes, and in a joint project proposal for the mobilization of external resources. The relevant Technical Agreements are being finalized for signature by both parties by the end of 2006.

E. IMPLEMENTATION BY WHO OF THE RECOMMENDATIONS OF THE GLOBAL TASK TEAM ON IMPROVING AIDS COORDINATION AMONG MULTILATERAL INSTITUTIONS AND INTERNATIONAL DONORS

36. Resolution WHA59.12 endorsed the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors and requested the Director-General to implement those recommendations, in collaboration with UNAIDS and its other cosponsors, and to report on progress to the Executive Board and to the Sixtieth World Health Assembly.

37. The Global Task Team's recommendations included the need for donors and multilateral institutions (e.g. WHO, UNAIDS, the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria and others) to work together more effectively in order to ensure that financial and technical support to national AIDS responses is harmonized and aligned in accordance with the "Three Ones" principle and with the Rome Declaration on Harmonization (2003) and the Paris Declaration on Aid Effectiveness (2005).

38. By the end of October 2006, UNAIDS had supported the establishment of joint United Nations teams on AIDS in 44 countries. WHO has played an active role in these teams, including participation in joint programming with other United Nations agencies and partners.

39. WHO's contribution to the implementation of the Global Task Team's recommendations has focused on improving coordination between multilateral agencies, especially for the provision of technical support at country level. As chair of the Global Joint Problem-Solving and Implementation Support Team, WHO leads work to overcome obstacles in the implementation of major grants for national HIV/AIDS programmes. Core members of the Support Team include WHO, UNDP, UNICEF, UNFPA, UNAIDS, the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Team facilitates in-country analysis of the obstacles and the design of technical support plans to overcome them. Monthly telephone and videoconferences are held with countries to review their technical support requests. Decisions about responsibilities for providing technical support are made within the agreed framework for the division of labour.¹

¹ *UNAIDS Technical Support Division of Labour: summary and rationale*, UNAIDS, August 2005.

40. The Support Team has coordinated and provided policy, technical and management support, with the close involvement of United Nations theme groups, joint United Nations country teams and other national and international partners. During the first year of its operation, the Support Team made rapid analyses of obstacles to programme implementation in 15 countries and facilitated action in nine. Support was provided in areas of procurement and supply management, ability to oversee and manage grants, monitoring and evaluation, and dealing with systemic challenges in relation to the policies, procedures and practices of multilateral institutions and their partners. In November 2006, membership of the Support Team was due to be expanded to include bilateral donors and civil society partners.

41. The Support Team's work complements the technical support provided to UNAIDS and its cosponsors at regional and country levels, for instance, through the knowledge hubs established by WHO and its partners, and UNAIDS' technical support facilities. WHO is also working with the Emergency Plan for AIDS Relief, launched by the President of the United States of America, and with the GTZ BACKUP Initiative to ensure that the technical assistance provided by bilateral agencies is consistent with United Nation system's work.

42. As countries' demand for technical support grows, efforts are continuing to ensure that adequate financing is available. Of the funds available for WHO's HIV/AIDS work in the current biennium, 79% has been distributed to regional and country offices. WHO is also working with UNAIDS and its other cosponsors to raise more resources for technical support, exploring, for example, the possibility of making additional funds available at country level from the UNAIDS Unified Budget and Workplan.

43. While contributing to broader coordination efforts, WHO's specific support for national AIDS responses remains focused on expanding key health-sector interventions in order to come as close as possible to the goal of universal access to prevention, treatment, care and support by 2010. In order to enhance the accountability of countries and their partners, WHO and UNAIDS are giving guidance to countries on setting national milestones for measuring progress towards universal access in key interventions such as provision of antiretroviral treatment, prevention of mother-to-child transmission of HIV and HIV testing and counselling, and will provide support to countries for integrating ambitious targets into national AIDS strategies and action plans.

G. WORLD REPORT ON VIOLENCE AND HEALTH: IMPLEMENTATION OF RECOMMENDATIONS¹

44. Resolution WHA56.24 urged Member States to promote the *World report on violence and health*, and encouraged Member States to prepare a report on violence and health and all those that had not already done so to appoint a violence-prevention focal point in the health ministry. The resolution requested the Director-General to cooperate with Member States in establishing policies and programmes for the implementation of measures to prevent violence.

45. Since 2005, the number of countries in which the report has been launched has increased from 40 to 52; the number producing national violence and health reports has risen from four to 15; and the number of focal points has doubled to 100. Countries that initiated new violence-prevention activities

¹ *World report on violence and health*. Geneva, World Health Organization, 2002.

in collaboration with WHO – such as data collection, research on the costs of violence, evaluation of prevention programmes, the establishment of national prevention institutes or task forces, and the improvement of victim services – include: Angola, Argentina, Colombia, Belgium, Brazil, Canada, Congo, El Salvador, Finland, France, Germany, Guatemala, Honduras, India, Jamaica, Jordan, Kenya, Latvia, Malaysia, Mongolia, Mozambique, Nepal, Nicaragua, Philippines, Peru, Russian Federation, South Africa, Thailand, The former Yugoslav Republic of Macedonia, Uganda, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, United States of America, and Yemen.

46. Some of these achievements were reviewed at a 2nd meeting on Milestones of a Global Campaign for Violence Prevention (San Francisco, United States of America, 19 October 2005),¹ and advances made by the Violence Prevention Alliance were assessed. Following this assessment, the Belgian Ministry of Health and WHO convened a meeting of experts from 14 countries (Brussels, 19–20 June 2006) to discuss the strategic direction of the Alliance. It was agreed to establish a high-level working group on advocacy for the inclusion of violence prevention in the global development agenda.

47. In 2005, the Regional Committee for Europe adopted resolution EUR/RC55/R9 urging Member States to prioritize prevention of violence and injury. Meetings of focal points from 34 Member States in the Region were subsequently held with the aim of agreeing a shared goal and devising a joint programme of activities. Earlier this year, 100 focal points from 67 countries, participating in the First Global Meeting of Health Focal Persons for Injury and Violence Prevention (Durban, South Africa, 31 March – 1 April 2006) agreed to create a network for exchanging information and strengthening national violence-prevention policies. In a subsequent consultation, some 30 African health ministers or their delegates made commitments to give violence prevention a higher priority in national health programmes and policies, and, by way of follow up, WHO has begun to prepare a report on violence and health in Africa.

48. Publications in 2005 and 2006 include the *WHO Multi-country study on women's health and domestic violence against women*,² *Injuries in Europe: why they matter and what can be done*,³ a series of fact sheets on interpersonal violence and alcohol,⁴ a package for teaching prevention of violence and injuries,⁵ *Developing policies to prevent injuries and violence*,⁶ and *Prehospital trauma care systems*.⁷

¹ *Milestones of a global campaign for violence prevention 2005: changing the face of violence*. Geneva, World Health Organization, 2005.

² Garcia-Moreno C, Jansen HAFM, Ellsberg M, Helse L, Watts C. *WHO multi-country study on women's health and domestic violence: initial results on prevalence, health outcomes and women's responses*. Geneva, World Health Organization, 2005.

³ Sethi D, Racioppi F, Baumgarten I, Vida P. *Injuries in Europe: why they matter and what can be done*. Copenhagen, WHO Regional Office for Europe, 2006.

⁴ Accessible at http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/en/index.html

⁵ Accessible at http://www.who.int/violence_injury_prevention/capacitybuilding/teach_vip/en/index.html

⁶ Schopper D, Lormand JD, Waxweiler R (Eds). *Developing policies to prevent injuries and violence: guidelines for policy-makers and planners*. Geneva, World Health Organization, 2006.

⁷ Sasser S, Varghese M, Kellermann A, Lormand JD. *Prehospital trauma care systems*. Geneva, World Health Organization, 2005.

49. With the Office of the High Commissioner for Human Rights and UNICEF, WHO provided data and technical input to the United Nations Secretary-General's Study on Violence Against Children. The report was presented to the General Assembly on 11 October 2006. WHO's follow-up will focus on supporting countries in their implementation of *Preventing child maltreatment: a guide to taking action and generating evidence*.¹

50. In 2006 the Secretariat established a task force on the prevention of sexual and intimate partner violence, which will draw up a draft global plan of action for the prevention of intimate partner and sexual violence. Expert consultations are planned for 2007.

51. Progress in violence prevention has led to increased country-level uptake of WHO's recommendations on violence prevention. Further progress requires intensifying support for country-level implementation of WHO guidelines, including investment in evaluation of outcomes.

H. HEALTH METRICS NETWORK

52. The Health Metrics Network, an innovative network of producers and users of health information, launched during the Fifty-eighth World Health Assembly in May 2005, aims to increase the availability, quality and use of timely and accurate health information at subnational, national and global levels. Partners include health ministries, national statistics offices, organizations of the United Nations system, development banks, global health partnerships, donors and technical experts.

53. The key objectives of the Network are:

- to define a framework, i.e. core set of standards for health-information systems, and data generation, analytical capacities, and guidelines to develop national health-information systems;
- to apply the framework at country level, mobilizing technical and financial support to catalyse development and improvement of health-information systems;
- to frame policies and create incentives to improve access to, and use of, information at local, regional and global levels.

54. A first version of the framework was drawn up during 2005 in collaboration with countries, technical partners and development agencies. It is a dynamic reflection of the best practice in health information to which partners are committed and are already aligning their health and statistical development assistance. Experience gained through such collaboration will help to stimulate further evolution of the framework.

55. After the Network was launched, requests from Member States for support to develop health-information systems surged. Forty countries received grants from the Network as a result of the first call for proposals and by the deadline for the second round, over 50 more countries had submitted proposals. Most of the proposals are from low- and lower-middle income countries which are in greatest need of sound information to guide decision-making and which have little technical and

¹ World Health Organization, International Society for Prevention of Child Abuse and Neglect. *Preventing child maltreatment: a guide to taking action and generating evidence*. Geneva, World Health Organization, 2006.

financial capacity. Grants are used to mobilize political, technical and financial support and to develop comprehensive, prioritized, costed and funded plans for development of health-information systems.

56. The Network is expected to define and implement strategies to overcome lack of resources for some components of the health-information system. Guidelines on demographic surveillance and sample registration, and harmonized verbal autopsy tools will enable countries to move towards the universal goal of comprehensive vital statistics. Methods for generating sound population-based data at subnational level will empower district managers and enhance equity. Tools to measure the functioning of health systems (such as availability and distribution of human, physical and financial resources for health) will permit better planning to meet health needs.

57. Use of the framework has revealed the need to elaborate further the architecture of a sound health-information system. It will therefore be expanded to address the relationship between demand and supply of health information, links between indicators and data sources, frequency of data collection and disaggregations, and ways of facilitating data flows across indicators and data sources. The policy frameworks, institutional mechanisms and leadership skills needed to ensure that data are converted into information and that knowledge is used to inform decision-making will also be examined.

58. By 2011, the framework should be the universally accepted standard for collection, reporting on, and use of, health information. Its adoption as the global standard will require strong political endorsement and consensus-building.

59. WHO provides the Network's secretariat, and is fostering collaboration among those involved in strengthening health systems and in the production and use of health information. For example, the WHO Regional Committee for South-East Asia urged Member States "to consider using the Health Metrics Framework as a tool for health-information systems assessment and in enhancing harmonization of country efforts related to the strengthening of health-information systems ...".¹ Regional strategic frameworks have been developed in order to strengthen health-information systems, to seize the new technical and financial opportunities opened up by the Network, and to contribute to better global reporting of health information.

ACTION BY THE EXECUTIVE BOARD

60. The Executive Board is invited to note the above progress reports.

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¹ Resolution SEA/RC59/R10.