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The programme budget as a strategic tool for accountability

A proposed 2012–2013 pilot trial for WHO reform

One of the instrumental goals within the WHO reform process is to ensure that the programme budget is developed in such a way that it can effectively reflect the chain of expected results and verification of their attainment by means of indicators. It is hoped that the way in which outcomes and outputs are defined will provide Member States with greater insight into WHO's specific contribution to global health and will more closely reflect agreed organizational priorities.

This information document is a response to the request by the Regional Committee at its sixtieth session for a tool to strengthen the governance and oversight function of the Committee. The document has been prepared by the Secretariat in collaboration with members of the Eighteenth Standing Committee of the Regional Committee.

It describes a strategic tool for increased accountability, enhanced management of resources and improved quality of funding, to be pilot tested during the 2012–2013 biennium within the context of the WHO reform process.

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Introduction

1. The Regional Director's vision for better health is to improve the level and distribution of health within and across the populations of Europe. This means daring to focus attention on where Member States and the WHO Secretariat together can make critical impacts on public health. It also means continuously striving to enhance the performance of health and other public systems, as well as of the Secretariat. Finally, it means building trust by ensuring transparency and defining the mutual responsibilities and accountabilities. The way in which outcomes and outputs are defined should provide Member States with greater insight into WHO's specific contributions to global health and reflect agreed organizational priorities. This should allow Member States to grant the Secretariat more flexibility in the management of resources, for better alignment between priority needs and "deliverables".

2. At its sixtieth session, the Regional Committee for Europe (RC60) noted with concern the continuing imbalance between the key health priorities endorsed by the European Member States and the designated voluntary funding for such priorities. The Committee requested the Regional Director, following approval of the 2012–2013 programme budget (PB) by the World Health Assembly in 2011 and in collaboration with the Standing Committee of the Regional Committee (SCRC), to submit a package of performance indicators and a list of key deliverables to RC61, in order to strengthen the Regional Committee's governance and oversight functions. At the same time, the Regional Committee urged Member States to keep agreed priorities in mind whenever voluntary contributions are attributed to the work of WHO.[1]

3. The proposal presented in this document should be viewed as a response to the request from RC60 and regarded as a pilot trial, i.e. early testing to operationalize the above concepts within the context of the WHO reform process.

4. The expected outcome of the WHO reforms is:

- greater coherence in global health, with WHO playing a leading role in enabling the many different actors to proactively and effectively contribute to the health of all peoples;
- improved health outcomes, with WHO meeting the expectations of its Member States and partners in addressing agreed global health priorities, focused on the actions and areas where the Organization has a unique function or comparative advantage, and financed in a way that facilitates this focus;
- an organization which pursues excellence; one that is effective, efficient, responsive, objective, transparent and accountable.[2]

5. The following focuses on Europe's component of the base programme budget segment in the WHO programme budget 2012–2013 as approved by the World Health Assembly in May 2011.

6. The World Health Organization is a specialized technical agency of the United Nations, and in Europe it consists of all its Member States (represented in the Organization's regional

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[1] EUR/RC60/R9

[2] *The future of financing for WHO – World Health Organization: reforms for a healthy future. Report by the Director-General*. Geneva, World Health Organization, 2011 (document A64/4, http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_4-en.pdf).

governing bodies, i.e. the Regional Committee and the Standing Committee of the Regional Committee) and the Secretariat at the Regional Office for Europe.

7. Within the overarching goal of achieving better health in Europe through more focused and concerted efforts by Member States and the Regional Office Secretariat, the objectives of WHO's results-based management framework, as reflected in the programme budget, are to:

- link agreed outcomes with resources and performance, with a view to promoting efficiency and effectiveness;
- give Member States a steadily improving framework for delivery, accountability and transparency, thus facilitating a higher degree of confidence that the work programme as approved by the governing bodies is implemented and that resources provided to the Secretariat are properly managed and accounted for;
- enable a higher degree of flexible financial and in-kind resource contributions;
- contribute to better predictability of resources for the regional priorities; and
- encourage all Member States to focus public health attention on the common priorities of the European Region as decided by the governing bodies, without impeding the inclusion of other relevant objectives when justified and necessary.

8. The 2012–2013 PB covers the last biennium of the Organization's current Medium-Term Strategic Plan (MTSP), requiring the completion of those aspects of the "organization-wide expected results" (OWERs) that are adapted to the needs of the European Region, including the most important and recent Regional Committee resolutions. With this in mind, an "outcome portfolio" is defined, consisting of "key priority outcomes"[3] (KPOs) and "other priority outcomes" (OPOs). All of these (both KPOs and OPOs) are formulated with consideration of their special relevance to broad strategic directions, providing guidance on *what needs to be done, why* and *how*. These directions include:

- concentrating efforts where the Regional Office should lead implementation of the most important current resolutions of the Regional Committee and the World Health Assembly in order to foster uptake by Member States and improve public health;
- tackling the major public health challenges of the Region: the level and distribution of health, solidarity and equity in health, and making progress on the unfinished public health agenda;
- working in partnership and collaboration with Member States, European institutions and experts to develop and apply public health tools for policy-making that are based on sound technical evidence;
- prioritizing intercountry modes of delivery whenever possible, using a multicountry mode when advisable or a country-specific mode when necessary, maintaining the appropriate balance according to needs; and
- ensuring financial sustainability and continuously improving efficiency and accountability, while maintaining a positive and empowering working environment.

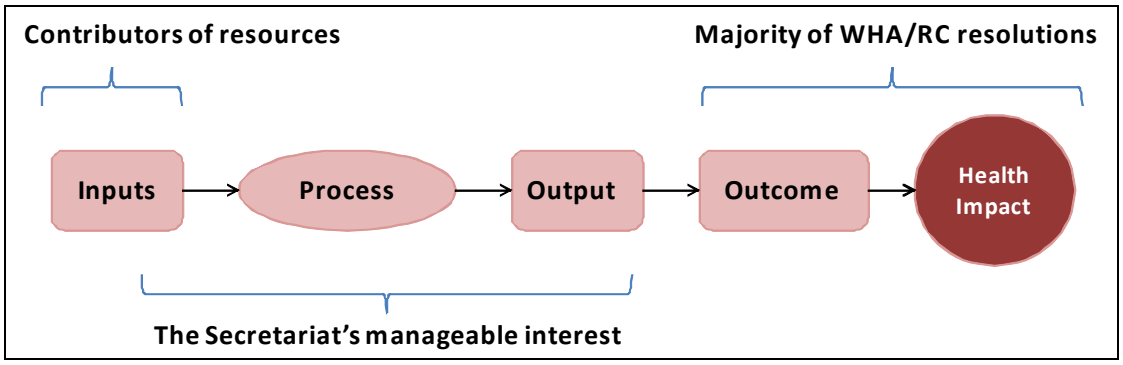
9. This document should be considered in conjunction with the Organization's programme budget 2012–2013.

[3] The specific criteria used to select the KPOs are described in paragraph 17

The value chain

10. The value chain (Fig. 1) illustrates the transformation of **inputs** (money, staff, information, etc.) into **public health impacts**, as expressed in terms of the overarching goal of improving the level and distribution of health in the European population.

Fig. 1: The value chain



11. Accountability for implementation of the Organization's MTSP and PB can be defined in at least two different forms: accountability for *outcomes* (i.e. uptake by Member States) and for *outputs* and *processes* (i.e. the deliverables and managerial performance of the Secretariat).

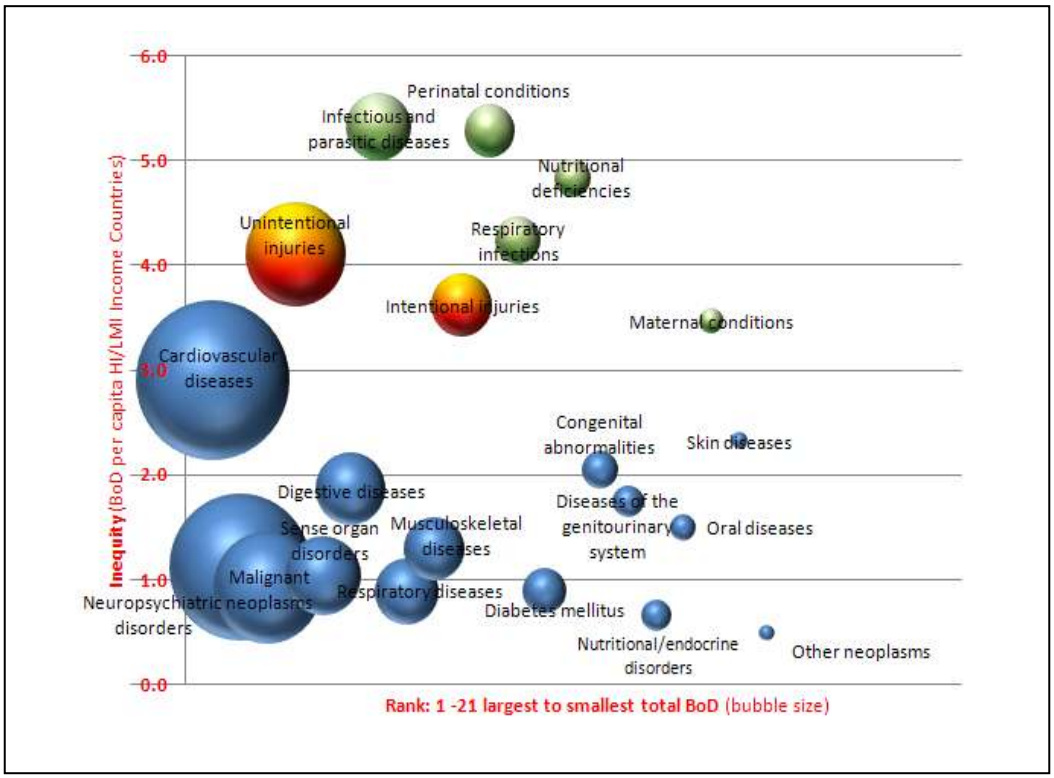
12. For outcomes, accountability is measured by the effectiveness in achieving results, which is the joint responsibility of public health authorities in individual Member States, the Secretariat, and donors and contributors. On the other hand, accountability for the productivity and efficiency of outputs and processes is the sole responsibility of the WHO Secretariat.

13. The Secretariat may be evaluated not only on the quality of the outputs it produces (i.e. policies, guidelines and manuals) but also on the efficiency with which it has used financial, human and technological resources, i.e. the inputs, to produce such outputs. The more conditions attached to the inputs, the less managerial authority the Secretariat has. At the one extreme, where the inputs are tightly earmarked, the Secretariat can be held accountable only for using the resources as specified by the donor agreement, i.e. not whether the most needed output has been produced but rather whether the specified activities have been carried out in the most efficient way. At the other extreme, where the inputs are totally flexible, the Secretariat can be accountable for the whole value chain up to outputs and can have a major role in ensuring delivery of joint outcomes.

The public health situation

14. Every year, 151 million disability-adjusted life-years (DALYs) are lost in the WHO European Region due to 21 groups of causes (Fig. 2). Most of this loss can be avoided through appropriately designed and implemented public health policies and interventions. Further, if the situation of the low- and middle-income (LMI) countries of the Region was similar to that of the high-income (HI) countries, 44 million DALYs would be saved annually.

Fig. 2: Burden of disease in the WHO European Region – level and distribution



15. Fig. 2 shows each of the major causes of the burden of disease classified by colour (blue for noncommunicable diseases, orange for injuries and green for the unfinished health agenda in tackling communicable diseases, maternal and perinatal conditions and nutritional deficiencies). The DALYs lost due to those pathologies are denoted by the size of the bubble, and the inequity between the LMI and HI countries of the Region are expressed along the Y-axis. The greatest inequalities exist in the green group, despite the successes in decreasing the absolute burden of these conditions. Infectious and parasitic diseases are more than five times more prevalent in LMI than in HI countries. However, inequities are seen in all groups of conditions: unintentional injuries, for instance, are more than four times more prevalent, while cardiovascular diseases are about three times more prevalent. Injuries, intentional as well as unintentional, are characterized by both a high burden and large inequities. Noncommunicable diseases, individually as well as a group, represent the largest overall burden, while some of them also show considerable and increasing inequity. For example, both the burden and the inequity associated with diabetes are on the rise.

The outcome portfolio

16. The overall regional outcome portfolio for 2012–2013 consists of 86 priority outcomes that seek to address the level and distribution of health within the Region. These outcomes capture the Regional Office's overall technical priorities for the biennium. Within this, 26 key priority outcomes (KPOs) have been identified for specific attention in the pilot trial; these are deemed to be "priorities within the priorities" and especially relevant to improving the level and distribution of health in the Region and to the mandate given to the Secretariat by the governing bodies. The other priority outcomes (OPOs) are also considered to be very important and consistent with the Organization's mandate for improving public health in Europe as reflected in the MTSP.

17. The 26 KPOs in this pilot programme to test accountability with respect to commitment, resource allocation, delivery and reporting were selected using the following specific criteria:

- contribution to the Regional Director's vision for better health in Europe, as mandated by RC60 and followed up by the SCRC (including the new European health policy, Health 2020, and appropriate consideration of cross-cutting issues such as strengthening health systems, expanding public health capacity and services, and tackling human rights and the needs of vulnerable groups);
- existing commitments (expressed through the World Health Assembly, the Regional Committee, the United Nations Millennium Development Goals, ministerial conference declarations), including those to disease eradication/elimination;
- actions that lie within WHO's core mandate and offer synergy with current partners;
- the existence of feasible interventions for action.

18. For each of the outcomes, the specific outputs to be produced by the Secretariat have been defined, and consultations have been held with Member States to plan which of them will collaborate on which outcomes. The achievements will be assessed in terms of the number of Member States taking up each outcome

Table 1. Base programme budget segment - budget and priority outcomes

	Strategic Objective	US$ Millions	Total # of Priority Outcomes	# of Key Priority Outcomes
1	Communicable diseases	15.0	9	3
2	HIV/AIDS, Tuberculosis and Malaria	21.0	9	3
3	Chronic non communicable conditions	16.5	10	3
4	Child, adolescent, maternal, sexual and reproductive health, and ageing	10.9	6	2
5	Emergencies and disasters	4.0	3	1
6	Risk factors for health	14.5	12	3
7	Social and economic determinants of health	5.9	6	2
8	Healthier environment	15.5	6	1
9	Nutrition and food safety	6.0	4	2
10	Health systems and services	25.5	18	5
11	Medical products and technologies	3.0	3	1
Sub-total SO 1-11		137.8	86	26
12	WHO leadership, governance and partnerships	27.5		
13	Enabling and support functions	26.5		
Sub-total SO 12-13		54.0		
Grand total		191.8		

19. The 26 KPOs will be funded from specified voluntary contributions (VCS), assessed contributions (AC), flexible funds provided at the level of WHO (CVCA) and flexible funds provided at the level of the Regional Office (RO). The funds will be managed applying the principle that the most specified resources will be spent first. The flexible corporate funds (AC, CVCA and RO) will be allocated to ensure full and even implementation across the 26 KPOs.

When all the KPOs are fully funded, any remaining corporate resources will be used for the OPOs.

20. The larger the share of flexible corporate funds, the more likely it is that all 26 KPOs will be fully accomplished. The distribution of the KPO budget across strategic objectives is based on the strategic directions stated in paragraph 7 above.

21. Details of the KPOs (description of outcome, number of Member States involved, and outputs to be delivered) are given in Annex I.

Processes

Business model

22. The ultimate result of WHO's work is measured by its impact on public health. This in turn is measured within as well as across Member States of the Region. The Secretariat will maintain a strong focus on technical assistance to countries, matching their needs and ensuring that the most effective and efficient way of working is chosen in each case. Three modes of operation are contemplated: intercountry (when all Member States are involved), multicountry (when a specified set of countries takes part) and country-specific (when only one country participates).

23. A main driver of the Regional Office's business model is the high level of skills and capacity that exist within European institutions and public services. These facts determine two main characteristics of the business model:

- Whenever feasible, the intercountry mode will prevail, i.e. addressing the common needs of countries through Region-wide approaches. It is expected that an increasing part of the Regional Office's work will be delivered in this way. When an output within an outcome is relevant to a limited number of countries only, then a multicountry model may be used, making optimal use of the resources that exist within the group. However, there are and will continue to be outputs that are very specific to the needs and circumstances of individual countries. Thus, the country-specific mode of operation will continue to be important and the chosen mode of delivery as appropriate.
- More systematic work with WHO collaborating centres across the Region will lead to a larger proportion of the outputs being delivered in collaboration with these centres, and with the Secretariat playing a lead role.

24. The country work will be planned with each Member State concerned and will be covered by a biennial collaborative agreement (BCA), specifying the impact to be achieved, the expected outcomes as well as the specific deliverables.[4]

25. The above represents somewhat of a departure from the past business model. However, it is expected that it will lead to effectiveness and efficiency gains and thus to increased value for money. The Regional Office envisages gradually placing greater emphasis on this model of operation for the entire portfolio of priority outcomes. However, special efforts, oversight and follow-up will be made during the 2012–2013 biennium to make this shift happen with respect to the KPOs.

[4] See also *A country strategy for the WHO Regional Office for Europe* (document EUR/RC61/17).

Performance indicators

26. Six performance indicators have been chosen, representing mutual accountabilities at the different stages of the value chain (Fig. 1). Baseline values are available for three of these indicators, and targets for 2012–2013 have been set for all of them.

Table 2. Performance indicators

	Indicator	Baseline	Target	Accountable
Results	Proportion of planned **key priority outcomes** (KPO) achieved	n.a	85%	Member States and Secretariat
	Proportion of planned **KPO outputs** delivered	n.a	95%	Secretariat
Process	Proportion of **total expenditures spent on staff** in base programmes (SOs 1–11)	60%[5]	55%	Secretariat
	Proportion of **corporate resources** in SOs 1–11[6] allocated to KPOs, with the remainder allocated to other priorities within these SOs	n.a	80%	Secretariat
Input	Proportion of voluntary contributions that are **flexible** at SO level or above	7%[7]	14%	Member States/ fund contributors
	Proportion of specified voluntary contributions that can be used for **funding salaries**[5]	50%	55%	Member States/ fund contributors

Reporting

27. Reporting on KPOs and performance indicators will be made to the SCRC, using information that is already available for internal management purposes. It will consist of:

- six-monthly reports on progress in achieving outcomes and outputs, summarizing enabling and constraining factors, including use of inputs. These reports will follow the internal six-month reviews and be in the form of brief "news sheets"; and
- annual reports on outcomes and outputs, in the form of comprehensive achievement reports, including details of enabling and constraining factors, as well as performance indicators.

[5] The baseline is May 2011. On average, staff costs account for 60% of total expenditures. The current under-recovery of staff costs from specified voluntary contributions puts a strain on the corporate resources.

[6] This assumes that the Director-General will allow the Regional Office to manage AC funds flexibly across SOs 1–11.

[7] As of May 2011

Commitments

28. The commitments and accountabilities of the three parties (Member States, Member States/donors, and the Secretariat) are summarized in the table below.

Table 3. Commitments

	Member States	Member States/donors	Secretariat
Results	Take up outputs to accomplish planned key priority outcomes (KPOs)		Deliver planned outputs, including technical guidance and assistance
Resources	Allocate adequate own resources for own work on KPOs	Provide sufficient resources, flexibly or aligned with KPOs	Manage resources to ensure even financing across all KPOs
Productivity and efficiency			Achieve the two process/efficiency targets set for 2012–2013

29. Successful achievement of the European KPOs requires fulfilment of all the commitments of all the three parties as indicated in the above table.

30. The Biennial Collaborative Agreements (BCAs) will continue to be the key instrument for expressing country-specific commitments and ensuring accountability and collaboration between individual Member States and the WHO Secretariat.

Evaluation

31. The Secretariat will undertake an internal mid-biennium desk review in February 2013 against the objectives outlined in paragraphs 6 and 7 above. The results of the review will shared with the SCRC and will inform any modifications to and continuation and/or institutionalization of the pilot programme within the context of the overall WHO reform process.

Annex I: Key Priority Outcomes

Strategic Objective	Outcome – Uptake by Member State	No. of MS in which uptake envisaged	Secretariat contribution (Output)
SO1	In support to national and regional health security, Member States have developed policies and national plans to implement the IHR, including strengthening their core public health capacities for disease surveillance and response, as well as preparedness for epidemic-prone diseases (such as influenza).		(1) Monitoring and joint risk assess. of all notifiable events under IHR; (2) Assess. and building of IHR core capacities; (3) Reg. and nat. tools, training, guidelines and plans for disease surv., risk assess. and preparedness and response, including pandemic preparedness; (4) Policy and technical support in national laboratory networks for quality systems, lab. diagnoses and biosafety; (5) Sub-regional and Reg. technical and ministerial meetings; (6)Training of IHR NFPs and their staff in systematic hazard detection and risk assessment using WHO training package.
SO1	Member States have made an initial assessment of the epidemiological situation of antibacterial resistance, antibiotic usage in all sectors (including food and agriculture) and have established a national coordination mechanisms and have developed national action plans based on the seven strategic objectives of the regional plan on the containment of antibiotic resistance.		(1) Technical support provided for AMR assessments in 6 countries per year; (2) Development of regional data base compatible with EARS-NET for non EU MS (3) Yearly report on AMR in coordination with ECDC and DG SANCO; (4) Provide technical assistance to MS to improve national programmes in one or more of the 7 regional AMR objectives.
SO1	Member States develop, implement, and maintain policies to sustain polio-free status (since 2002) and achieve elimination of measles and rubella in the European Region by 2015 through strengthening the quality of disease surveillance and delivery of immunization services.		(1) Secretariat support to establish a regional process for the verification of measles and rubella elimination (2) Technical and material assistance to Member States for maintaining high quality laboratory-based surveillance systems for measles, and rubella; (3) Policy and strategy guidance to MS for increased access to immunization services with special focus to under-immunized groups and, where needed, conducting supplementary immunization activities; (4) Follow-up monitoring and evaluation of supplementary immunization activities (SIAs)
SO2	Member States adopt policies and strategies for prevention and control of MXDR-TB through strengthened health systems and public health approaches.		(1) TA to update National MXDR-TB Response Plans in 15 MDR-TB burden countries in line with the Regional MXDR-TB action Plan. (2) A regional Green Light Committee mechanism established to assist Member States for scaling up of MDR-TB treatment. (3) A health system assessment tool for MXDR-TB developed and implemented in five countries. (4) Technical assistance to member states to scale up Stop TB strategy and M/XDR-TB response

SO2	Remaining affected Member States are implementing strategies that lead to malaria elimination by 2015 and will sustain malaria-free status.		(1) Normative and technical guidance to eligible MS on prevention of re-introduction and certification of malaria elimination. (2) Assistance to eligible MS to sustain political commitments, mobilize resources and involve communities to attain MAL elimination goals. (3) Normative assistance to eligible MS to promote and coordinate operational research on malaria elimination.
SO2	Member States adopt policies and strategies aiming at strengthening health system and implementing public health approaches for prevention and control of HIV/AIDS, including programmes linked to TB control, drug dependence (including opioid substitute therapy) and sexual and reproductive health, to halt the rise of HIV epidemic in Europe.		(1) Priority MS assisted to adopt and implement WHO European Action Plan for HIV/AIDS 2012-15. (2) Technical support, guidance, and tools to link HIV/AIDS surveillance, policy development, and monitoring and evaluation of evidence-informed interventions with related health services. (3) Policy and strategy guidance to MS to reach universal access for prevention and care, particularly for key populations at higher risk.
SO3	Evidence based programming increased in Member States to reduce inequalities in burden from violence and injuries		(1) National prevalence surveys of adverse childhood experiences and elder maltreatment conducted in selected countries. (2) European report on child maltreatment prevention developed and disseminated. (3) Policy dialogue workshops held in selected countries to strengthen child maltreatment prevention programmes. (4) Network meeting of national focal points of VIP. (5) Capacity building using TEACH-VIP and a train the trainer approach in selected countries. (6) Regional policy briefing developed based on 2nd Global status report on road safety and policy workshops in selected countries.
SO3	Member States adoption of a priority list of evidence-based actions for prevention and control of NCDs consistent with the European NCD Action Plan. These actions include integrating surveillance systems, using fiscal measures, product reformulation and control of marketing to promote healthier consumption, promoting wellness in workplace, managing cardiometabolic risk, and stepwise		(1) Two meetings organized of a broad intersectoral coalition of NCD stakeholders; (2) An integrated system of NCD surveilance is published and implemented; (3) 2-3 guidelines for action across sectors are developed and disseminated (e.g. fiscal, marketing, salt, trans-fats; (4) National plans for NCD are developed or strengthened in pioneer countries; (5) National assessment of health systems and capacity for NCD control conducted with

	approaches to cancer control.		emphasis on a social determinants framework. (6) Continued support to the Health Behaviour in School-aged Children survey international coordination
SO3	Member States apply principles and evidence based interventions according to the European Mental Health Strategy and Action Plan and mhGAP (with the aim of improving mental wellbeing of the population and quality of life of people with mental disorders) .		(1) European MNH strategy and Action Plan developed; (2) Member States implement evidence based activities that improve mental wellbeing of the population across the lifespan and reduce suicides; (3) Community based mental health service planned in a number of countries; (4) Evidence on safe and effective interventions disseminated; (5) Workforce competency framework developed.
SO4	Evidence-based gender responsive practices for improving maternal, perinatal, newborn, and child health adopted (or adapted) and implemented by Member States.		(1) Assessment of quality of primary health care for mothers and newborn in selected Member States; (2) Assessment of quality of primary and hospital care for children in selected Member States; (3)Technical assistance to implementation of maternal and perinatal mortality and morbidity audit; (4) Technical assistance to develop and implement comprehensive, gender responsive maternal and child health policies in line with MDG targets; (5) Focal point meeting on impact of social determinants, inequalities and gender on women's and children's health
SO4	An increasing proportion of the older population are covered by public initiatives of healthy aging, disability policy and services in Member States		(1) Technical assistance to develop, implement and monitor healthy ageing policies using existing and new relevant WHO tools; (2) Develop European Strategy and Action Plan on Healthy Ageing; (3) Technical assistance to develop, implement and monitor policies of long-term care services at the boundary of health and social care systems;
SO5	Enhanced preparedness and response capacities of Member States to emergencies and disasters through all-hazard risk management programmes, in line with humanitarian needs and also IHR requirements.		(1)Technical assistance to MS to develop and improve national emergency preparedness plans including the roll out the toolkit for assessing and monitoring health systems capacities for crisis management. (2)Guidance and tools for disaster risk reduction including mass gathering preparedness, hospital resilience and safety and rollout of the WHO Europe hospital emergency response checklist: An all-hazards tool. (3)Training package and capacity building for "public health and emergency management" including rollout of

			regional and national training programmes.
SO6	Strengthened national programmes to reduce the harmful use of alcohol in line with European Alcohol Action Plan 2012-2020		(1) Publish a guidance tool including the adopted European Action Plan to reduce the harmful use of alcohol 2012 - 2020. (2) Give guidance to MS on alcohol prevention by using the new European Action Plan to reduce the harmful use of alcohol 2012 - 2020. (3) Contribute to the implementation of the NCD Action Plan with focus on increased taxation, regulations on promotion of alcohol products and on decreased availability.
SO6	Obesity prevention and control Action Plans, including healthy diet and physical activity, developed and implemented in Member States based on the European Charter to Counteract Obesity Principles		(1) Progress Rep Implementation Charter Counteracting Obesity. (2) Technical support for Nat Obesity Action Plans. (3) Obesity surveillance system established as a contribution to NCD AP. (4) Database on Nut, PA & Obesity as per NCD AP. (5) Policy tools developed to promote cost-effective interventions on diet, PA and obesity focused on active mobility and Marketing food to Children contributing to NCD AP. (6) Policy Tools & technical advice to achieve targets in salt reduction & elimination trans fat. (7) Best-practice manual use of fiscal and price measures to influence diet and PA as part of the NCD AP.
SO6	Multi-sectoral policies and strategies established within Member States to increase the level of implementation of the WHO FCTC by using the MPOWER framework.		(1) Policy tools, including evaluation tool of programmes and policies, with special attention to tax and marketing policies. (2) Technical advice based on latest global and regional evidence. (3) Best practices for strengthening capacity to implement the WHO FCTC. (4) Political support for strengthening of policies and legislation and their enforcement
SO7	Member States develop comprehensive national (NHP) and sub-national policies, strategies and plans for health and wellbeing based on/or aligned with the Health2020 policy framework and develop capacity to implement whole of government and multi-stakeholder governance processes and mechanisms for Health 2020. All Member States will have endorsed the new policy for Health - Health 2020 at RC 62 in Malta (September 2012)		(1) Health 2020 main developed through a participative process and finalized following consultations with MS and key stakeholders. (2)Report of European Review on Social Determinants and Health Divide informing Health 2020 finalized. (3) Report with practical guidance and case studies on good governance for health prepared. (4) Technical support provided to Member States in the form of tools and consultations for developing capacities and processes for developing and

			implementing Health 2020
SO7	Greater capacity and commitment among Member States to better addressing the health needs of poor, vulnerable and socially excluded groups (VGs) with particular emphasis on actions for migrants and Roma populations.		(1) Evidence and resource packages to strengthen the capacity of MS to better understand/meet the health needs of VGs ; (2) Reports with analyses on Roma, migrants and VGs' health and health system access produced in partnership with UN agencies; (3) Training package and capacity-building supporting the Roma Decade health action plans; (4), technical assistance to national authorities to help mainstream Roma health in relevant national policies and programmes and overall advising MSs on health policies and programmes addressing the issue of VGs.
SO8	Member States implement evidence-based intersectoral policies and strategies at regional and national level to meet Parma Declaration commitments with effective new governance for the European environment and health process (EEHP).		(1) Secretariat for the European Environment and Health Process (EEHP) and Regional governance in environment and health, including multilateral agreements; (2)New tools for evidence based policy and strategies including guidelines, policy guidance and advice on multiple environmental exposures and risks; (3) Capacity building tools/activities in MSs for environment and health risk and emergencies assessment and management, climate change and related extreme events in a IHR framework; (4) Technical assistance for implementation of the European Framework for Action on protecting health under a changing climate.
SO9	Member States develop, implement and evaluate National plans and strategies for the promotion of appropriate nutrition in accordance with the "WHO European Action Plan for Food and Nutrition Policy", prioritizing the areas of nutritional status surveillance and monitoring of the population with a focus on children.		(1) Progress Report on the Implementation of the 2nd FNAP and development of the 3rd WHO European Region Food and Nutrition Action Plan. (2) Issue reports and publications with the nutritional status surveillance data on a Regional basis every 2 years. (3) Technical Assistance to Member States for the implementation of the National Surveillance Systems. (4) Set of implementation indicators developed to evaluate Nutrition Policies. (5) Policy summary & scientific review produced for the MS Nutrition Action Networks. (6) Policy tools to assist MS in implementation of priority actions in Nutrition. (7) Support provided to MS in food security emergencies. (8) Capacity building mechanisms development for the health workforce and recommendations for breastfeeding, complimentary feeding and infant nutrition are delivered.

	Member states enhance their capacities and resource allocations for addressing food safety, food borne diseases and food hazards		(1) Strengthen the partnership with FAO, EC, EFSA and ECDC and other relevant organizations (e.g. OIE and the WB) on food safety issues. (2) Promote surveillance of food borne disease and contamination in the food chain, e.g. through sub-regional GFN activities. (3) Coordinate Codex-related activities at the regional level in collaboration with FAO and WHO HQ, including Codex Trust Fund issues, such as joint FAO/WHO sub-regional capacity activities funded by CTF. (4) Provide support in times of food safety emergencies impacting on the region. (5) Support the strengthening of food safety risk communication.
SO10	Member States improve the performance of public health services and operations by developing, implementing, evaluating evidence-informed public health policies.		(1) European Action Plan for Strengthening Public Health Capacities and Services 2020; (2) WHO Europe Self-Assessment Tool for Evaluation of Public Health Capacities and Services, incl. health promotion, health protection and disease prevention; (3) Review of Public Health policies and instruments; (4) Sub-regional Public Health strengthening products: (i) Review and assessment of national mechanisms for financing and human resources for PHS and developing recommendations for actions, (ii) Training of trainers on PHS planning, management, monitoring and evaluation, (iii) Standards and procedures for accreditation of PHS, (iv)Policy Dialogue of NIS on PHS strengthening for improved NCD prevention and control
SO10	Increased quality of and capacity for health situations analysis, including collection, use of standards, analysis and dissemination of health information in Member States		(1) ICD-10 web-based training delivered in different languages; (2) Guidance &technical support for the integration of health information systems provided; (3) Guidance for assessments &quality improvement of health information &statistics provided to MS; (4)Standards for improving availability, quality &comparability of health information in MS;
SO10	A common European health information system agreed and established jointly with the EC for harmonized health information and evidence used for decision making at regional and Member State levels.		(1) A framework for a common European Health Information System developed and roadmap for action agreed jointly with the EC; (2) An integrated health info platform with DBs, analytical reports and other info products developed;
SO10	Member States apply a strategic and systematic approach to health policy development with a focus on health system strengthening resulting into national and sub/national health plans and strategies and health system performance assessment		(1) Training materials to strengthen core competencies for governance for health and NHP and sub-national health development; (2) Good practices in process/content of NHP, reflecting the framework, principles & values in Health2020; (3) Toolkit to support MS in developing HSPA; (4) Case studies on HPAUs;

			(5) Assessment of MS capacities/institutions in evidence-informed policy development; (6) Tallinn Charter follow up learning activities.
SO10	Member States implemented health financing policies to make progress towards, or sustain existing achievements of, universal health coverage, with attention to minimizing the negative effects of the financial crisis on the health sector and ensuring that financing arrangements are well aligned to priority health care and public health services.		(1) Reports on health financing, universal coverage and lessons learned from the response to the global economic crisis; (2) Policy briefs on health financing & system institutional arrangements to better address priority health issues, with a particular focus on TB/MDR-TB and NCDs; (3) Technical assistance for strengthening MS institutional capacity to address priority health financing issues
SO11	Member states improve equitable access to good quality medical products (medicines, vaccines, blood products) and technologies		(1) networking and technical guidance on medicines pricing, supply and reimbursement and health technology assessment policies. (2) policy guidance and networking of medical products regulatory authorities. (3) policy guidance for improving the prescribing and use of medicines. (4) support for WHA plan of action on public health, innovation and intellectual property. (5) policy development and support to national programmes for safe blood and clinical technologies. (6) guidance on risk assessment and management strategy for vaccine safety/quality. (7) development of WHO regional strategic plan on medical products and technologies.