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**Biennial Collaborative Agreement (BCA)**

**between**

**the Ministry of Health of the Republic of Latvia**

**and**

**the Regional Office for Europe**

**of the World Health Organization**

**2012/2013**

***Signed by:***

*For the Ministry of Health*

###### Signature Date

###### Name Ingrida Circene Title Minister for Health

*For the WHO Regional Office for Europe*

###### Signature Date

###### Name Zsuzsanna Jakab Title Regional Director

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# Introduction

In Latvia circulatory (heart) diseases have continued to be the main cause of death. In the last decade, mortality from diseases of the circulatory system is on the increase among men and constant in females, diverging substantially from overall European trends. The large gap in mortality – especially premature mortality – between Latvia and the EU15 has been persistent for years. Mostly it is attributable to handful of causes, namely the high probability that Latvians face of dying from heart attack, stroke or external causes. This is a major health problem for men in Latvia and also the better numbers for women are still multiple times worse than the numbers in the EU15.

*The main challenge of disease burden* is premature mortality caused by external causes and lifestyle-related risk factors. Similar to other industrialized countries, the main causes of mortality are the diseases of the circulatory system, cancer and external causes of death. The lifestyle risk factors causing the disease burden are alcohol consumption, use of tobacco, low physical activity and low intake of fruits and vegetables. A growing challenge is the increasing prevalence of obesity. In the past decade, a new challenge of tackling communicable diseases such as HIV/AIDS and multidrug-resistant tuberculosis has emerged. Latvia has kept other communicable diseases under control with broad vaccination programms implemented with high coverage.

The infant mortality rate has decreased in recent years but still remains comparatively high. A positive tendency can be observed with a slight increase in the total number of healthy children. The number of infants being breastfed at 6 months of age is increasing since 2000 reaching 48.9% in 2008 and the rate is still growing.

Serious economic downfall has been the main characteristic of Latvia in recent years starting from 2008, after a number of years of rapid economic growths. Economic downfall in Latvia was marked by high inflation, the halt of crediting and real estate market, decrease of production, increase of unemployment rate. The health sector was *hit* along with other sectors, leading to cuts of employment, streamlining the governance of health sector and reductions in infrastructure.

Over the last decade, and particularly in recent years, the health sector reforms have taken place in Latvia and have been aimed at strengthening the primary health care, making improvements in efficiency of hospitals, rationalizing use of medicines, creating of united emergency care and protecting poor. A number of strategic documents have been developed and implemented over the last decade. A new Public Health Strategy 2011-2017 with *health in all policies* approach was launched by Government in 2011. Although a number of strategic decisions have been undertaken, various challenges remained in improving the health system and public health services further. Namely the necessity to improve the stewardship role within the health sector; ensuring continuity of care and chronic disease management and improving inter-sectoral links between health care, public health and social care; addressing the quality of care; limiting out-of-pocket payments and managing the cost increase of services; ensuring financial sustainability in terms of demographic changes and other cost drivers in health care; addressing the questions related to human resources for health and balancing the competences within the system to respond to current practices; responding to environmental and public health threats.

This document constitutes the Biennial Collaborative Agreement (BCA) between the Ministry of Health of the Republic of Latvia on behalf of its government and the World Health Organization Regional Office for Europe for the biennium 2012–2013. The BCA is done in duplicate in English language. The BCA comes into force on the date of the last signature.

This 2012–2013 BCA is part of a provisional Medium-term framework for collaboration between the WHO Regional Office for Europe and the Ministry of Health of the Republic of Latvia for the six-year period 2008–2013, which corresponds to the period covered by the WHO Medium-term strategic plan (MTSP 2008–2013). The document reflects the new vision of the WHO Regional Office for Europe as approved by the sixtieth session of the Regional Committee for Europe – Better Health for Europe, as well as the concepts, principles and values underpinning the development of the WHO Regional Office for Europe’s new Country Strategy and the European Policy for Health – Health 2020.

Achieving the objectives of the BCA is the responsibility of both the Ministry of Health of the Republic of Latvia and the WHO.

This document represents a practical framework for collaboration which has been elaborated through successive consultations between national health authorities and the WHO Regional Office for Europe Secretariat.

The agreed medium-term priorities for collaboration 2008–2013, specified in Part 1 of the document, were taken as the starting point for the process leading to the specific priority outcomes for collaboration. **In 2010, the sixtieth session of the Regional Committee approved new strategic priorities of work, which reflect the main issues faced by most Member States in the WHO European Region and which are addressed through the development of the new European Policy for Health – Health 2020. Among these key priorities, the following are highlighted: *strengthening health systems*, particularly primary health care; *rejuvenating public health*, including improved surveillance, disease prevention and health promotion; *tackling behavioural health determinants* and risk factors; *controlling noncommunicable diseases* such as heart disease, cancer and diabetes; *addressing communicable disease incidence*, with particular reference to poliomyelitis, HIV/Aids, MDR-TB, measles and malaria; implementing international health regulations; *ensuring emergency preparedness; supporting progress in Environment and Health*; and *fostering the harmonization of health information systems* and knowledge sharing throughout the region.** The priorities and outcomes detailed in this agreement are based on those key priority areas. The outcomes are based on analyses of the public health situation of the Region and input from national health authorities, while they also take into account WHO global priorities (World Health Assembly and Regional Committee resolutions), policy directions and country priorities and reflect the WHO strategic assessment.

**Outcomes** represent uptake by Member States. Their achievements are the joint responsibility of the individual Member State and the Secretariat. For each outcome (i.e. expected result), a number of **outputs** (products and services) are defined to enable and facilitate uptake by Member States. The delivery of these outputs is the responsibility of the Secretariat.

The document is structured as follows:

1. Part 1 includes health impact aimed for through the agreed medium-term priorities and objectives *for collaboration* for the period 2008–2013, to be the focus of the joint efforts of the individual government and WHO Secretariat. It also describes the specific priorities to be achieved during 2012 – 2013.
2. Part 2 includes sections on the budget for the BCA, its financing and the mutual commitments by the WHO Secretariat and individual government.

An Annex to this BCA includes a summary of priority outcomes as well as outputs and mode of delivery. Three modes are envisioned:

* + The **intercountry mode**, which addresses the common needs of countries through region-wide approaches. It is expected that an increasing part of the work will be delivered in this way.
  + The **multicountry mode** is used whenan output within an outcome is relevant to a limited number of countries. The resources that exist within the group will be deployed optimally.
  + The **country-specific mode** of operation is used for outputs that are highly specific to the needs and circumstances of individual countries. It will continue to be important and the chosen mode of delivery in many cases.

# Terms of Collaboration

The *Medium-term priorities (part 1)* provide a provisional framework for collaboration for 2008–2013. The medium-term priorities may be revised every two years by mutual agreement, where prevailing circumstances indicate a need for change.

The biennial priority outcomes and outputs for 2012–2013, presented in the Annex, may be amended by mutual agreement in writing between the WHO Regional Office for Europe and the individual country as a result of, for instance, changes in the country’s health situation, changes in the country capacity to implement the agreed activities, specific needs emerging during the biennium, or changes in the Regional Office’s capacity to provide the agreed outputs, or in light of changes in funding. Either party may initiate amendments.

After the Biennial Collaborative Agreement is signed, the Ministry of Health of the Republic of Latvia will identify/confirm responsible national focal points for each of the priority outcomes as well as appoint an overall national counterpart to liaise with all national focal points on a regular basis. The national counterpart will be responsible for the overall implementation of the BCA on the part of the ministry, while the Head of the WHO Country Office (HWCO) will be responsible on behalf of WHO. The BCA *workplan*, including planned outputs and implementation schedule, will be agreed accordingly. Implementation will start at the beginning of the biennium 2012–2013. The Regional Office will provide the highest possible level of technical assistance to the country and shall be facilitated and supported by the country office or other modalities present in the country. Overall coordination and management of the country workplan is the responsibility of the HWCO.

WHO budget allocation for the biennium indicates the estimated costs of providing the planned outputs predominantly at country level, including the cost of staff in countries required to implement the country workplan. The funding will come from both WHO corporate resources and any other resources available through WHO. These funds should not be used to subsidize or fill financing gaps in the health sector, as a supplement to salaries or for the purchase of supplies. Purchases of supplies and donations within crisis response operations or as part of demonstration projects will continue to be funded through additional mechanisms in line with WHO rules and regulations.

The value of WHO technical and management staff based in the Regional Office, Geographically Dispersed Offices (GDOs) and of the input of the Country Office for delivering planned outputs is not reflected in the indicated budget, and hence the figures greatly understate the real value of the support to be provided to the country. The funds included in this Agreement are the WHO`s funds allocated for Regional Office cooperation within the country workplan.

Thus, the value of WHO contribution goes beyond the indicated monetary figures in this document, as it includes technical assistance and other inputs from HQ, RO, GDOs and unfunded inputs from COs.

The corporate resources (Assessed contributions, CVCA[[1]](#footnote-1), and WHO Regional Office for Europe Flexible[[2]](#footnote-2) resources) will predominantly be used to ensure full achievement of the regional Key Priority Outcomes (KPO) as described in the document “*The Programme budget as a strategic tool for accountability*” (RC61/Inf.Doc/10).

The value of Ministry of Health input – other than what might be channelled through the WHO Secretariat – is not estimated in the BCA.

It should also be noted that this Biennial Collaborative Agreement is open to further development and contributions from other sources in order to supplement existing shared objectives or to introduce activities that have not been included at this stage.

In particular, the WHO Regional Office for Europe will facilitate coordination with WHO headquarters in order to maximize the effectiveness of country interventions in the spirit of the “One WHO” principle.

# PART 1. Medium-Term priorities for collaboration for 2008-2013 and priorities for 2012-2013

The following priorities for collaboration for 2008–2013 were selected in response to public health concerns and ongoing national efforts to improve the performance of the health system.

**Priority 1: Health promotion with emphasis on control of tobacco, alcohol and drugs; cancer prevention; mental health; promoting healthy nutrition policies and addressing physical inactivity, unhealthy diets and unsafe sex.**

* *Objective 1:* To develop and strengthen the national policy and capacity in addressing risk factors, including policies on preventing unsafe sex and implementing a national programme on cancer prevention
* *Objective 2:* To strengthen surveillance of risk factors
* *Objective 3:* To implement the national alcohol programme
* *Objective 4:* To promote healthy nutrition policies
* *Objective 5:* To strengthen capacity in addressing mental health problems

**Priority 2: Health system strengthening, especially with regard to public health services, primary health care, health financing, human resources for health and responsiveness to address domestic violence.**

* *Objective 1:* To strengthen comprehensive public health services
* *Objective 2:* To improve the performance of the health financing arrangements
* *Objective 3:* To analyse and strengthen emergency health services
* *Objective 4:*  To advance the capacity building of the health workforce
* *Objective 5:* To develop quality indicators in primary health care
* *Objective 6:* To improve health systems responsiveness to address domestic violence

The above agreed Medium-term priorities for collaboration 2008–2013 were taken as a starting point, while the new vision of the WHO Regional Office for Europe as approved by the sixtieth session of the Regional Committee for Europe – Better Health for Europe, as well as the concepts, principles and values underpinning the development of the Regional Office’s new Country Strategy and the European Policy for Health – Health 2020 were taken into account. The aim of the Biennial Collaborative Agreement (BCA) is to impact health, i.e., *to raise the level of health and reduce the inequity in the distribution of health within the population*.

The agreed medium-term priorities facilitate the strategic orientation of collaboration and serve as a basis for focusing collaboration on a select number of priority outcomes (uptake by Member States) deemed feasible to achieve and essential to improving the health situation and where WHO can make a unique contribution.

The 2012-2013 Priorities are as follow:

PRIORITY 1: **European Health Policy – Health 2020**

Social determinants of health/Health indicators

National Health Policies, Strategies and action plans

PRIORITY 2 : **Health Systems strengthening and Public Health**

Health Finance

Public Health, Primary health care, Hospitals

PRIORITY 3: **Non-Communicable Diseases, Health Promotion and Healthy Lifestyles**

Reducing morbidity, disability and premature mortality owing to chronic non-communicable diseases, mental disorders, as well as the promotion of healthy lifestyles.

PRIORITY 4: **Communicable Diseases, Health Security and Environment**

Reducing the burden of communicable diseases, including their social and economic consequences, including HIV/AIDS and tuberculosis.

PRIORITY5: **Health Information, Evidence, Research and Innovation**

Analysis of Health information

Reliable and comparable Health information data

# PART 2. Budget and Commitments for 2012–2013

## Budget and Financing

The total budget of the within-country workplan amounts to US$ 474 000\*.

|  |  |  |
| --- | --- | --- |
|  | **Financing**  **(US$ Thousands)** | **Budget**  **(US$ Thousands)** |
| * Corporate funds (AC, CVCA, and WHO Regional Office for Europe Flexible) * Projected VCS (Known with great certainty)\*\* * Additional VCS to be mobilized | 70  72 | 70  72  332 |
| **TOTAL** | **142** | **474** |

*\*The total budget is subject to adjustments on the basis of the planned “mode of delivery”*

*\*\* Projected VCS funds are subject to adjustments on the basis of actual availability.*

The value of WHO contribution thus goes beyond the indicated monetary figures in this document, as it includes technical assistance and other inputs from HQ, RO, GDOs and also COs. The WHO Secretariat will, as part of its annual and biennial Programme budget implementation report to the Regional Committee, include an estimate of how the actual costs of the intercountry programme are distributed across different levels (regions and countries), as well as for the latter across individual countries.

## Commitments

The Ministry of Health of the Republic of Latvia and the WHO/EURO Secretariat jointly commit to work together to mobilize the additional funds required to achieve the Outcomes defined in this agreement.

### 2.2.1 Commitments of the WHO Secretariat

WHO agrees to provide, subject to the availability of funds and its rules and regulations, the outputs defined in the Annex. Separate agreements will be concluded for any local cost subsidy or direct financial cooperation inputs at the time of execution.

### 2.2.2 Commitments of the Ministry of Health of the Republic of Latvia

The Ministry of Health shall engage in the policy and strategy formulation and implementation processes required and provide available personnel, materials, supplies, equipment and local expenses necessary for the **uptake of the priority outcomes identified in the Annex**.

# Annex: Priority Outcomes and Outputs

This Annex is subject to further amendments as stipulated in the Terms of Collaboration of the BCA.

**PRIORITY 1: European Health Policy – *Health 2020***

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| --- | --- | --- | --- | --- | --- |
| **SO** | **Outcomes** | **Outputs** | **Mode of delivery** | | |
| Country specific **(CS)** | Multi country **(MC)** | Inter country **(IC)** |
| 7 | (CNT 1010) (ex 40)(R00) LVA to develop national and sub-national policies for health and wellbeing based on/or aligned with the H2020 policy framework and develop capacity to implement whole of government and inter-sectoral processes and mechanisms for H2020. | 1) Strengthened capacity of the Ministry of Health in order to design and lead multisectoral approach and reduce social and health determinants and inequities through Health in All policies; | X |  |  |
| 2) Continue support to the implementation of the PH Strategy of Latvia | X |  |  |
| 7 | (043)(RO2)Improved capacity and uptake for governance for action on the social determinants of health and health inequities within the Health 2020 Policy Framework and consistent to WHA 62.14 | 1) Capacity Building Program to strengthen know how and skills to implement whole of government and society approaches to SDH/ Equity, including exchange of promising practices and innovations in policy formulation, investment, delivery and accountability for health equity | X |  |  |

**PRIORITY 2: Health Systems strengthening and Public Health**

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| **SO** | **Outcomes** | **Outputs** | **Mode of delivery** | | |
| Country specific **(CS)** | Multi country **(MC)** | Inter country **(IC)** |
| 11 | (103)  Member states have improved capacity and developed policies for the rational use of medical products (medicines, vaccines, blood products) and technologies | 1) Support for national programme on rational selection (using HTA) and prescribing of medicines; |  |  | X |
| 2) Baltic policy dialogues and capacity building on medicines policies |  | X |  |
| 10 | (CNT 983)(R00) Health financing policies implemented in Member States 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 and service delivery arrangements for priority personal and public health services are well aligned. | 1) Report and recommendations on the sustainability of the health financing system in Latvia in the context of the ongoing reforms and the economic crisis | X |  |  |
| 2) Continued technical advise on Hospital sector reforms in context of economic crises | X |  |  |
| 3) Baltic Policy dialogue 2012 jointly with OBS on health financing, hospitals/contracting issues |  | X |  |
| 10 | (987) Member States equipped with and use evidence on their own health system, the health system of other countries and ongoing evidence updates to support decision making, and reform processes | 1) HIT update for Latvia; | X |  |  |
| 2) HIT launch to be linked to policy dialogue on key reform theme | X | X |  |
| 10 | (1145) MS will mobilise and use inputs from accross disciplines and international boundaries and the principles of knowledge brokering to bring evidence to bear on policy decisions and on the assessment and evaluation of the impact of reforms. | 1) Baltic Policy Dialogue 2012 hosting of dialogue (possibly linked to financing as at outcome 983); | X |  |  |
| 2) Baltic Policy Dialogue 2013 in Estonia - participation of ministerial delegation; |  | X |  |

**PRIORITY 3: Non-Communicable Diseases, Health Promotion and Healthy Lifestyles**

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| **SO** | **Outcomes** | **Outputs** | **Mode of delivery** | | |
| Country specific **(CS)** | Multi country **(MC)** | Inter country **(IC)** |
| 3 | Member States develop and implement national cancer control programmes with an emphasis on the early detection of breast, cervical and colorectal cancers developed | 1)System of early detection of cervical cancer evaluated; | X |  |  |
| 2) Consensus on early detection of breast, cervical and colorectal cancers developed; | X |  |  |
| 3) Action research projects (including health systems components) initiated in pioneer countries (including Latvia) on the above, with a view to documenting effects of intervention; | X | X |  |
| 3 | (CNT 23a)MS 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 approaches to cancer control. | 1) two meetings organised of a board inter-sectoral coalition of NCD stakeholders; |  |  | X |
| 2) Latvia participates in EURO organised meetings/workshops on NCDs, including on cervical cancer |  |  | X |
|  |  |  |  |
| 4 | (024) Member States competent in developing, implementing and monitoring adolescent health programmes using a whole-of-society perspective | 1)Continued support to the Health Behaviour in School-aged Children survey international coordination | X |  | X |
| 6 | (CNT 1009) Obesity prevention and control Action Plans, including health and physical activity developed and implemented in MS based on the European Charter to Counteract Obesity Principles | 1) National Food and Nutrition Plan revised; | X |  |  |
| 2) Salt reduction strategy adopted and approved | X |  |  |
| 3) Marketing of food HFSS (foods high in fat, sugar or salt)  to children policy adopted. | X |  |  |
| 6 | (39r)  Member States have established or strengthened National surveillance systems of tobacco consumption and exposure to tobacco smoke built on sustainability, standardization and comparability across countries and use data for policy making in line with the WHO FCTC | 1) Capacity building and technical assistance to implement youth surveys in countries | X |  |  |
| 2) Capacity building and technical assistance to use survey data for sound and evidence based policy making in line with WHO FCTC and its guidelines | X |  |  |
| 6 | (39i)  Member States have implemented comprehensive health interventions within their prison system. | 1) to provide technical support to MoH (report with recommendations; strengthening of inter-sectorial approaches, especially links with MoJ; stakeholders meeting)for integration of the prisons health system into public health system | X |  |  |
| 6 | CNT 1008)  Member States have strengthened their national programmes to reduce the harmful use of alcohol in line with European Alcohol Action Plan 2012-2020 | 1) Collect data on alcohol consumption, harm and responses for use in the European Information System for Alcohol and Health and participate in yearly meetings. Provide data for the European Information System for Alcohol and Health. | X |  |  |
| 2) Assessment of alcohol consumption, related harm and policy responses | X |  |  |
| 3) Guidance on development of national alcohol action plan by using the European Action Plan to reduce the harmful use of alcohol | X |  | X |
| 4) Exchange of best practice on alcohol prevention and participate in meeting for national counterparts for alcohol policy. | X |  | X |
| 6 | Multisectoral health and wellbeing strategies and plans developed and capacity for health promotion and health equity strengthened at the local level in Member States in line with Health 2020 principles and approaches. Completion of Phase V of the Healthy Cities Programme. | 1) Development of guidance and tools on local/urban health leadership, health literacy, equity, healthy ageing and healthy urban planning;  2)Ensuring local governments input in the development of Health 2020;  3) Strategic management and leadership of WHO healthy cities networks and organizing annual Healthy cities conference;  4) Expanding healthy cities in countries of the Region that are not currently involved members of the network;  5) Participation and support of 2012 WHD European and global activities | X  X  X | X  X  X  X |  |

**PRIORITY 4: Communicable Diseases, Health Security and Environment**

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| **SO** | **Outcomes** | **Outputs** | **Mode of delivery** | | |
| Country specific **(CS)** | Multi country **(MC)** | Inter country **(IC)** |
| 1 | (001)(R00) Member States able to strengthen immunization systems in the context of health systems strengthening in order to maximize equitable access of all people to vaccines of assured quality, including new or underutilized immunization products and technologies, and to integrate other essential family and child health interventions with immunization. | 1)improved coverage with routine vaccination; | X |  |  |
| 2) sustainability (decision making, financial, multi-year) with regards to introduction of new vaccines; | X |  |  |
| 3) pulled procurement of National Immunisation Programme vaccines |  |  | X |
| 1 | (CNT 1001) In support to national and regional health security, Member States have developed multisectoral policies and plans to implement the IHR, including strengthening their core public health capacities for disease surveillance and response as well as preparedness for epidemic and pandemic-prone diseases such as influenza. | 1) technical support to implementation of IHR in Latvia through strengthened inter-sectoral collaboration | X |  |  |
| 2) participation of Latvia in regional meetings/workshops/capacity building activities |  |  | X |
| 1 | (004)(R00) Member States' equipped to carry out communicable diseases surveillance and response, including laboratory, as part of a comprehensive surveillance and health information system. | 1) Surveillance policies developed, data management systems strengthened | X |  | X |
| 2) Technical assistance to Latvia to develop lab capacity and policy support for conf. of targeted diseases. |  |  | X |
| 3) Standard tools for data management and support for transition to case-based survey | X |  |  |
| 4) Updated regularly guidance on flu surveillance | X |  |  |
| 5) Technical assistance to Latvia to strengthen ILI and SARI surveillance |  |  | X |
| 6) Support for surveillance of other communicable diseases | X |  | X |
| 2 | (011)(R00) Member States build strong and sustainable systems in which HIV, STIs viral hepatitis and other essential services are available, accessible and affordable | 1) Strengthen Latvia to collect, collate, analyse and use strategic information |  |  | X |
| 2) Assist Latvia to develop, adapt, integrate and link client centred service delivery models for key populations (UNAIDS Treatment 2.0) |  |  | X |
| 3) Assist Latvia to ensure uninterrupted supply of medicines, diagnostics and other commodities |  |  | X |
| 4) Develop practical quality improvement tools for HIV prevention. Assist Latvia to monitor and improve the quality of services; |  |  | X |
| 5) continued support for implementation of WHO/EURO mission's recommendations | X |  |  |
| 2 | (CNT 1005) MS adopt policies and strategies for prevention and control of MDR-TB through strengthened health systems and public health approaches. | 1) National MXDR-TB Response Plan updated and endorsed in line with the Regional MXDR-TB Action Plan; | X |  |  |
| 2) technical assistance to Latvia to scale up STOP TB Strategy and MXDR-TB response | X |  |  |
| 8 | (062) Intersectoral approaches addressing environmental determinants of health implemented in Member States ( e.g. in transport, built environment, workplaces) | 1) Capacity building and cross-sectoral training on HIA (Health Impact Assesment) methods and tools; | X |  | X |
| 2) technical support provided to analyse of environmental health data; | X |  | X |
| 3) completion and monitoring of use of guidance on HIA implementation at national level | X | X |  |

**PRIORITY 5: Health Information, Evidence, Research and Innovation**

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| **SO** | **Outcomes** | **Outputs** | **Mode of delivery** | | |
| Country specific **(CS)** | Multi country **(MC)** | Inter country **(IC)** |
| 10 | (096)  Member States utilize the information and analytical products provided by EURO to Member States for planning, monitoring and evaluation of health situation and inequalities at country level | 1) Enhanced analytical outputs for different reports and other dissemination and communication products based on HFA DB. Available national core health data sets allowing analysis of health needs and inequalities to inform decision makers.  2) ICD-10 web based training delivered. Application of tools for improving the collection and quality of vital and other health statistics | X  X |  |  |

# LIST OF ABBREVIATIONS

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| **General abbreviations** |
| AC – Assessed contributions  BCA – Biennial Collaborative Agreement  CVCA – Core Voluntary Contributions Account  HWCO – Head of the WHO Country Office |
| HQ – World Health Organization headquarters  KPO – Key Priority Outcome  MTSP – WHO Medium Term Strategic Plan  ODA – Official Development Assistance  OPO – Other Priority Outcome  SO – Strategic objective  VCS – Specified Voluntary Contributions  RO – Regional Office  GDO – Geographically Dispersed Office  CO – Country Office |

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| **Technical abbreviations** |
| MDG – Millennium Development Goals |
| PHC – Primary Health Care |
| SDH/HI ­–­ Social determinants of health and inequities |
| NHPS&P ­– National health policies, strategies and plans |
| WHO FCTC ­– WHO Framework Convention on tobacco control |
| MPOWER ­ – A Policy package to reverse the tobacco epidemic (Monitor, Protect, Offer, Warn, Enforce, Raise) |
| NCD ­– Non-communicable diseases |
| IHR ­– International Health regulations |
| NFPs ­– National focal points |
| M/XDR-TB ­– Multidrug and extensively drug resistant TB |
| CBOs ­– Community based organisations |
| HiT ­– Health in transition |
| HIA – Health impact assesment |

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1. CVCA (Core Voluntary Contributions Account) = Official Development Assistance (ODA) funds provided flexibly and globally to WHO by donors for funding activities in support of ODA-eligible countries [↑](#footnote-ref-1)
2. WHO Regional Office for Europe Flexible funds are voluntary funds provided flexibly at the level of the WHO Regional Office for Europe [↑](#footnote-ref-2)