25 January 2009

BACKGROUND NOTE[1]

ECOSOC Annual Ministerial Substantive Review (AMR)
2009 e-Discussion on Global Public Health

I. THE 2009 ANNUAL MINISTERIAL REVIEW

The Annual Ministerial Review (AMR) is a new function of the Economic and Social Council (ECOSOC) mandated at the 2005 World Summit[2]. Its purpose is to assess the progress made towards the MDGs and the implementation of the other goals and targets agreed at the major UN conferences and summits over the past 15 years, which constitute the United Nations Development Agenda (UNDA). See Annex I for further details.

The theme for the 2009 Annual Ministerial Review is *"Implementing the internationally agreed goals and commitments in regard to global public health"*.

The 2009 report of the Secretary-General on the Annual Ministerial Review will provide a succinct overview of progress towards the international agreed development goals, in particular those related to health. The report is expected to underscore the underpinning principle that health is key to human development and human security; highlight the challenge of inequities in health and access to health services; address the urgency of sustaining progress in health outcomes in times of crisis; examine the need for global health policies that strengthen health systems through a renewal of primary health care and ensure policy coherence across sectors; make the case for increasing aid for health and aid effectiveness; discuss widening the circle of health partnerships and enhancing their impact; and introduce a number of emerging and future global health challenges. The report will also include a number of recommendations for consideration by ECOSOC.

The 2009 AMR process is anticipated to lead to a Ministerial Declaration and concrete initiatives that will build upon and advance work being undertaken in global public health.

II. OBEJCTIVE AND STRUCTURE OF THE E-DISCUSSION

The AMR e-discussion is a mechanism to engage experts, practitioners and policy-makers from various regions and stakeholder groups in a global dialogue on specific aspects of the AMR theme. It provides a vehicle to develop recommendations for Member States to help strengthen their efforts to address some of the most significant global public health challenges. It also serves to provide the intergovernmental process -- especially the Economic and Social Council -- with constructive input on efforts it can undertake to reduce inequities and improve health worldwide. Contributions made by e-discussion participants may be channeled into various parts of the AMR process as appropriate, including the report of the Secretary-General, the regional and national review processes, and the global review at the ECOSOC Substantive Session.

---

[1] This note is largely based on a number of recent WHO documents and reports.
[2] A/RES/60/1, para. 155

The online forum will be organized in two parts around the themes: (I) Strengthening health systems (29 January - 11 February); and (II) Emerging and future health challenges (12 - 26 February). Expert guest moderators will guide and enrich the discussion.

As the 2009 AMR theme is broad, a series of questions have been formulated to form the basis of the e-discussion. The subsequent sections provide some background context.

III. PART ONE: Strengthening health systems (29 January - 11 February)

Questions

1. How can we overcome health inequities, achieve universal coverage and renew primary health care (PHC)? What are examples of successes toward universal coverage that could be replicated or scaled up? How can countries learn from each others experience in this?

2. What steps can both developed and developing country governments take to overcome the shortage of health care workers? What can be done to limit the damage and create opportunities through increased migration of health professionals? What specific initiatives can the Economic and Social Council (ECOSOC) launch in July 2009?

Health inequities and the social determinants of health

The health of the world's population has improved over the last 30 years. This is partly the result of better nutrition, water supply, sanitation, housing, and education. Although some countries have shown sustained improvement in health outcomes, others have lagged behind or even experienced reversals. In part, these differences can be attributed to socio-economic, political, and ecological constraints.

Health authorities in many countries are aware that progress towards improved health outcomes, including, but not limited to, the Millennium Development Goals (MDGs), is too slow and unequal, that performance does not meet expectations, and that they are ill-prepared to respond to challenges and demands. This dissatisfaction is echoed by international agencies, global health initiatives, donors, and civil society organizations.

Health inequities are increasing both within and between countries. A gap in life expectancy of more than 40 years exists between the richest and poorest countries. Moreover, gross inequities in health status divide different groups of people within all countries, regardless of income. Such health inequities are not inevitable. Instead, they mostly point to policy failure, reflecting inequities in daily living conditions and in access to power, resources, and participation in society.

The "social determinants of health" are the structural determinants and conditions of daily life responsible for a major part of health inequities between and within countries. They include the distribution of power, income, goods and services, and the circumstances of people's lives, such as their access to health care, schools and education; their conditions of work and leisure; and the state of their housing and environment. The term "social

determinants" is thus shorthand for the social, political, economic, environmental and cultural factors that greatly affect health status.

In 2008, the WHO Commission on the Social Determinants of Health made three main recommendations to improve health equity:(a) improve daily living conditions
(b) tackle the inequitable distribution of power, money and resources
(c) measure and understand the problem and assess the impact of action[3].

Social determinants must be addressed in order to achieve many disease-specific targets, including the health-related MDGs, and to control and eliminate epidemics endangering entire populations. Most priority public health conditions share key social determinants, including determinants of exposure to risks, disease vulnerability, access to care, and the consequences of disease.

Ample opportunities exist to deal with these determinants collectively, both within and outside the health system. Coordinated action on public health conditions within strong systems based on primary health care is needed to achieve the MDGs and reduce health inequities, in addition to improving the population's overall health.

Universal primary health care: improving health outcomes and restoring equity

One of the key conclusions of the Commission on the Social Determinants of Health is that there is a need for action beyond the health sector, a need to consider "health in all policies". The Commission's report can be seen as an exhaustive review of the range of policies that require consideration in implementing multisectoral action for health, as part of a revitalization of primary health care.

Many health authorities recognize the potential of primary health care for providing a stronger sense of direction and unity in segmented and fragmented health systems, and for providing the framework that integrates health into all policies. Global stakeholders – including international agencies, global health initiatives, donors, and civil society organizations – are also increasingly recognizing the need for improved health systems performance based on the values of primary health care. Supporting this, *The world health report 2008*[4] noted that, in rich and in poor countries alike, a health sector organized according to the tenets of primary health care has the greatest potential for producing better health outcomes, improving health equity and responding to social expectations. Indeed, there is a growing consensus that health will not improve without functioning health systems, that health systems function best when they are based on primary health care, and that there is an opportunity to align more fully the agenda for responding to specific diseases with the agenda for strengthening health systems.

The rapid expansion and growing economic and social weight of the health sector – a long-term trend across the world, with the exception of fragile States – provides leverage to

[3] For a comprehensive discussion of the recommendations, please see: Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health.* Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization, 2008.
[4] *The world health report 2008: Primary health care, now more than ever.* Geneva, World Health Organization, 2008.

obtain the policy changes primary health care requires. There are four broad policy areas WHO has identified for essential changes: (1) dealing with health inequalities by moving towards universal coverage; (2) putting people at the centre of service delivery; (3) integrating health into public policies across sectors; and (4) providing inclusive leadership for health governance.

The first policy area is particularly relevant to this e-discussion. If health systems are to reduce health inequities, a precondition is to make services available to all, i.e. to bridge the gap in the supply of services. As the overall supply of health services has improved, it has become more obvious that barriers to access are important factors of inequity: user fees, in particular, are important sources of exclusion from needed care. Moreover, when people have to purchase health care at a price that is beyond their means, a health problem can quickly precipitate them into poverty or bankruptcy.

That is why extension of the supply of services has to go hand-in-hand with social health protection, through pooling and pre-payment instead of out-of-pocket payment of user fees. The reforms to bring about universal coverage – i.e. universal access combined with social health protection – constitute a necessary condition to improved health equity. Additional measures are required to benefit socially marginalized groups, such as better targeting investments in under-served areas, reducing transport cost barriers, better coordinating services, and improving responsiveness of health services to their needs. Moreover, adopting a social determinants approach recognizes that improvements in social factors that can be changed and controlled by policy – e.g. increasing coverage of early child development services – result in lifelong benefits in health, education and economic prospects.

Making progress towards all the Millennium Development Goals requires, among other measures, addressing health inequities – particularly within countries, strengthening health systems based on primary health care, and action on social determinants.

Health worker shortage

The health workforce is a vital building block of health systems. Fifty-seven countries, most of them in Africa and Asia, face a severe health workforce crisis[5]. Health workers are also inequitably distributed throughout the world, with severe imbalances between developed and developing countries, as well as within countries: in general, there is a lack of adequate staff in rural areas compared to cities. Sub-Saharan Africa faces the greatest challenges. While it has 11 per cent of the world's population and 24 per cent of the global burden of disease, it has only 3 per cent of the world's health workers.

The numbers of migrating health workers have significantly increased in the past few decades, with patterns of migration becoming more complicated and involving more countries. Such migration from those countries that are already experiencing a crisis in their health workforce, particularly in sub-Saharan Africa, is further weakening already fragile health systems, and represents a serious impediment to achieving the health-related MDGs. There is a strong need for greater emphasis on national action and multilateral cooperation to determine the impact of health-personnel recruitment on countries experiencing a health workforce crisis, particularly developing States and to formulate national and international

[5] See http://www.who.int/mediacentre/factsheets/fs302/en/index.html.

policy instruments for promoting global coordination and national action in order to maximize the benefits, and mitigate the negative impact, of international migration of health personnel.

There is more commitment to addressing the health workforce crisis than ever. In 2006, WHO dedicated the World Health Report[6] to the theme of Human Resources for Health, identifying the major crisis areas and countries and devising strategies to address it globally.

At national level, multi-sectoral approaches across all sectors to plan the reconstruction of the health workforce need to be pursued involving ministries of labour, education, finance, public service administration and relevant partners from the non-governmental sector to ensure coordinated planning and development of the total health system workforce. This facilitates coordinated and joint responses and helps to concentrate resources around universally agreed support strategies.

At the multilateral level, the World Health Assembly passed a Resolution in 2006, which calls for a rapid scaling up of the production of human resources for health, and for establishing and strengthening partnerships between institutions from developed and developing countries in the area of health workforce education and training. The rapid scaling up of production and deployment of health workforce calls for a significant investment. The international community -- which has made commitments to supporting developing countries to achieve the MDGs -- must increase funding to support this critical area.

The Global Health Workforce Alliance (GHWA)[7] was also created in 2006 as a common platform for action to address the crisis. The Alliance is a global partnership of national governments, civil society, international agencies, finance institutions, researchers, educators and professional associations dedicated to identifying, implementing and advocating for solutions. In 2008, GHWA convened the first-ever global stakeholder conference in Kampala which culminated in the endorsement of the Kampala Declaration and Agenda for Global Action on Human Resources for Health[8] These agreements provide a framework to develop human resources for health over the next decade.

In its 2008 Declaration,[9] the G8 recognised the importance of the Kampala documents in driving forward the response, and pledged to work towards increasing the health workforce by supporting efforts, such as those of GHWA, in developing robust health workforce plans, policies, and country-led milestones. Specific commitments from the UK, the US and Japan to train new health workers and help poor countries retain those they already have - including through PEPFAR - have boosted the response to the workforce crisis.

At the UN High Level Meeting on the MDGs (September 2008), resolving the health workforce crisis was underlined as central to the achievement of the health-related targets. A new taskforce on Innovative Financing for Health was launched, the mandate of which includes finding solutions for funding over 1 million additional health workers by 2015.

---

[6] See http://www.who.int/whr/2006/en/.
[7] See http://www.who.int/workforcealliance/en/.
[8] The Kampala Declaration and Agenda for Global Action. Global Health Workforce Alliance / World Health Organization.
[9] G8 Hokkaido Toyako Summit Leaders Declaration, Hokkaido Toyako, 8 July 2008

WHO is drawing up a voluntary code of practice on the international recruitment of health personnel. The code sets forth guiding principles and voluntary international standards for recruitment of health workers, to increase the consistency of national policies and discourage unethical practices, while promoting an equitable balance of interests among health workers, source countries and destination countries, with a particular emphasis on the negative effects of health-worker migration on countries experiencing a health-workforce crisis. It also covers the need for effective health-workforce planning, gathering of national and international data, and research, as well as for strengthening Member States' capacity to implement its objectives. It also aims to create a platform for substantive international discussions.

These efforts and many others are heading in the right direction, but much more will need to be done to meet the demands for trained health care professionals in both developed and developing countries and to transform commitments into concrete action in the context of an unprecedented global financial crisis.

IV. PART TWO: Emerging and future health challenges (12 - 26 February)

Questions

3. What are the essential elements of national strategies to addresses the growing magnitude of noncommunicable diseases (cardiovascular diseases, cancers, chronic respiratory diseases and diabetes) and their modifiable risk factors (tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol) and social determinants? What sectors besides the health sector must be involved in designing and implementing the strategies?

4. In the wake of the financial crisis, how can we maintain and enhance the favourable policy and resource trends for global health of the recent past? How can we better define the roles different stakeholders can play, including through collaborative intersectoral efforts, towards the achievement of public health goals?

5. What further innovations should be incorporated into global health partnerships and collaborative arrangements to improve their performance, reduce transaction costs and increase synergy of action aligned to country priorities? What other innovative ways of working can be considered that strive for greater coordination and collaboration of all actors in health?

The noncommunicable disease gap in the development agenda

The rapid rise of noncommunicable diseases, especially cardiovascular diseases, cancers, diabetes and chronic respiratory diseases, represent one of the major health challenges to global development in the 21st century. NCDs alone caused an estimated 35 million deaths in 2005 – sixty per cent of all deaths globally. Eighty per cent of NCD deaths occur in low- and middle-income countries. Mortality is projected to increase by 17 per cent over the next 10 years. If nothing is done, noncommunicable diseases will increase by 27 per cent in Africa, 25 per cent in the Middle-East and 21 per cent in Asia and the Pacific over the next 10 years. The highest number of deaths in 2015 from NCDs are forecast to occur in the

Western Pacific Region (11,440,329 deaths) and South-East Asian Region (9,579,477 deaths). These diseases will dominate health care needs in most low- and middle-income countries, with serious implications for economic growth and poverty reduction strategies.

These four noncommunicable diseases and their four shared modifiable risk factors (tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol) are closely related to chronic poverty and contribute to poverty. While widespread undernutrition and micronutrient deficiencies persist in most developing countries, obesity is also fast emerging as a problem. Underweight children and overweight adults are now often found in the same households. Initial evidence suggests that the origins of obesity and NCDs start very early in life, often in the womb.

The costs of treatment of NCDs can be impoverishing for people and families in the lowest income groups, but behaviours associated with risk factors such as tobacco use and harmful use of alcohol are also costly. There is also evidence that the four risk factors are significantly associated with an increased mortality from communicable diseases.

These health problems have serious implications for macro-economic development in low- and middle-income countries and could derail international efforts at poverty reduction. If left unaddressed, an estimated $84 billion of economic production will be lost between 2006 and 2015 due to lost or diminished labour supply from premature deaths caused by heart disease, stroke, and diabetes alone in 23 low- and middle-income countries.

NCDs account for a third of excess deaths among the world's two poorest quintiles. In all low- and middle-income countries and by any metric, these diseases account for a large enough share of the disease burden of the poor to merit a serious policy response. The challenges policy makers increasingly face in developing countries include how to address the links between poverty and NCDs, how to minimize the health and economic losses among the economically active population, and how to prepare for the pressures on health systems resulting from the growing number of people with NCDs.

In May 2008, the 193 Member States of the World Health Organization endorsed a six-year action plan to address noncommunicable diseases. The six objectives of the Action Plan 2008-2013 for the Global NCD Strategy include raising the priority accorded to noncommunicable diseases in development work, establishing national policies and plans, promoting interventions to reduce the four main shared modifiable risk factors, promoting research on the burden and its impact on socio-economic development, promoting partnerships with stakeholders, and tracking data on the magnitude and trends and evaluating the effectiveness and impact of interventions.

The plan calls on the international community to do more about the prevention and control of noncommunicable diseases. There is a strong evidence of cost-effective interventions in the arena of tobacco control, promotion of healthy diets and physical activity, as well as primary health care interventions, such as blood pressure treatment and good management of diabetes, which could provide the basis for turning the situation around. Investing in such interventions, particularly those related to primary prevention, provide the highest return in health and economic terms. To be cost-effective, these solutions need to be mainstreamed into development programmes, including national health development plans and overall health system strengthening with a special focus on universal coverage of primary health

care. Many of the issues involved constitute what is often referred to as a health systems approach to improving outcomes. Health systems strengthening should ensure to respond to the health-care needs of people with NCDs as well.

Yet, less than 1 per cent of official development assistance is provided to help low- and middle-income countries to integrate such workable solutions into their primary health care. For that reason, it will be critical for the international community to speed up the process to include noncommunicable diseases in global discussions on development.

How easily can the poor be reached through NCD interventions? This is becoming an important challenge for many policy makers in developing countries to address. In all countries, a national policy and planning framework is essential to give noncommunicable diseases appropriate priority and to organize resources efficiently in reaching the poor. A sound and explicit government policy is the key to effective prevention and control of NCDs. Comprehensive action requires combining population-wide approaches that seek to reduce the risks throughout the entire population with strategies that target individuals at high risk. The challenge is to find innovative approaches to make interventions pro-poor and accessible. Even a small shift in the average population levels of several risk factors can lead to a large reduction in the burden of these four noncommunicable diseases.

As discussed above, because major determinants of the noncommunicable disease burden lie outside the health sector, action across the whole of government is necessary at all stages of policy formulation and implementation. An intersectoral committee for policy-making should be convened by the ministry of health, but with representation from other relevant ministries and organizations. Different sectors may have different and sometimes even conflicting priorities. In such situations, the health sector needs the capacity to provide leadership, to provide arguments for a win-win situation and to adapt to the agendas and priorities of other sectors.

The threat of the financial crisis to health

The commitment to improving global health has never been higher than in recent years. The world has seen record levels of development aid for health, especially as part of the ambitious drive to achieve the MDGs. It has doubled, coming both from traditional and innovative sources, although more is yet needed. Several countries, notably in Africa, have increased levels of domestic spending on health on the back of economic growth, although government expenditure for most still has not reached the Abuja target of 15 per cent.

However, the economic consequences of the present global financial crisis may jeopardize future progress on health-related and other MDGs. Fiscal pressures in affluent countries may prompt cuts to official development assistance, and many countries, especially low-income countries, may be forced to make cuts in social spending, such as in health, education and social protection. Any significant deterioration in health outcomes at country level will fuel the inevitable and destabilising political and social fall-out from the crisis.

During this financial and economic crisis, means to protect the health and income, particularly of the most vulnerable, through social safety nets and other insurance-based mechanisms should be a high priority for governments and development agencies alike.

It will also be important to further harness the energies of non-governmental, private and civil society groups at the country and global levels to help in protecting health spending from donors and by countries themselves.

A previous effort to use health as the route to socioeconomic development, launched in 1978, was followed almost immediately by a fuel crisis, soaring oil prices, and the debt crisis of the early 1980s. In the international response to these crises, mistakes were made when budgets were shifted away from investments in the social sectors, most notably health and education. Many countries are still suffering the consequences of these decisions. It is essential to learn from past mistakes and counter this period of economic downturn and *increase* investment in health and the social sector.

Health partnerships

The nature of global health has changed dramatically in the past two decades, bringing in many actors with a common desire to expand resources to global health needs, including service delivery, prevention, and research and development. Besides governmental activities, the involvement in health of nongovernmental organizations, non-state-sector providers of health, industry, faith-based organizations and civil society has increased.

Few successful health initiatives now depend on a single organization. The consequent multisectoral engagement and multiplicity of stakeholders have introduced new requirements for effective management of these interactions at global and country levels. Numerous global health partnerships and similar collaborative arrangements have been established to raise visibility and provide common platforms for working together by combining the strengths of public and non-state organizations and civil society.

The number of these partnerships and collaborative arrangements has increased steadily over the past decade. More than 100 now exist, although the term "partnerships" encompasses a large diversity of organizational structures, relationships and collaborative arrangements among participating stakeholders. Not all health conditions benefit from these entities, as they mirror development trends and priorities.

Global health partnerships present challenges, including risks of duplication of effort, possible high transaction costs to governments and partners, varying accountability, variable country ownership, the inability of countries to absorb funds, a lack of alignment with country priorities and systems, and insufficient country coordination of partnerships. There is a recognized need for national and global harmonization and efficiency in resource mobilization, resource allocation, technical assistance, monitoring and cross-cutting approaches that reinforce long-term predictability and sustainability of funding and increase information flow among stakeholders. Moreover, the many partnerships devoted to specific health conditions need to be aligned with broader health system development efforts, financing and initiatives.

There is a need to address the challenges posed by the growing number and size of global health partnerships working in health. Consequently, issues of stewardship and governance have emerged as they relate to the functions and applications of partnerships. Global partnerships -- and partners -- must align their work and focus to global and national priorities; they must orient their own priorities to fill identified gaps, to reduce inequities, to

complement what others are doing, and ultimately to work on behalf of the people who are receiving inadequate health services or are unnecessarily put at risk of health problems. Aligning with the Paris Declaration on Aid Effectiveness and the recent Accra Action Plan are of great importance to effectively supporting national plans and strategies and to reducing transaction costs.

A set of best practice principles for global health partnership activities at country level[10] was presented at the third High-Level Forum on the Health Millennium Development Goals (Paris, November 2005). These principles were adapted from the five key areas of the Paris Declaration. They focus primarily on partnerships that provide substantial financing in countries; however, many are relevant for other types of partnerships that involve national governments as participating partners. Partnerships such as the GAVI Alliance and Stop TB have endorsed them, and some donors are using them to guide their engagement.

Partnerships and other collaborative arrangements are a means to an end. They represent one avenue for collaboration of various stakeholders, but not the entirety of how development actors coordinate at country level, internationally, nor advance multisectoral action. At the center must be national plans and priorities.

In this regard, the international community needs a re-evaluation of the various forms of collaboration and innovative ways to foster collaboration among groups that historically have not always worked together but need to do so in order to address the underlying causes and determinants of poor health and especially persisting inequities in health. For example, improving women's health, especially the health of the poorest, requires an extraordinary range of interventions, long-term policy changes, legal reforms, and cultural sensitivity.

More recent initiatives to support health include those that are designed to rely on existing institutions with the aim of mobilizing different players to work together in new ways. These include the Measles Initiative, the International Health Partnership and related initiatives (IHP+), the Global Polio Eradication Initiative, and others.
At least three additional means of widening global collaboration and partnering for health could also be considered: (1) better defining the role that nonstate providers of health can contribute to achieving health goals, along with increased refinement of potential appropriate roles for business and the corporate sector at global and country level, (2) engaging donors from emerging economies in the global health agenda, and (3) expanding programmes of South-South cooperation. Underlying all of these includes the overriding need to ensure respect for and alignment with national strategies and processes, and linkage to existing health institutions.

[10] See: http://www.hlfhealthmdgs.org/Documents/GlobalHealthPartnerships.pdf.

ANNEX I

The ECOSOC Annual Ministerial Review

At the 2005 World Summit, leaders mandated[11] the Economic and Social Council (ECOSOC) to hold an annual ministerial substantive review (AMR)[12] to assess the progress made towards the MDGs and the implementation of the other goals and targets agreed at the major UN conferences and summits over the past 15 years, which constitute the United Nations Development Agenda (UNDA). The first AMR was held in Geneva on 3-4 July 2007.

Format. The AMR takes the form of a two-day ministerial-level meeting during the ECOSOC high-level segment in July. It consists of:

- a *global review* of the United Nations development agenda for systematic review and monitoring of progress made in the implementation of the UNDA,
- a *thematic review* related to a subset of the UNDA that is agreed upon by the Council in the multi-year programme of work for the AMR, and
- *national voluntary reviews* where countries present the progress they have made in implementing their national development strategy.

Not an event, but a process. The AMR is not limited to the two-day event but is, rather, a process including the preparation spanning many months before the session and the follow-up afterwards. In 200, the following activities are being organized to lead up to the review:

- An *e-discussion* hosted on UNDP's mdg-net will capture important feedback and insights from the country level in January and February.
- A global AMR *preparatory event* is planned to take place in New York in March.
- The ten countries volunteering to make national presentations at the 2009 ECOSOC substantive session in July are envisaged to hold *national consultative meetings* with key stakeholders, including from civil society and the private sector, on the implementation of their national development strategies prior to the High-level segment in July.
- In preparation for the AMR thematic debate, two *regional consultations* are planned to be held in March and April.
- An *Innovation Fair* showcasing innovative programmes and projects that is held alongside the AMR in July will promote an exchange of practical examples of what has worked to help identify polices that merit scaling-up.

Strengthening the AMR in 2009. Preparations for the 2008 Annual Ministerial Review aim at two major overriding objectives: (i) to strengthen the AMR as the major mechanism for monitoring and evaluating the implementation of commitments contained the UN Development Agenda; and (ii) to mobilize support for the realization of the agenda, including through the global partnership for development.

[11] A/RES/60/1, para. 155

[12] For more information, please see http://www.un.org/ecosoc/newfunct/amr.shtml.