



WHO Results Report

Programme Budget 2016-2017



World Health
Organization

WHO Results Report

Programme Budget 2016-2017

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Director-General's foreword

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Dr Tedros Adhanom Ghebreyesus,
Director-General



Accountability is vital for the success of any organization, especially one that asks the nations of the world to entrust it with their funds, pledging to use them to improve health globally.

It's even more vital in a world marked both by increasing competition for limited development resources, and by greater scrutiny of results obtained. Countries and other donors rightly want to know what their contributions are achieving.

That's what this report is all about. It details WHO's successes, of which there are many: we are closer than ever to wiping polio from the face of the earth; we've drawn attention to, and mobilized resources to combat, the threat of antimicrobial resistance; and we have catalysed unprecedented political commitment to universal health coverage.

My predecessor, Dr Margaret Chan, deserves enormous credit for these achievements, and for learning the painful lessons of the outbreak of Ebola virus disease in West Africa, which has led to a WHO that is better prepared than ever to respond to the outbreaks and other health emergencies.

The previous edition of this report was entitled the "WHO programmatic and financial report". Running to 180 pages, it was a detailed if somewhat dense and daunting account of WHO's activities for the biennium 2014-2015.

With the present report we have taken a new approach, starting with the name. The WHO Results Report: Programme budget 2016-2017 sets out to do what its title says, namely: give a more digestible, user-friendly snapshot of who funds WHO, what we do with the money, and the results we achieve.

The name change reflects the fact that WHO itself is changing. It must. To remain relevant, to remain worthy of the trust that Member States and donors place in us, some fundamental transformations are unavoidable.

One of them is to move from a focus on outputs to a much sharper focus on outcomes and impact. WHO is a technical agency, not an academic institution. Our technical expertise is not an end in itself, but rather the means of achieving an incalculably greater goal: to save lives, prevent disease, and improve health for every person. The guidelines, checklists, reports and other normative tools we produce matter only inasmuch as they make a difference where it counts the most: to people, in countries.

WHO's draft thirteenth general programme of work, 2019-2023, and its accompanying impact framework, sets three concrete, ambitious goals: 1 billion more people benefitting from universal health coverage; 1 billion more people better protected from health emergencies; and 1 billion more people enjoying better health and well-being.

Of course, WHO cannot hope to achieve these goals on its own. Success will depend on fostering dynamic partnerships that leverage the strengths of the numerous actors in global health. But it acknowledges that unless we aim high, WHO will continue to underdeliver.

The global health architecture is unrecognizable today from what it was in 1948, the year of WHO's founding, but our vision remains as bold and relevant as it was then: a world in which all people enjoy the highest attainable standard of health.

The task before us now is to ensure that WHO is an organization capable of fulfilling that vision, of delivering value for money to its donors and, above all, of creating a healthier, safer and fairer world.

”

Introduction

The **WHO Results Report 2016–2017** summarizes the Organization's key programmatic achievements and financial highlights during the biennium. In bringing these two areas together, effectively pairing achievement of results with resources allocated, the Organization is holding itself more accountable for investments made by Member States and donors. This report also seeks to review results through the lens of outcomes and impacts rather than processes and outputs, or by achievements rather than activities.

New beginnings and directions

The biennium 2016–2017 marked a sea change for WHO, with the Organization embarking on new ventures and setting new directions. A brand new agenda for work was set in the Sustainable Development Goals, adopted by the United Nations General Assembly in 2015.¹ During the biennium, all levels of the Organization were involved in developing road maps, strategies and plans to lay the necessary foundations for reaching the ambitious health targets by 2030. The pledge to “leave no one behind,” made by Heads of State and Government in adopting the 2030 Agenda for Sustainable Development is embodied in the transformational target of universal health coverage, which underpins all the other health-related goals. The drive to reorient and strengthen health systems so that they can offer “access to all” comes almost four decades after the historic Declaration of Alma-Ata in 1978, with its goal of “Health for All”.

In May 2017, Dr Tedros Adhanom Ghebreyesus was appointed WHO's new Director-General. He brought with him a new perspective and, as a firm champion of universal health coverage, he made this a top priority for WHO. His vision of health as a fundamental human right reaffirms a core tenet of WHO, which is enshrined in WHO's Constitution and central to the Organization's mandate – the right to health. Dr Tedros has called on countries to take three concrete steps towards universal health coverage, pledging WHO support through “world-class technical know-how” and “relentless political advocacy”.

Other new beginnings for WHO include the establishment of the new WHO Health Emergencies Programme in 2016, which emerged in the aftermath of the severe outbreak of Ebola virus disease in West Africa. This marks a profound change in the global architecture for health emergencies, and gives WHO a

stronger operational arm, beyond its traditional technical and normative roles. The Programme will lead and coordinate the international health response to contain outbreaks and provide relief in emergencies and disasters. It has already responded to 50 emergencies in 47 countries and every month screens 5000 signals of new outbreaks. A dashboard provides real-time data on emergencies. Once a fortnight, the new WHO Health Security Council, which includes the Director-General, reviews all emergencies in detail. The improved management of outbreaks was evident in WHO's coordinated and rapid response to the recent Zika and yellow fever outbreaks, while in Madagascar, an outbreak of plague was rapidly brought under control.

The growing realization of the threat to global health posed by antimicrobial resistance has also led to a change of pace in the response to the issue. Following a high-level meeting of the General Assembly on antimicrobial resistance in New York in 2016, efforts were scaled up at all levels of the Organization in order to implement a cross-sectoral global action plan. The need for greater collaboration led to strengthened ties with other international organizations in the “One Health” approach, and in the Global Antibiotic Research & Development Partnership to advance research.

Running the “last mile”

Just as the Organization was opening new doors, it was also moving to close some old ones – most notably the campaign to eradicate poliovirus. A decade ago, progress had stalled amid mounting operational challenges in Nigeria and rising cases in India. Strategies that had previously proven to reduce incidence were failing to win the war in the last remaining strongholds of the virus. New approaches had to be found and the campaign was put on an emergency footing. Finally, breakthroughs were achieved and this year, remarkably, the world is moving closer than ever to eradication, with a real possibility of zero incidence.

The polio campaign offers many lessons. One is that different strategic and technical approaches are needed when the burden of disease shifts from dozens of countries in which a disease is endemic to a handful of cases across the globe. The last mile of eradication efforts is the hardest and longest to travel. Innovative and even extraordinary approaches may be needed to wipe out stubborn centres of infection.

¹ United Nations General Assembly resolution 70/1.

Progress has also been made in the battle against other diseases. Measles has now been eliminated from the WHO Region of the Americas, and the end is in sight for two or more neglected tropical diseases. To win the final battle against dracunculiasis – the painful guinea worm disease – community surveillance is being set up in every village in which the disease is known to be endemic.

The drive to reach every last case, in every known village, lays the groundwork for universal health coverage. Likewise, those pursuing efforts to “end the epidemics” of HIV/AIDS, tuberculosis and malaria as a public health threat will need to reach out to the poorest, most vulnerable and most marginalized members of society, to ensure that no one is left behind, paving the way for a future of health for all. The same is true for efforts to end maternal mortality and neonatal mortality, which will require health services to be improved and access to care expanded.

After seeing exponential gains in progress, sustained efforts are required to cover the last ground on these battlefronts. Fresh approaches will be needed, including ones to address equity, human rights, gender and social determinants of health.

Evolution and transformation

Amid these beginnings and endings, the global health landscape is also changing, and WHO itself is also in the midst of transformation. WHO is working to strengthen its foundations through strong leadership and by revamping resource mobilization; in addition, the Organization is working on further improving efficiency, transparency and accountability.

Compared with the situation two decades ago, global health is accorded higher priority now, with greater mobilization of resources and aid.

There are more synergistic and collaborative partnerships – involving civil society, academic institutions and philanthropic foundations – while the monitoring and measuring of targets and indicators is more focused and ambitious. Pioneering new initiatives are using modern technology; mobile phones, for example, are being used to help people quit smoking. The landscape in which WHO operates is complex and

diverse, yet the role of the Organization is as vital as ever. In championing tobacco control, waking the world up to noncommunicable diseases, and advocating for emerging issues such as healthy ageing and adolescent health, WHO is continuing to play a critical leadership role.

Building political momentum and advocating for health at the highest level – as well as engaging high-level champions and ambassadors – is an increasingly significant component of WHO’s work. For example, an independent high-level commission on noncommunicable diseases is helping to prepare for this year’s United Nations General Assembly third High-level Meeting on the Prevention and Control of Non-communicable Diseases.

In response to current health challenges and disease patterns, and against the backdrop of a changing global health architecture, WHO is about to unveil a bold and radical new plan. Exactly 70 years since WHO was founded, the draft thirteenth general programme of work, 2019–2023 sets out not just to transform WHO, but to transform global health and, ultimately, human lives. It starts by clarifying WHO’s mission – to promote health, keep the world safe and serve the vulnerable – and it goes on to outline several strategic shifts to achieve that mission.

The objectives laid out are ambitious, but significantly, they come with concrete numbers:

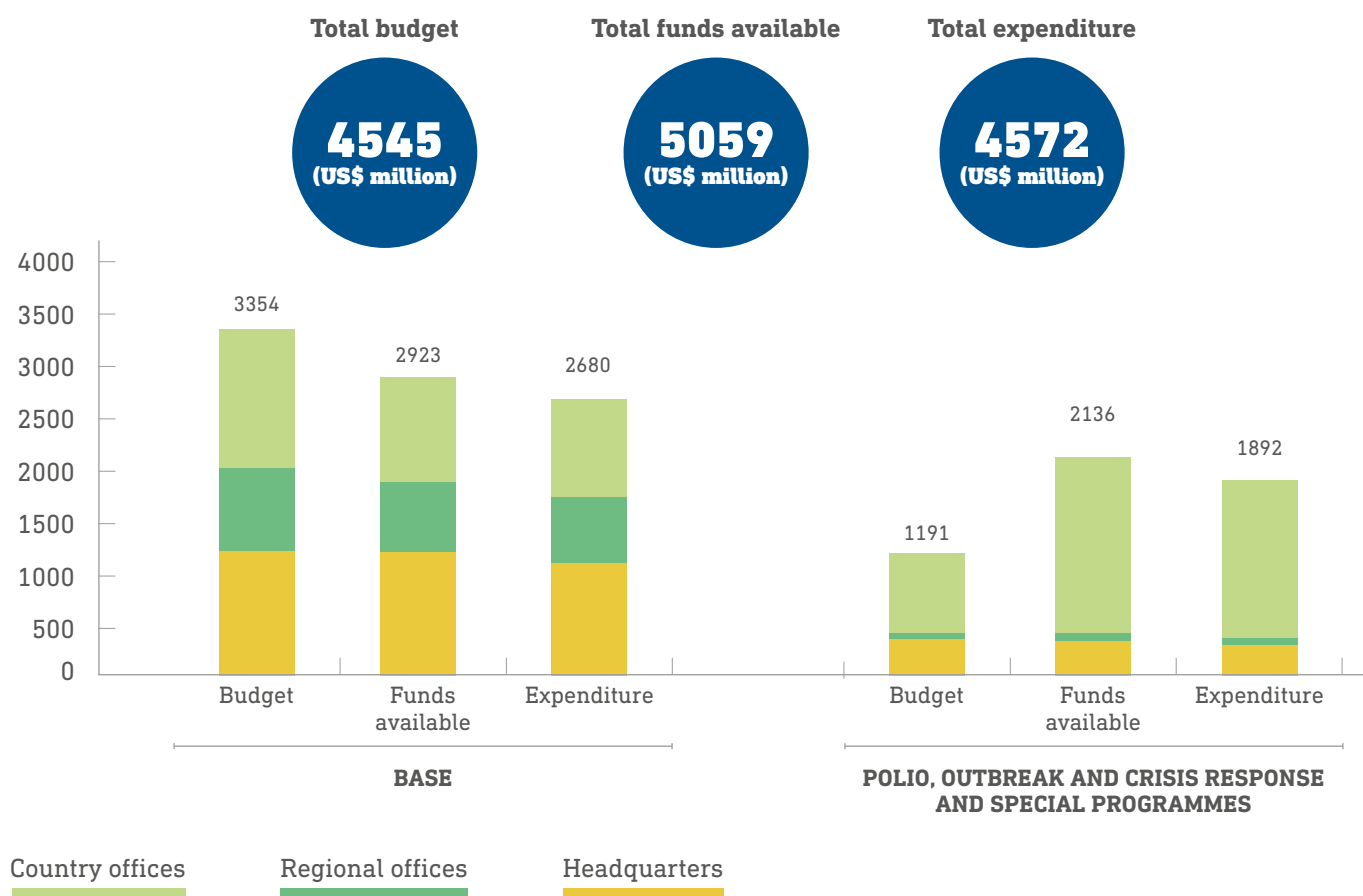
- 1 billion more people benefitting from universal health coverage
- 1 billion more people better protected from health emergencies
- 1 billion more people enjoying better health and well-being.

The “triple-billion” goal is no small matter. It is revolutionary. But at a time when the world is faced with enormous challenges, a bold vision of the future may be the best medicine that the doctor can prescribe.

Budget and financial highlights



Budget, funds available and expenditure for the Programme budget 2016–2017
(in US\$ millions)



The Programme budget 2016–2017 was originally approved by the Health Assembly in May 2015 at US\$ 4385 million. In May 2016, the Health Assembly, in decision WHA69(9), decided inter alia to increase the budget to US\$ 4545 million, providing a further US\$ 160 million for the WHO Health Emergencies Programme. Base programmes represent 74% of the approved Programme budget, or US\$ 3354 million. The remaining Programme budget is for polio, outbreak and crisis response and special programmes.

The graph above summarizes the revised approved budget, funds available and expenditure, by level, for 2016–2017 and shows that over 50% goes to country offices.¹

Where does WHO funding come from

Total funds available for 2016–2017 amounted to US\$ 5059 million, of which US\$ 2923 million was available for base programmes, representing 87% of the base programme budget.

The available funding for non-base programmes (i.e. polio, outbreak and crisis response) is higher than the Programme budget due to the event-driven nature of the work. These could not be predicted at the time of the development of the Programme budget. For polio, additional resources were required to scale up activities to stop transmission in several key countries such as Afghanistan, Nigeria and Pakistan.

¹ Further information on budget, funds available and expenditure, by major office, country office, category and programme area is available through the programme budget web portal. (<http://open.who.int/>, accessed 6 March 2018).

For outbreak and crisis response, the increase is due to a number of significant emergency response efforts in countries such as South Sudan, Syria and Yemen.

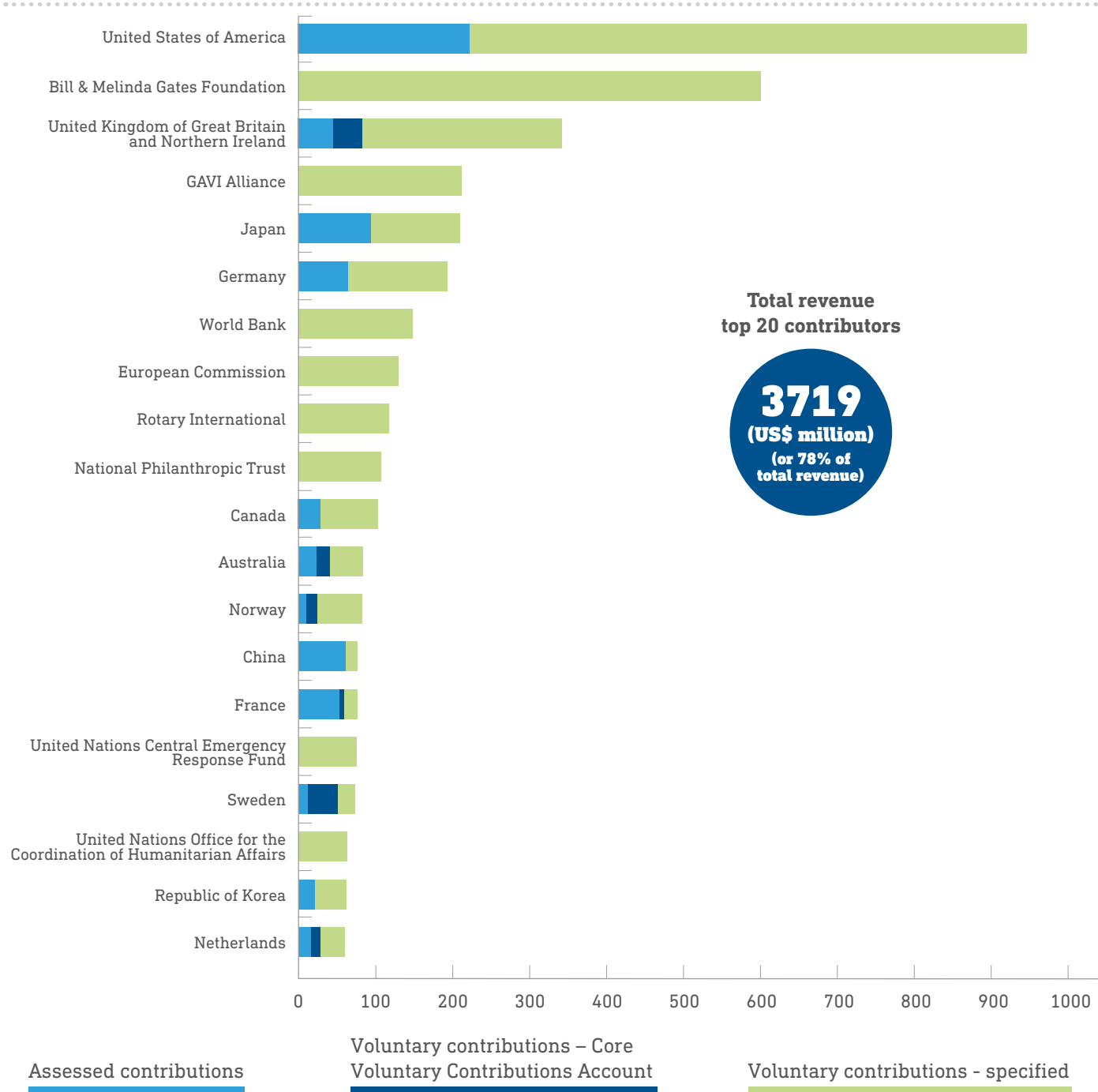
There are two major sources of financing for the Programme budget: specified voluntary contributions and flexible funds, comprising assessed contributions, programme support costs and core voluntary contributions. Financing from specified voluntary contributions accounted for 72% of the available funds.

Funds available comprise the revenue recorded in the current biennium, plus the funds brought forward from the previous biennium, less any funds carried forward to the next biennium.

Total revenue recorded for the Programme budget 2016–2017 was US\$ 4756 million, comprising assessed contributions from Member States of US\$ 928 million and voluntary contributions of US\$ 3828 million.²

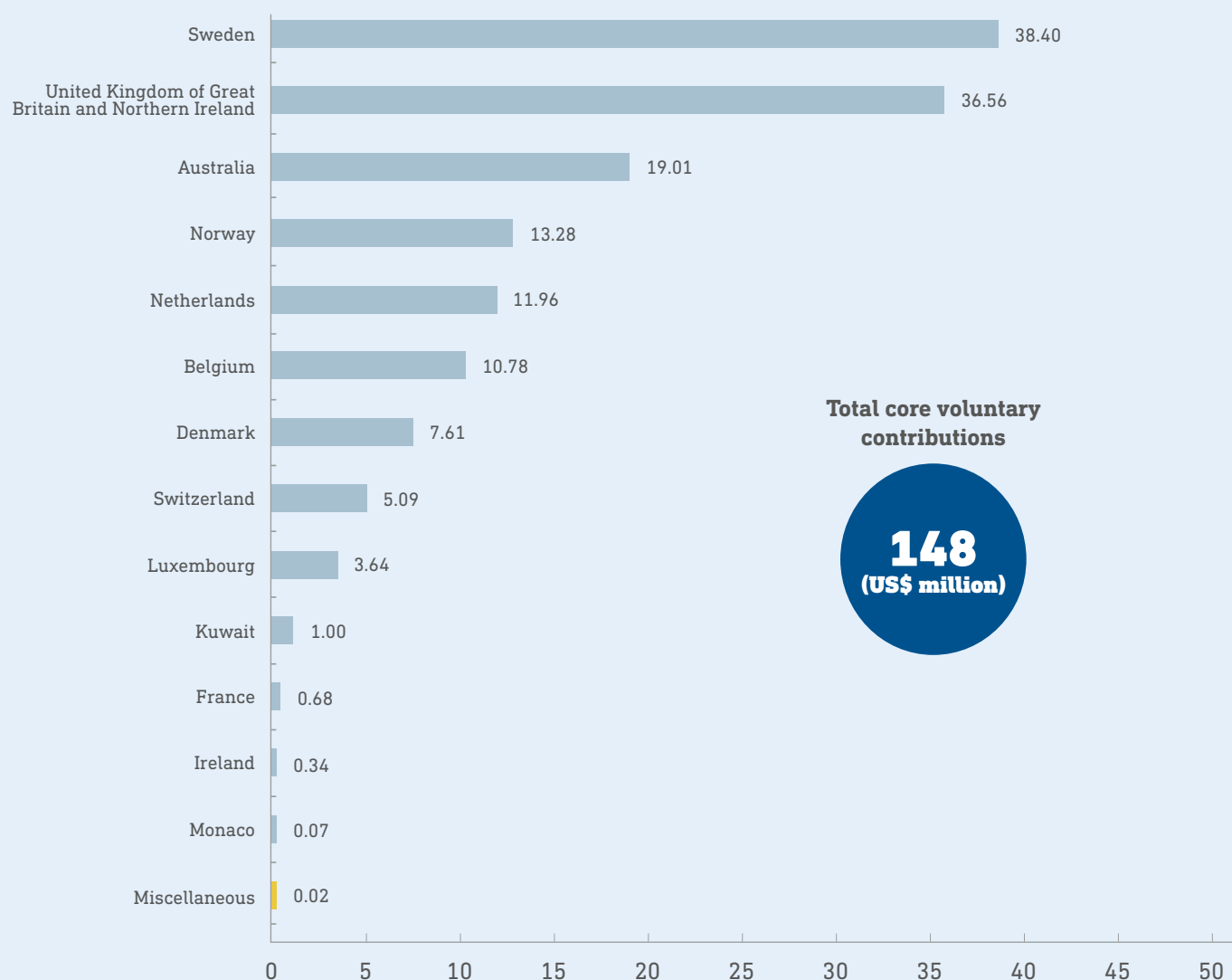


Top 20 contributors to the Programme budget 2016–2017 (US\$ millions)



² Full lists for 2016 and 2017 of all voluntary contributions, by fund and by contributor are provided in separate reports. Documents A70/INF./4 and A71/INF./2, respectively.

Contributors to the Core Voluntary Contributions Account for 2016–2017 (US\$ millions)



Core Voluntary Contributions Account

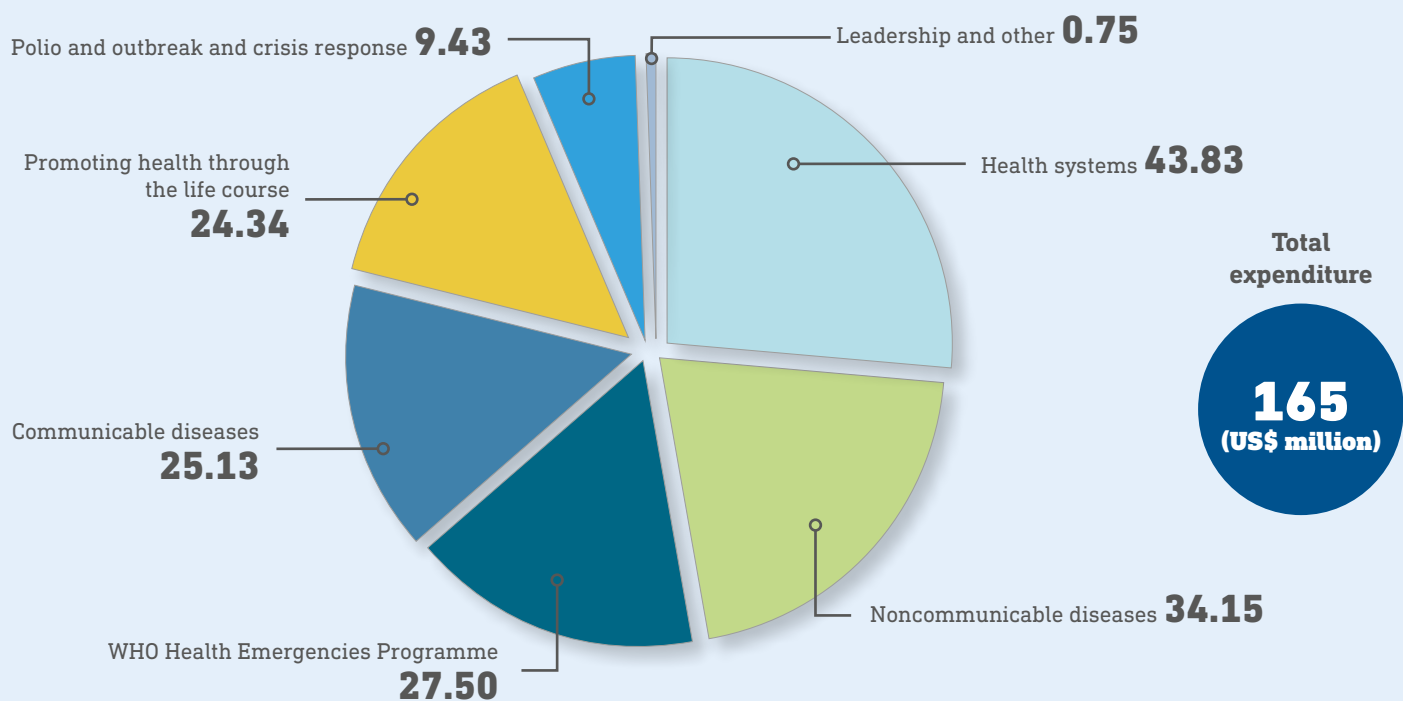
Of total voluntary contribution funding for 2016–2017, US\$ 148 million (or 4%) is for the Core Voluntary Contributions Account. The graph above summarizes its funding by donor.

Funding to the Account has decreased this biennium, with several important contributors reducing or stopping their contributions, mainly due to internal funding decisions.

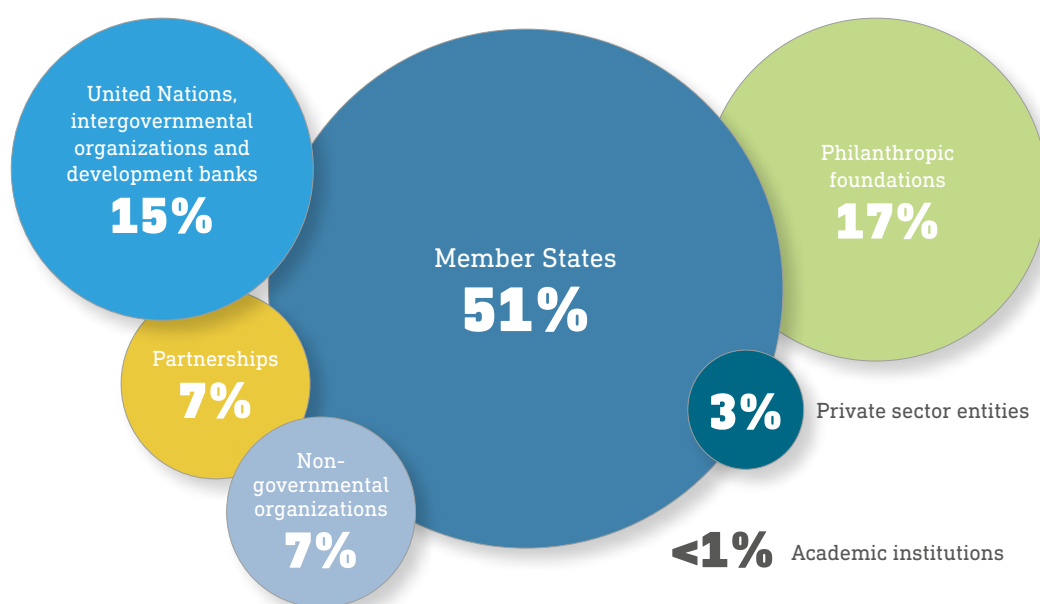
Core voluntary contributions provide flexible funding across many underfunded categories and programmes. Without this catalytic funding it would be difficult to deliver WHO's programmatic results as per the approved Programme budget. On the right page is a summary of the expenditure by category. Expenditure exceeded revenue in this biennium, resulting in a reduced carry-forward to 2018–2019.



Core Voluntary Contributions Account expenses, by category, 2016–2017 (US\$ millions)



Revenue for 2016–2017, by source



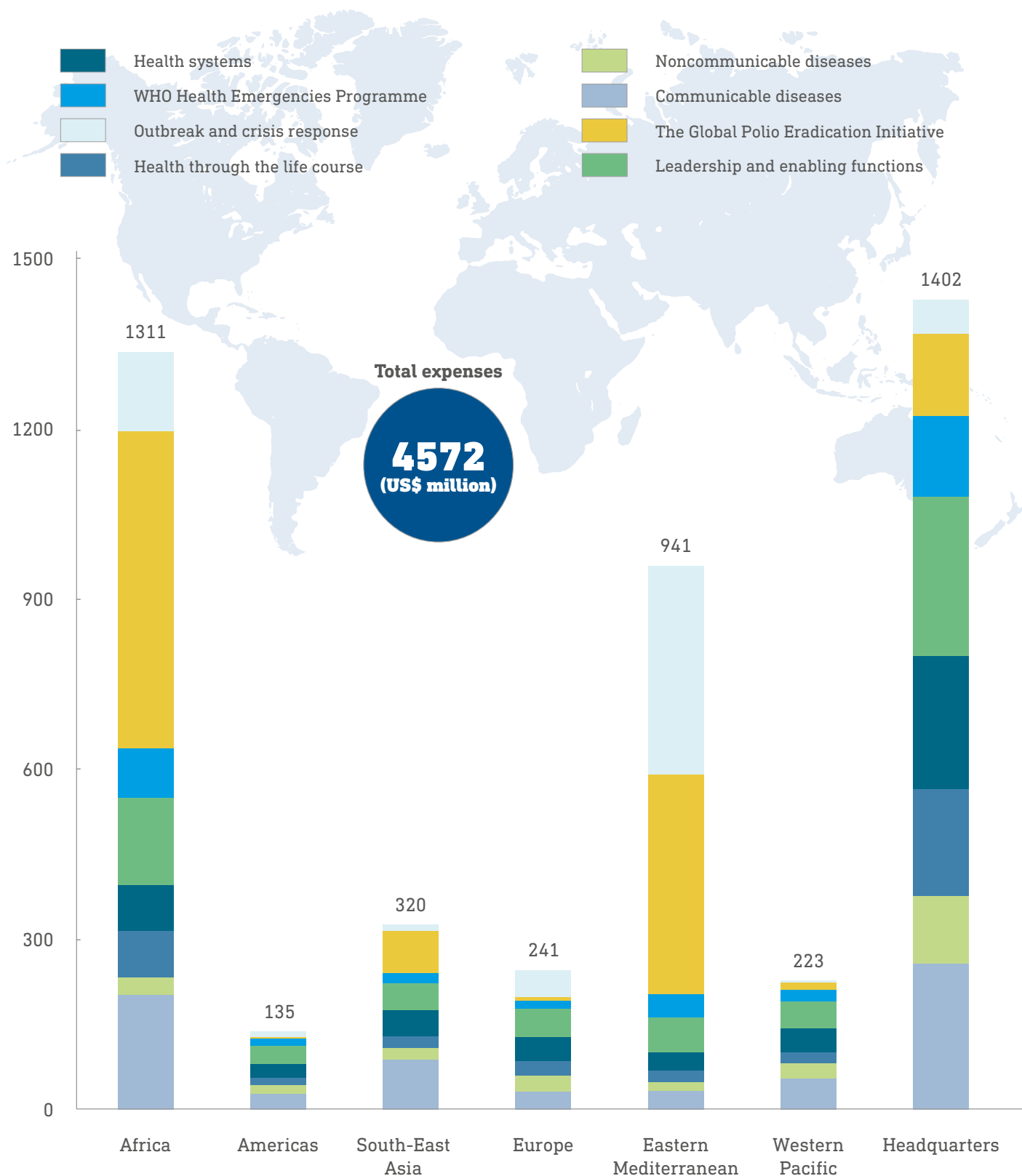
Revenue by source

Member States continue to be the largest source of voluntary contributions, contributing 51% of total voluntary contributions in 2016–2017. Compared with 2014–2015, the biggest change

has been an increase in revenue from philanthropic foundations resulting from higher contributions to the Global Polio Eradication Initiative.

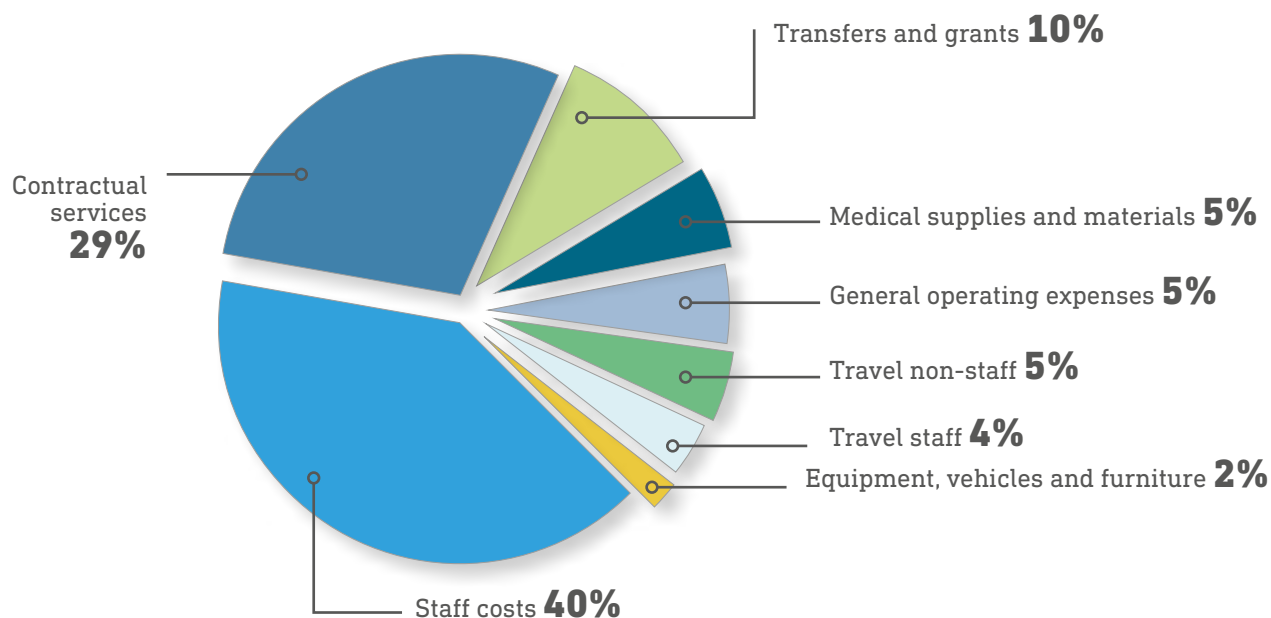


Programme budget expenses, by major office and category, 2016–2017 (US\$ millions)





Programme budget expenses, by expense type, 2016–2017



Where is WHO funding spent

In 2016–2017, total Programme budget expenditure was US\$ 4572 million (in 2014–2015, US\$ 4357 million), which represented an increase of 4% from 2014–2015. The graph on the left summarizes the expenditure by region and by category.

In 2016–2017, base programmes represented 59% of expenditure (61% in 2014–2015), while polio, emergencies and special programmes represented 41% (39% in 2014–2015).

Certain offices are very dependent on polio eradication and emergency activities. In the Eastern Mediterranean Region, 79% of expenditure is on polio eradication and outbreak and crisis response, leaving only 21% as base. This creates financial vulnerability in a number of country offices that are dependent on short-term emergency funds.

The graph above provides a summary of Programme budget expenses, by expense type, for 2016–2017.

Programme budget expenditure for 2016–2017 has increased by US\$ 215 million, or 5%, from the biennium 2014–2015, which is principally attributable to increased activities in emergency operations.

Staff costs are the biggest expenditure type, representing 40% of total costs in 2016–2017. Staff costs increased by 4% compared with 2014–2015, with the largest increases recorded

in offices in countries experiencing emergencies and the WHO Health Emergencies Programme. The staff count increased by 5% with a total workforce reported as 8027.³

The second-largest expenditure type is contractual services, representing 29% of the total costs for the biennium 2016–2017, and covering the expenses of suppliers engaged by WHO to provide services to support WHO programmatic activities. Contractual services increased by 21% from 2014–2015, mainly for direct implementation where WHO carries out immunization campaigns in collaboration with national governments.

Travel expenses decreased by 5% between 2014–2015 and 2016–2017. The main reasons for the savings in travel costs were: a lower overall level of staff travel compared with the period, mainly in 2015, when Ebola-related travel costs peaked, and revised policies and procedures leading to efficiencies in this expenditure category across the Organization. Of total travel expenditure, only 44% was for staff travel, the rest being for non-staff travel, mainly for meeting participants.

Transfers and grants to counterparts decreased by 11% in 2016–2017 compared with 2014–2015. The decrease was mainly due to a reduction in direct financial cooperation, as a consequence of the new policies in this area, also corresponding to an increase in directly managed implementation, as mentioned above.

³ Human resources: workforce data as of 31 December 2017. (<http://www.who.int/about/finances-accountability/budget/en>).

HEALTH SYSTEMS

“

The right to the highest attainable standard of health must inform everything that we do, and must intersect with other human rights concerns... Leaving no one behind must be the mantra of a new progressive universalism in which the provision of high-quality public health care is non-negotiable.

Dr Poonam Khetrapal Singh
WHO Regional Director for South-East Asia

”



Programme areas

**National
health policies,
strategies and
plans**

**Integrated people-
centred health
services**

**Access to medicines
and health
technologies,
and strengthening
regulatory capacity**

**Health systems,
information and
evidence**

Key objectives



To strengthen health systems in order to achieve universal health coverage



To build health systems on firm foundations: financial protection; accessible, people-centred essential health services; safe, effective medicines and health technologies; and sufficient skilled human resources



To promote health systems research, information and evidence



To strengthen national health policies, strategies and plans

The following scenario is all too common in health care: the breadwinner in a family falls sick; to pay for treatment, the family have to spend all their savings and may even remove a child from school to send them to work. The costs ultimately prove catastrophic, pushing the family into poverty. Moreover, if the sick family member happens to be a girl, her survival might not even be taken into consideration: she would be one of those “left behind”.

In this way, 100 million people every year end up in extreme poverty (living on less than US\$ 1.90 a day). Furthermore, nearly 200 million people spend a quarter of their household budget on health care.

The goal of universal health coverage – with all people having access to the health services they need without enduring financial hardship – is enshrined in the 2030 Agenda for Sustainable Development, under the slogan “leave no-one behind”.

The work of WHO in strengthening health systems is aimed at supporting countries to build equitable, people-centred health systems that provide universal health coverage.

Key achievements

Global commitment to achieving universal health coverage has increased, with more consultations to improve understanding of its meaning in the context of the Sustainable Development Goals. WHO has made significant efforts to develop a consensus on priorities for health systems strengthening to promote universal health coverage. Headquarters pioneered the **Fit for Purpose, Fit for Context** approach to tailored interventions for health systems.

All regional offices have developed strategies to advance universal health coverage. In the Region of the Americas, 26 countries are preparing comprehensive national health policies, strategies, and plans within the context of the regional strategy. Among Caribbean countries, comprehensive reform processes are under way. Furthermore, 13 countries have implemented a monitoring framework for universal health. The Regional Office for the Western Pacific has promoted an action framework on the Sustainable Development Goals that mobilizes parliamentarians and WHO collaborating centres. The Regional Office for Africa has also developed an action framework and provided technical support to 23 countries to develop comprehensive national health strategic plans.

The WHO Secretariat also supports countries to “rethink health care” in order to improve the efficiency and effectiveness of health services, so they are fit to face twenty-first century challenges.



A friend of mine was diagnosed with cancer a few years ago. He had two options. He could be treated, but it would cost him most of all the money he had put aside for his family's future. Or he could forgo treatment, allow the disease to run its course and die... He chose the latter. He chose death because he could not afford the treatment that could have kept him alive.

This is an outrage. No one should have to choose between death and financial hardship.

Dr Tedros Adhanom Ghebreyesus,
WHO Director-General.



New vision for health systems

Global leaders and health agencies are increasingly advocating a change in perspective, moving away from vertical programmes towards a broader, more coordinated approach to health systems strengthening that is fully aligned with national health strategies. In that context, the Government of Japan, which held the G7 Presidency in 2016, announced the **G7 Ise-Shima Vision for Global Health**.

The call to tie in health systems strengthening, universal health coverage and health security was spearheaded by the leaders of Germany and Japan, and was discussed at the meeting of G20 countries in 2017. There is recognition that resilient, functioning health systems are cost-efficient in the long term, compared to the resources consumed in emergency responses.

The International **Health Partnership Global Compact (IHP+)** established UHC 2030 to broaden the Partnership's scope in working towards attaining universal health coverage by 2030. WHO, together with the World Bank, has been instrumental in driving this evolution forward.

The Secretariat has supported Member States in shaping a people-centred approach that ensures accessible, high quality, efficient health services that are responsive to needs. The 2016 **WHO Framework on integrated people-centred health services** is aimed at addressing such issues by calling for a fundamental shift in the way health services are managed and delivered. The Framework helps countries to advance towards universal health coverage by designing health systems for people, rather than around diseases and health institutions. Many Member States have aligned donors with disease programmes in the process of developing health strategies and service packages. The Eastern Mediterranean Region has actively promoted family practice at the primary health care level to improve coverage and quality of care.

**Integrated health services in
15 more countries
in line with the WHO strategy**

12 countries developed
comprehensive health sector plans in
2016–2017, with goals and targets

26 more countries
their progress towards financial
protection with WHO support for health
financing options

Leaving no-one behind in Timor-Leste

The Democratic Republic of Timor-Leste is a young country still recovering from the trauma of conflict. Prior to 2002, when the country achieved independence, most of its public infrastructure had been destroyed, including all public health centres. The country also faced other issues: a high burden of childhood illnesses, low immunization coverage and one of the world's highest levels of tobacco use, with 70% of men and 42% of adolescents (aged 13–15) smoking. The goal of free universal health care is enshrined in the Constitution and the WHO country office has supported the Government's efforts to that end.

Under the **Saúde na Família (Health in the Family)** programme, launched in 2015, health workers fan out to visit homes so that everyone is able to receive primary health care. Through such home visits, health professionals identify those needing follow-up care, following the principle enshrined in the Sustainable Development Goals: to leave no one behind.

WHO helped to develop the service package and home visit guidelines, and provided operational support and essential primary health care equipment. In addition, WHO provided:

- political engagement at the highest level for anti-tobacco campaigns, leading to a comprehensive tobacco control law;
- a WHO package of essential services to combat major noncommunicable diseases;
- assistance for a new immunization schedule;
- technical assistance to maintain the low incidence rate of malaria.

By the end of 2016, the **Saúde na Família** programme had succeeded in visiting and registering 90% of the country's 200 000 households.



Transforming the health workforce

In 2016, an intersectoral **High-Level Commission on Health Employment and Economic Growth** produced evidence that rather than a consumptive cost, investing in the health workforce is a driver of inclusive economic growth, and a powerful means of making gains across the Sustainable Development Goals. In May 2017, the Commission's recommendations were forged into a five-year action plan, "**Working for Health and Growth**".

The recommendations were also adopted by 14 international forums, culminating in the "Dublin Declaration on Human Resources for Health: Building the Health Workforce of the Future". In addition, more than 50 countries are reporting disaggregated health workforce. Twenty countries have agreed on the scope of the labour mobility platform.

Tackling the health service crisis in Mali

Following the outbreak of armed conflict in 2012, Mali is facing a complex crisis. Almost one in five health facilities have been damaged, while in the conflict-ridden north, 42% of facilities have suffered partial damage.

In 2016, the WHO country office in Mali supported the Government in a health resources availability mapping system (HeRAMS) exercise to obtain a situation analysis of service delivery (including health workers). The results showed a dire lack of health facilities, with fewer than one for every 10 000 people, and a severe shortage of health professionals – 2.8 health care workers per 10 000 people (versus 23 per 10 000, in accordance with the WHO norm).

The following key interventions were undertaken:

- advocacy to raise funds to recruit health workers;
- production of data on health workers for use in planning and budgeting, with partners;
- support to draft a document to help resource mobilization.

The Government took immediate action. In 2017, the budget for recruiting health workers more than tripled to nearly US\$ 6 million. By September 2017, some 1227 health workers had been recruited, a considerable increase from 389 in 2016.

Brazil's Mais Médicos programme is providing more rural doctors

Brazil's large territory and forest cover presents a challenge to achieving universal health coverage. Due to recruitment and retention problems, certain areas and populations (poor and indigenous people) suffer from a critical lack of physicians.

In 2013, the Government created the Mais Médicos programme, with a key goal of helping to alleviate the shortage of medical doctors. Through collaboration between the Regional Office for the Americas/PAHO and Brazil and Cuba, roughly 19 000 doctors have been brought in to work in 27 states – often in poor, vulnerable or violent areas. About 700 municipalities were able to have a doctor for the first time. The programme, which now includes Brazilian doctors, has helped expand primary health care to remote and deprived populations, which has been key in controlling and preventing the Zika virus disease epidemic and yellow fever outbreak.



The Global Strategy on Human Resources for Health: Workforce 2030 sets out a strategic vision for attaining universal health coverage and the Sustainable Development Goals.

In the African Region, a framework for the implementation of the Global Strategy was adopted by the sixty-seventh session of the Regional Committee in 2017, and country and regional

capacity was built for using and applying the Workload Indicator Staffing Need (WISN) tool. Furthermore, human resources observatories have been set up in several countries, leading to the development of policy briefs on community health workers. The output has contributed to increasing access to quality health services.

In the Eastern Mediterranean Region, a framework for action on health workforce development was adopted. In the regions, WHO provided support for: health workforce assessment, planning, regulation, and measures to strengthen educational institutions for health professionals. The Western Pacific Region is continuing to produce future health leaders through the Global Health Learning Centre.

Transforming the Greek health system

Greece has begun to transform its health system into a more modern, people-centred system providing universal health coverage. In December 2017, progress was made with the inauguration of three new health units in the wider Thessaloniki urban area which aim to address inequalities and barriers affecting access to services.

The *Topikes Monades Ygias* (TOMY), key elements of the newly-designed primary health care system, will serve as the first point of contact and the main coordinator of care for people in the area. They will provide disease prevention, health promotion, diagnosis, treatment, monitoring and care. Multidisciplinary teams, which include family doctors, nurses and social workers, will provide continuous care – in contrast to the current fragmented network.

The transformation process of the local health units will include:

- revision of the service package and contractual arrangements;
- evaluation of the training needs of staff, development of a short-term re-training programme, and a revised curriculum for post-graduate training of general practitioners;
- analysis of the health workforce needs for primary health care; and
- a new law on primary health care, which was passed in August 2017.

Ensuring access to essential medicines

The high price of innovative medicines is challenging the sustainability of health systems in countries. In 2017, WHO launched the much-needed **Fair Pricing Forum** in Amsterdam, which is intended to convene all stakeholders to develop principles on the pricing of medicines and other health technologies. To support Member States in ensuring access to essential medicines, the WHO Secretariat provided input into the deliberations of the United Nations Secretary-General's **High-Level Panel on Access to Medicines**. A number of eastern European nations have made progress, particularly in terms of reimbursement and legislation. Efforts to strengthen national regulatory authorities have been scaled up in the Region of the Americas.

600 000 people living with HIV/AIDS in 30 countries in the Region of the Americas received treatment through the PAHO Strategic Fund

Health situation assessment and trends analysed in 37 more countries in 2016–2017, providing important data and evidence for policy-making

Better hand hygiene in hospitals in 29 countries through the African Partnership for Patient Safety



Snapshot at the end of 2017

Progress was also seen in the South-East Asia Region, particularly in the following areas:

- a regional procurement mechanism to support access to life-saving medicines;
- a regional platform for price and quality information sharing to support cost-effective procurement;
- strengthened regulatory capacity and better cooperation in access to medicines via the South-East Asia Regulatory Network, which has four working groups covering quality assurance and standards of medical products, good regulatory practices, vigilance for medical products and information sharing.

Progress has been made on developing an integrated antimicrobial consumption monitoring system in Bangladesh and Thailand.

Regulation of medical products is also a priority for countries in the Eastern Mediterranean Region. In order to harmonize and merge regulatory functions, especially in resource-limited settings, the Regional Office supported the establishment of an intergovernmental authority on development to promote the harmonization of medicines regulation in Djibouti, Somalia and the Sudan. It is a crucial contributor to public health and promotes rapid access to quality, safe and efficacious medicines to treat priority diseases.

Setting standards for pharmaceutical products, in the development, production and procurement of essential health products, is at the core of the WHO Constitution. Such standards help ensure that products meet acceptable standards of quality, safety and efficacy. In 2016–2017, that work included, inter alia, the establishment of 11 measurement standards – six for in vitro diagnostics, including for Zika virus disease, Ebola virus disease, dengue and hepatitis, and five for blood products. The standards are used as tools in the development, licensing and lot release of products.

WHO and the Drugs for Neglected Diseases initiative (DNDi) launched the **Global Antibiotic Research & Development Partnership** (GARDP), a not-for-profit partnership to promote research and development for new antibiotics where old ones no longer effective against resistant bugs. The Partnership has received seed funding and pledges exceeding € 57 million from the Governments of Germany, Netherlands, South Africa, Switzerland and the United Kingdom of Great Britain and Northern Ireland in order to help develop new treatments to fight antibiotic resistance.

The **Global Model Regulatory Framework for Medical Devices**, published in 2017 and evaluated by means of a comprehensive global analysis, offers guidance on developing regulation for medical devices in a step-by-step process, in line with a country's existing regulatory maturity.

Ebola vaccine

**tested and found to be effective;
now in regulatory review and three
diagnostic tests assessed**

100 core indicators

**to track health trends and situations for
global standards on health data, agreed
by global community**



Snapshot at the end of 2017

Improving health information systems

In March 2016, WHO launched the **Health Data Collaborative** with 38 development partners committed to strengthening country health information systems in the context of the Sustainable Development Goals.

The 2016 edition of **World Health Statistics** provides an assessment of the current capacity of country health information systems to monitor the health-related Sustainable Development Goal targets and indicators. Several regional and country offices worked with Member States on issues related to monitoring progress towards the Goals and universal health coverage in order to enhance progress assessment and accountability. The Regional Office for South-East Asia completed a first measurement of universal health coverage in the Region.

In 2017, the **Global Observatory on Health Research and Development**, a new initiative to gather information on research spending, was launched. Various initiatives to support health research have also been implemented in the regional offices.

European health information networks

In 2016, the WHO European Region adopted an action plan to strengthen the use of evidence, information and research for policy-making.

The European Health Information Initiative serves as a framework for coordinating and implementing the activities outlined in the plan. Coordinated by the Regional Office, it supports the integration and sharing of existing knowledge, expertise and good practices in health information, and provides a vehicle for integrating regional health information.

Membership of the European Health Information Initiative has grown rapidly: in December 2017, there were 38 participants, mostly Member States and international organizations. Now, most of the Region is involved in health information activities through information networks linked to the Initiative.

Improved data

**on substandard and falsified medical
products with WHO's new surveillance
and monitoring system**



Health centre rebuilt in Syria's Aleppo city

.....

The ongoing civil conflict in Syria has devastated one of the more advanced health care systems in the Middle East. In 2016, over half the country's hospitals and health centres were closed or only partially functioning and two thirds of health professionals had fled the country.

In eastern Aleppo city, all public hospitals and 18 of the 21 primary health care centres were non-functional due to significant infrastructure damage, staff shortages and limited medical supplies.

After aid agencies gained access to Aleppo in January 2017, the rehabilitation of the Saad Ibn Abi Waqas health centre began, with contributions from WHO and support from the Government of Japan. The centre reopened in September 2017 with five specialized clinics for internal medicine, reproductive health and child care, and orthopaedic and dermatological care. Not only is this a major step forward in providing health care in the area, it is also generating employment for medical staff who had lost their jobs. Services are provided by 34 health workers, including 10 physicians and 12 nurses.

WHO considers that the reopening of the centre could provide a model to encourage families and medical staff to return to their neighbourhood and jobs and resume their normal lives.

Refugee Health in Turkey: a breakthrough model in public health

.....

Turkey hosts the largest number of refugees in the world and the Refugee Health Programme is part of the country's health response to the Syrian conflict.

In 2016, the government enacted a law that allows Syrian health professionals to enter the workforce in the Turkish health system. Since then more than 1200 Syrian health care providers have been trained in 7 Refugee Health Training Centres and more than 600 Syrian medical staff have been hired by the Ministry of Health to provide health services for Syrian refugees.

The WHO Regional Office for Europe is working closely with the Ministry on this initiative. The Centre links culture and health and uses an innovative solution to the challenge of large population movements.

Looking forward

WHO will vigorously support every country to make progress towards achieving universal health coverage, leaving no one behind, as articulated in Sustainable Development Goals indicator 3.8.1. In order to reach that goal by 2030, the world will need, at the very least, to meet WHO's own goal of one billion more people benefiting from universal health coverage by 2023. Challenges in securing resources may mean that further prioritization is required, notably in the area of health systems information and evidence.

Universal health coverage cannot succeed unless governments commit to raising US\$ 4 billion to scale up efforts and facilitate changes in how Member States and the Secretariat work. The tools needed are already available, but without the political will to finance them there can be no universal health coverage.

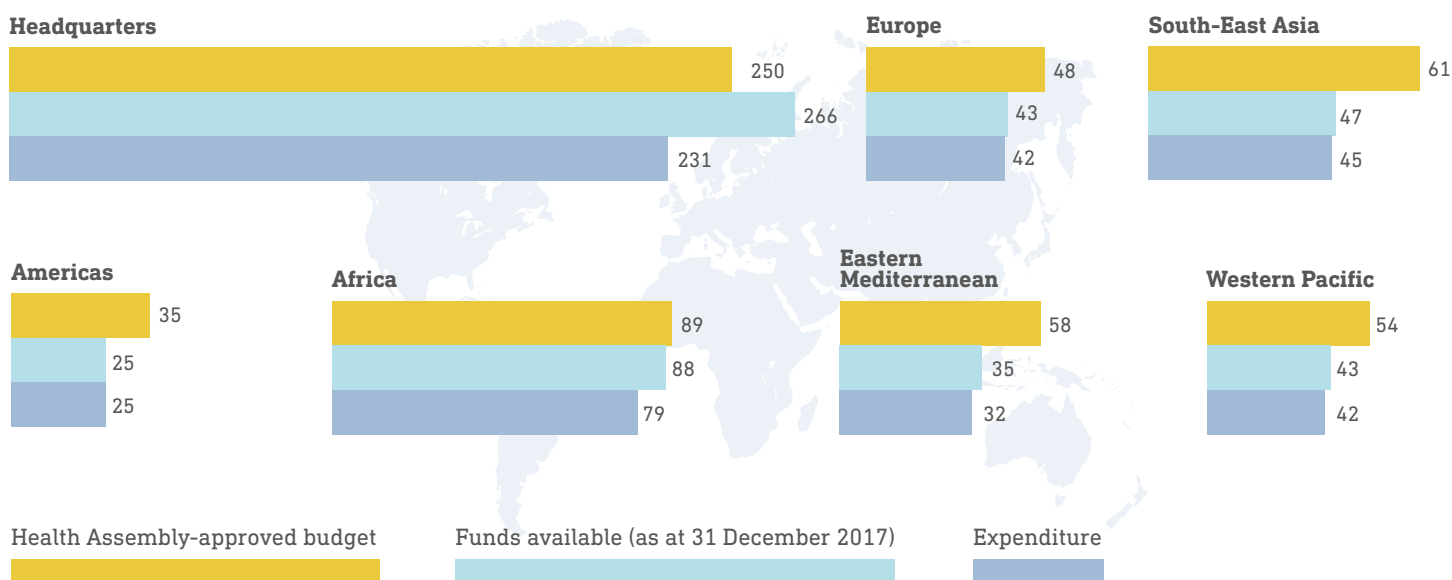
Key figures for 2016–2017

Approved Programme budget: US\$ 595 million

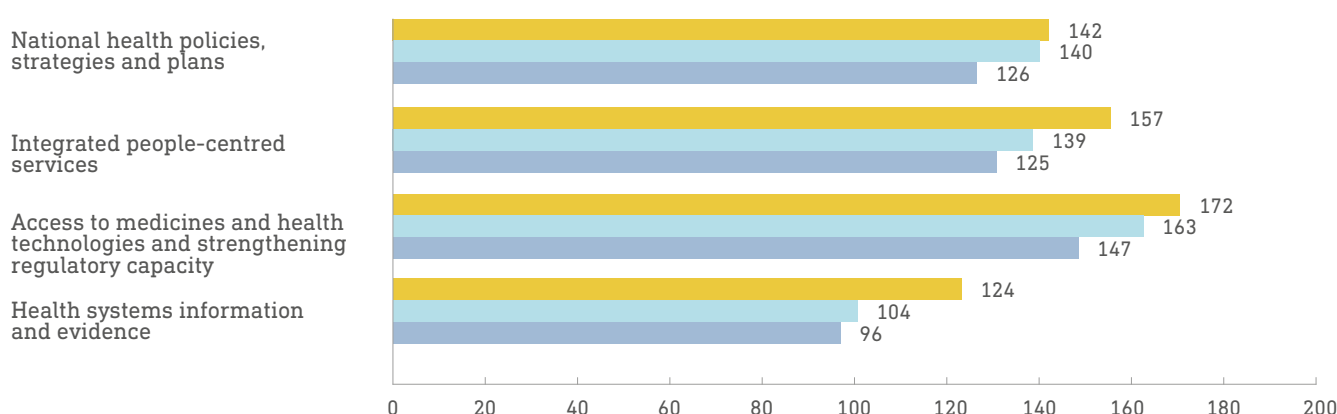
Funds available: US\$ 546 million (92% of Programme budget)

Expenditure: US\$ 494 million (83% of Programme budget, 91% of available resources)

Budget, funds available and expenditure by major office (in US\$ millions)



Budget, funds available and expenditure by programme (in US\$ millions)



Budget and financing

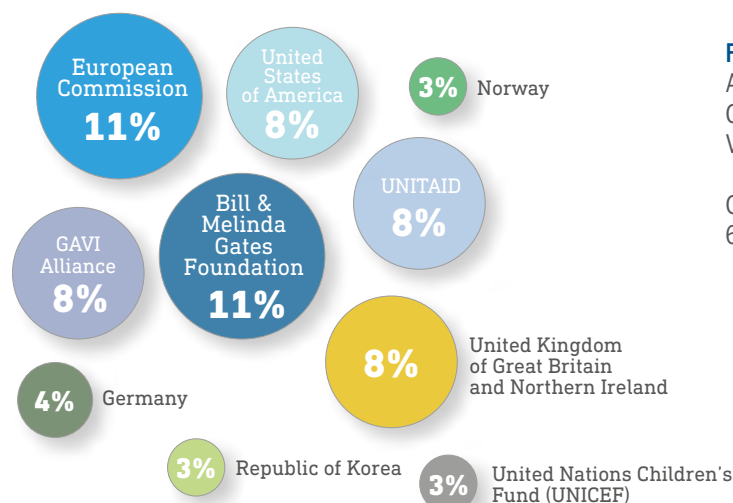
The Category raised 93% of funds compared to the approved Programme budget. Furthermore almost half the available funds are flexible, which is relatively high compared with other areas. Most of the voluntary contributions are highly specified for “Access to medicines and health technologies and strengthening regulatory capacity”. That also explains why, at headquarters, the available funds exceed the budget. Of the Core Voluntary Contributions Account, 8% goes into “Health systems information and evidence” to fill the financing gap in

the regions. However, the data shows that this is not sufficient to cover the gaps.

Overall, the areas under health systems are underfunded mainly because of the highly specified nature of some funding and insufficient funding for health systems work in the regions and countries.



Top 10 voluntary contributors (specified)



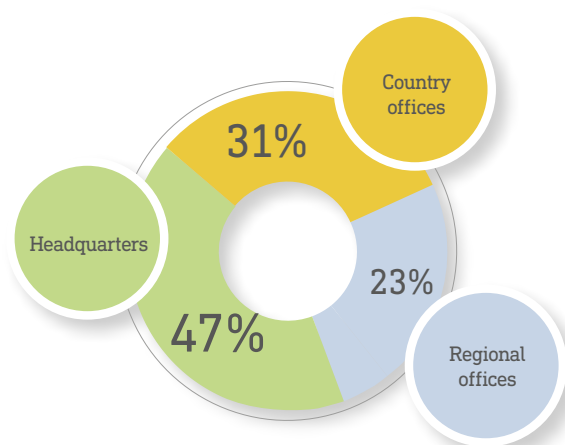
Funding source::

Assessed contributions: 33%
Core Voluntary Contributions Account: 8%
Voluntary contributions – specified: 59%

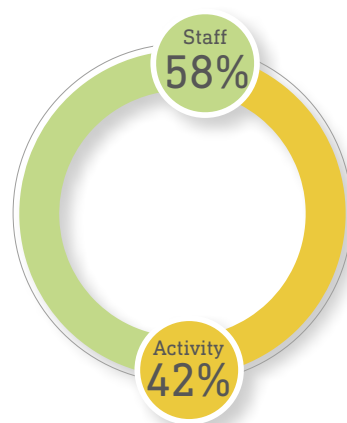
Of the total voluntary contributions specified, 62 % were from 10 contributors (shown beside)



Expenditure by level



Expenditure: staff vs. activity



Expenditure

One third of expenditure was invested directly at country level to implement initiatives with national governments. Most of the investment funding is spent on national health policies, strategies and plans and on integrated people-centred services. In Sierra Leone, the country with the highest expenses, funds were mainly used to implement the health sector recovery plan, as part of the response to Ebola virus disease. In other countries, expenses are more closely related to the formulation of national health plans.

A significant part of the funding is also spent at headquarters, especially on global assessment work and research. Implementation against available funding is relatively high in all regions except at the country level in the African Region, owing to the high specificity of voluntary contributions.

WHO HEALTH EMERGENCIES PROGRAMME

“

Preparedness requires more than emergency plans and simulation exercises... It means building resilience, strengthening core aspects of health systems, from human resources and access to medicines, to health information systems and even legal measures to support public health action.

Dr Carissa F. Etienne
Regional Director for the Americas

”



Programme areas

**Infectious
hazard
management**

**Country health
emergency
preparedness
and the
International
Health
Regulations
(2005)**

**Health
emergency
information
and risk
assessment**

**Emergency
operations**

**Emergency
core services
(management,
administration
and external
relations,
planning and
performance
management)**

Key objectives



All countries are equipped to prevent and control risks from **high-threat infectious hazards**



All countries assess and address **critical gaps** in health emergency **risk management capacities**, including those under the **International Health Regulations (2005)**



Global surveillance and early warning systems rapidly detect and assess the risk of new public health events



Populations affected by health emergencies have access to **essential life-saving health services** and public health interventions



National health emergency programmes are **supported by** a well-resourced and efficient **WHO Health Emergencies Programme**

The direct health impact of emergencies is severe. During the biennium millions of people have been affected by infectious disease outbreaks. In humanitarian crises, direct impacts go far beyond infectious disease risk to include a wide range of short- and longer-term health risks.

Every country is vulnerable to epidemics and emergencies. Early detection, risk assessment, information sharing and rapid response are essential in to avoiding illness, death and economic losses on a large scale. However, not all countries have the same health emergency risk management capacities. In today's interconnected world, we are only as safe as our weakest link.

Health emergencies weaken health systems. Conversely, weak health systems amplify health emergencies. Strong health systems are our best defence in preventing disease outbreaks from becoming epidemics and in mitigating the risks caused by the breakdown of health systems in fragile settings, such as those caused by conflict.

In these settings, WHO focuses on preventing the collapse of health systems, maintaining critical services for the people most in need, and helping to rebuild resilient health systems after crises. Fragile, vulnerable and conflict settings account for a large proportion of high-impact epidemics and unmet Sustainable Development Goals, and therefore require intensive collaboration in order to make the world safer, serve the most vulnerable and promote health.

Key achievements

Prepare

Assessing and addressing critical gaps in health emergency risk management

The Secretariat has continued to work with Member States and partners to increase health emergency risk management capacities across all phases of emergency management through implementation of the **International Health Regulations (2005)** and the **Sendai Framework for Disaster Risk Reduction 2015–2030**.

WHO has worked collaboratively to progressively strengthen the capacity of national authorities and local communities to manage health emergencies by taking an all-hazards approach and by building strong public health-oriented and people-centred health systems.

WHO has provided technical support and assistance in preparing assessments, simulations, and after-action reviews – as well as in translating the findings of these assessments and simulations into national action plans.

67
joint external
evaluations

17
after-action
reviews

68
simulation
exercises

Countries **increasingly prepared** to address outbreaks and emergencies with health consequences

National capacities strengthened to make the world safer

Pakistan, with other Member States, is a State Party to the International Health Regulations (2005) and is committed to building resilient health systems that can adapt and respond to the challenges posed by outbreaks, other health hazards and emergencies of national and international concern. Pakistan was the first country in the Eastern Mediterranean Region to volunteer for, and successfully conduct, a Joint External Evaluation of its core capacities under the International Health Regulations (2005) in 2016. The results and recommendations of the Joint External Evaluation formed the basis of the country's costed 5 Year National Action Plan for Health Security. The Plan is aimed at developing a strong public health system in keeping with the standards and competencies required to implement the International Health Regulations (2005).



Prevent

Preventing and controlling risks from high-threat infectious hazards

Together with partners, WHO developed and led the adoption of two major global strategies for disease prevention and control, **Ending Cholera – A Global Road Map to 2030** and **Eliminating Yellow Fever Epidemics (EYE) by 2026**. WHO also took the lead in drawing up the work plan to improve global preparedness and response to Middle East respiratory syndrome coronavirus (MERS-CoV), **the Pandemic influenza preparedness (PIP) High Level Implementation Plan II** and national influenza pandemic plans.

WHO is working closely with partners on the implementation of the **research and development blueprint for action to prevent epidemics**. The overall goal of the blueprint is to reduce delays between the detection of an outbreak and the deployment of effective medical interventions to save lives and minimize socioeconomic disruption. Bringing research into the mainstream of WHO's response is successfully reducing the time needed for products to be available to those who need them.

2 global prevention and control strategies for priority epidemic-prone diseases (such as cholera and yellow fever)

Research and development blueprint:

6 target product profiles

2 diagnostic target product profiles developed for several priority pathogens

Detect

Rapidly detecting and assessing the risk of new public health events

WHO established continuous, event-based surveillance of public health events, with verification and assessment activities as required. A standardized risk assessment process is systematically applied across the three levels of the Organization. The Secretariat continues to work with Member States to build national and international surveillance and detection systems and capacities.

Critical tools for emergency information management have been strengthened, such as the **Early Warning Alert and Response System (EWARS)** for infectious disease surveillance, and the **Health Resources Availability Monitoring System (HeRAMS)** to assess health service availability in crisis settings. Global implementation of the Event Management System, an online platform for documenting event response, and the creation of a health emergencies dashboard have dramatically improved WHO's capability in the global management of public health risks.

5000
signals
screened

300
events
followed up

30
events
investigated
per month

Respond

Providing access to essential life-saving health services and public health interventions

WHO responded to 50 emergencies in 47 countries and territories, targeting over 70 million people for humanitarian assistance. Among the acute emergencies, nine were classified as Grade 3 emergencies, which is the highest level based on the Emergency Response Framework, requiring a major WHO response and mobilization of substantial Organization-wide support for the collective response with partners.

Major events triggering substantive WHO operations included: the food famine/pre-famine crisis across the Horn of Africa; the conflict and displacement in the north-eastern part of Nigeria; and the deteriorating humanitarian and health situations in South Sudan and the Democratic Republic of the Congo. Major disease outbreaks also requiring a scaled-up WHO response included: Ebola virus disease and cholera in the Democratic Republic of the Congo; plague in Madagascar; Marburg virus disease in Uganda; yellow fever and malaria in Nigeria; malaria in Cape Verde; and necrotizing cellulitis in São Tomé and Príncipe.

WHO continued supporting the response in countries experiencing an escalation in humanitarian and health

Rapid detection through effective surveillance

The timely alert by local authorities of suspected cases of Ebola virus disease, in April 2017, triggered an immediate and effective response to the outbreak in the Democratic Republic of the Congo, which came to an end in July 2017.

The early announcement of the outbreak by the Government, the testing of blood samples as a result of strengthened national laboratory capacity, rapid response activities by local and national health authorities with the robust support of international partners, and speedy access to flexible funding, led to a rapid containment of the outbreak.

Critical coordination support was provided on the ground by the WHO Health Emergencies Programme and an incident management system was set up within 24 hours of the outbreak being announced. WHO deployed more than 50 experts to work closely with the Government and partners. The rapid control and containment of the 2017 Ebola virus disease outbreak in the Democratic Republic of the Congo cost the international community less than US\$ 2 million (compared with the more than US\$ 3.5 billion spent on containing the West African Ebola virus disease outbreak).



emergencies, including Iraq, Somalia, the Syrian Arab Republic and Yemen.

Working with partners, WHO supported the efforts of national governments with life-saving interventions, in order to increase the quality and coverage of health services, strengthen primary and secondary health and hospital care by operating mobile teams and health facilities, improve surveillance and early warning systems, conduct vaccination campaigns, distribute medicines and supplies, and train health workers. WHO also led or co-led health sector coordination.

No new Public Health Emergency of International Concern, as per the International Health Regulations (2005) was declared in 2017.

International networks of partners include the **Global Outbreak Alert and Response Network**, the **Global Health Cluster**, **Emergency Medical Teams and Standby Partners**, which are providing technical assistance and life-saving services to affected populations.

In 2017 more than 700 partners across 23 Health Clusters worked collectively to address the needs of over 70 million people, led by WHO



Providing life-saving services to vulnerable populations

In Yemen, despite significant operational challenges, WHO and health sector partners are responding to the health needs by: expanding coverage of public health interventions in all districts; strengthening surveillance; improving vaccination programmes and controlling outbreaks; providing life-saving and life-sustaining services to people with chronic illnesses; and responding to outbreaks, including cholera and diphtheria, with comprehensive disease control actions.

For example, in November 2017, WHO delivered medicines to tackle an outbreak of diphtheria, it warned that sustained humanitarian access was critical to stopping its spread. The shipment of 1000 vials of life-saving anti-toxins and 17 tonnes of medical supplies had finally arrived in Sana'a after being stalled by the three-week closure of ports and airports. The anti-toxins can help stop the spread of the bacterium to vital organs in patients already infected with diphtheria. No supplies had been available in Yemen before the arrival of the WHO shipment. Left unchecked, diphtheria can cause devastating epidemics, mainly affecting children.

Despite the conflict and previous port closure, WHO, UNICEF and partners continued to work with the available supplies, vaccinating 8500 children under 5 years of age in al-Sadah and Yarim districts in the Ibb Governorate during November.

WHO is also actively involved in rebuilding existing therapeutic feeding centres and it has distributed 120 nutritional kits to all centres in Yemen. These life-saving kits can treat up to 6000 cases of severe acute malnutrition. In addition, WHO is training health workers to work in and to manage the centres.



The El Niño phenomenon 2015–2016, namely a warming of the central to eastern tropical Pacific Ocean, affected more than 60 million people, particularly in eastern and southern Africa, the Horn of Africa, Latin America and the Caribbean, and the Asia-Pacific region. WHO and its partners supported nearly 30 countries as they responded to the health effects of El Niño.



Looking forward

WHO's strategic priorities are:

- to build and sustain the resilient national, regional and global capacities required to keep the world safe from epidemics and other health emergencies;
- to ensure that populations affected by acute and protracted outbreaks and emergencies have rapid access to essential life-saving health services, including health promotion and disease prevention.

WHO's aim is to see that 1 billion more people better protected from health emergencies, in accordance with Sustainable Development Goal indicator 3.d.1 (International Health Regulations (IHR) capacity and health emergency preparedness). Working towards this goal makes the world better prepared for health emergencies by measurably increasing the strength and resilience of health systems for a population of 1 billion people.

The Secretariat will work with Member States and partners to increase risk management capacities across all phases of emergency management, from risk prevention, emergency preparedness, response and recovery through the implementation of the International Health Regulations (2005) and the Sendai Framework for Disaster Risk Reduction. National action plans to build and maintain critical core capacities – in response to after-action reviews and internal and external assessments, and tested through simulations – serve to better protect populations at local, national and global levels.

WHO will continue to work with national authorities and partners to ensure that essential, life-saving health services, including health promotion and disease prevention, reach the people most in need.

Ensuring cooperation and buy-in from national partners, especially in sharing data and developing compliance with the core capacities required by the International Health Regulations (2005), will be crucial in building resilience and ensuring an effective and cohesive response in emergencies.

Securing long-term, predictable, transparent and flexible funding and employing highly-qualified technical staff will safeguard the delivery of services to populations most in need. At the same time, WHO must work to address the security risks during emergencies and in fragile contexts, in order to ensure the safety of its staff and allow safe access to populations in need.

Efforts will continue to strengthen emergency administrative processes and promote effective programme delivery.

In fragile, conflict and vulnerable settings, working closely together with other programmes across WHO and with partners, the WHO Health Emergencies Programme will focus on preventing health system collapse, maintaining critical health services, protecting health security and rebuilding health systems after crises. Pursuing joint solutions with a multitude of partners to effectively tackle global humanitarian health challenges will continue to be a priority for WHO in the future.

Key figures for 2016–2017 WHO Health Emergencies Programme

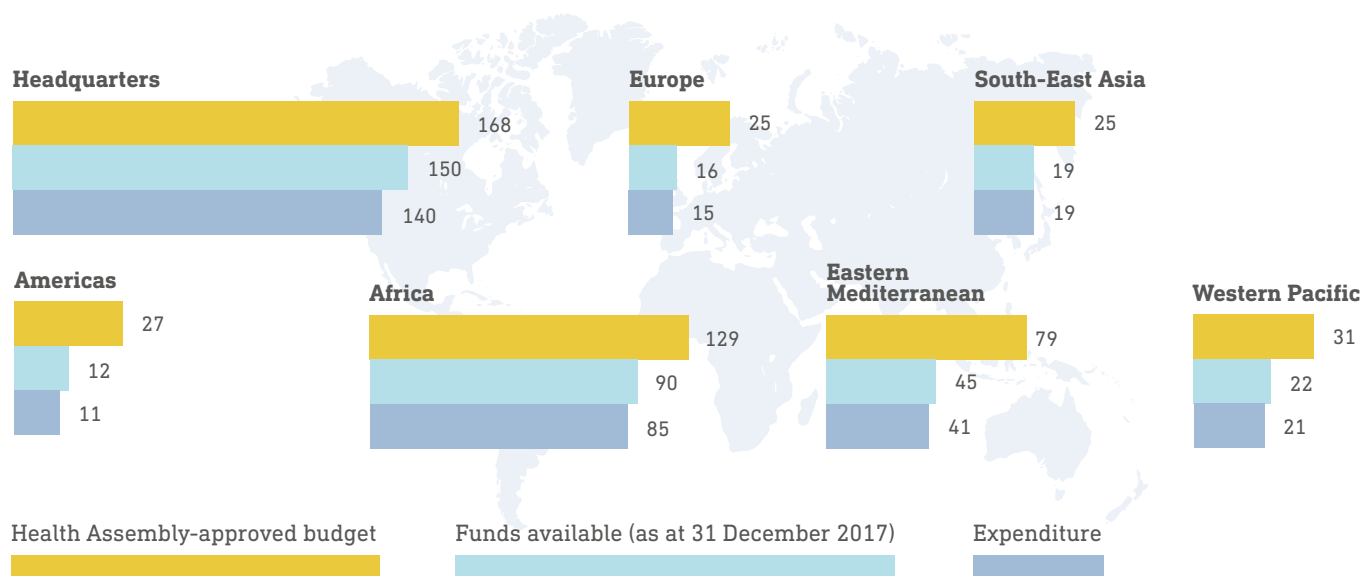
Approved Programme budget: US\$ 485 million

Funds available: US\$ 354 million (73% of Programme budget)

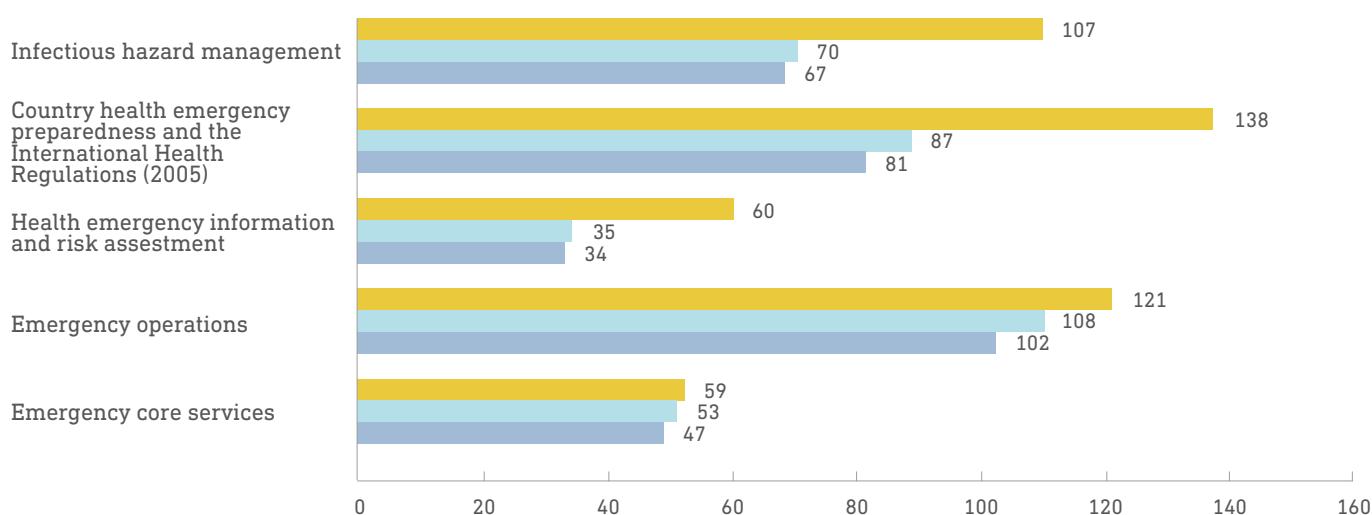
Expenditure: US\$ 330 million (68% of Programme budget, 93% of available resources)



Budget, funds available and expenditure by major office (in US\$ millions)



Budget, funds available and expenditure by programme (in US\$ millions)



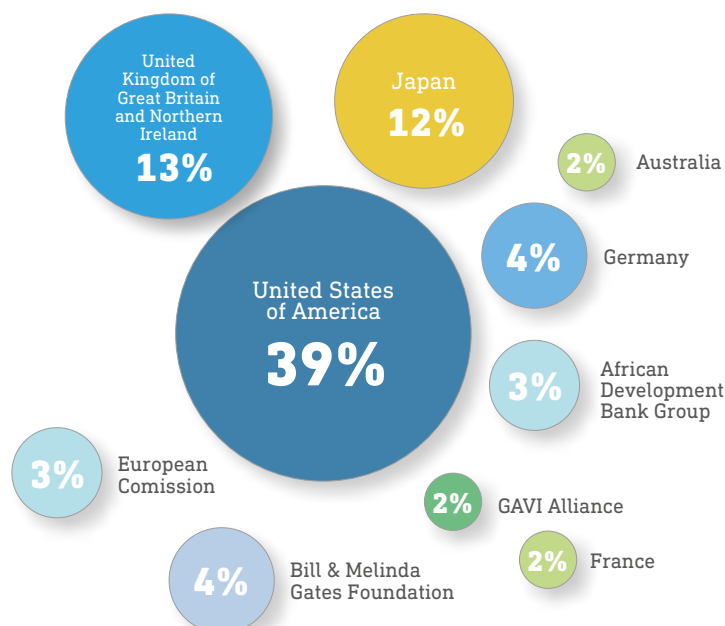
Budget and financing

For the biennium, the budget of the WHO Health Emergencies Programme stood at US\$ 485 million, up from US\$ 342.2 million in July 2016, when the Programme had been established. That represents a 42% increase in the budget, based on decision WHA69(9) (2016).

Towards the new budget, Member States provided US\$ 354 million, or 73% of the approved budget. Moving into 2018, a more sustained commitment will be required to ensure that programme areas across the three levels of the Organization, particularly at country level, will have sufficient capacity to deliver on the expectations of Member States.



Top 10 voluntary contributors (specified)



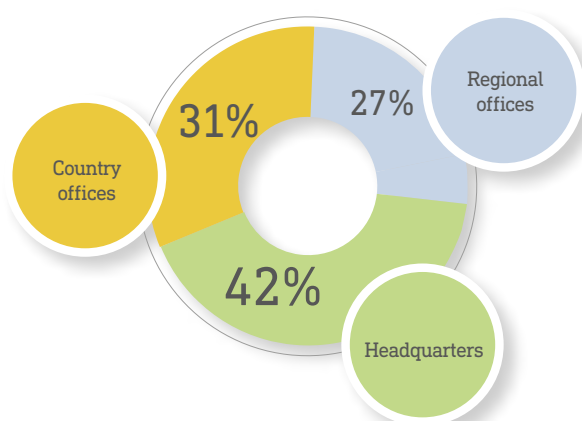
Funding Source:

Assessed contributions: 21%
Core Voluntary Contributions Account: 8%
Voluntary contributions – specified: 71%

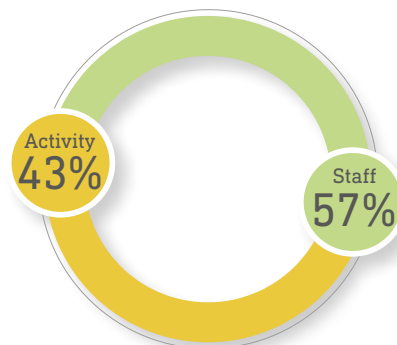
Of the total voluntary contributions specified, 84% were from 10 contributors (shown beside)



Expenditure by level



Expenditure: staff vs. activity



Expenditure

The Programme has demonstrated its capacity to deliver, having implemented 93% of the available funds.

Professional capacity at country and regional levels has been significantly increased during the biennium, with a 37%

increase at country office level (from 77 to 107 occupied professional positions) and a 74% increase at regional office level (from 78 to 136 occupied professional positions).

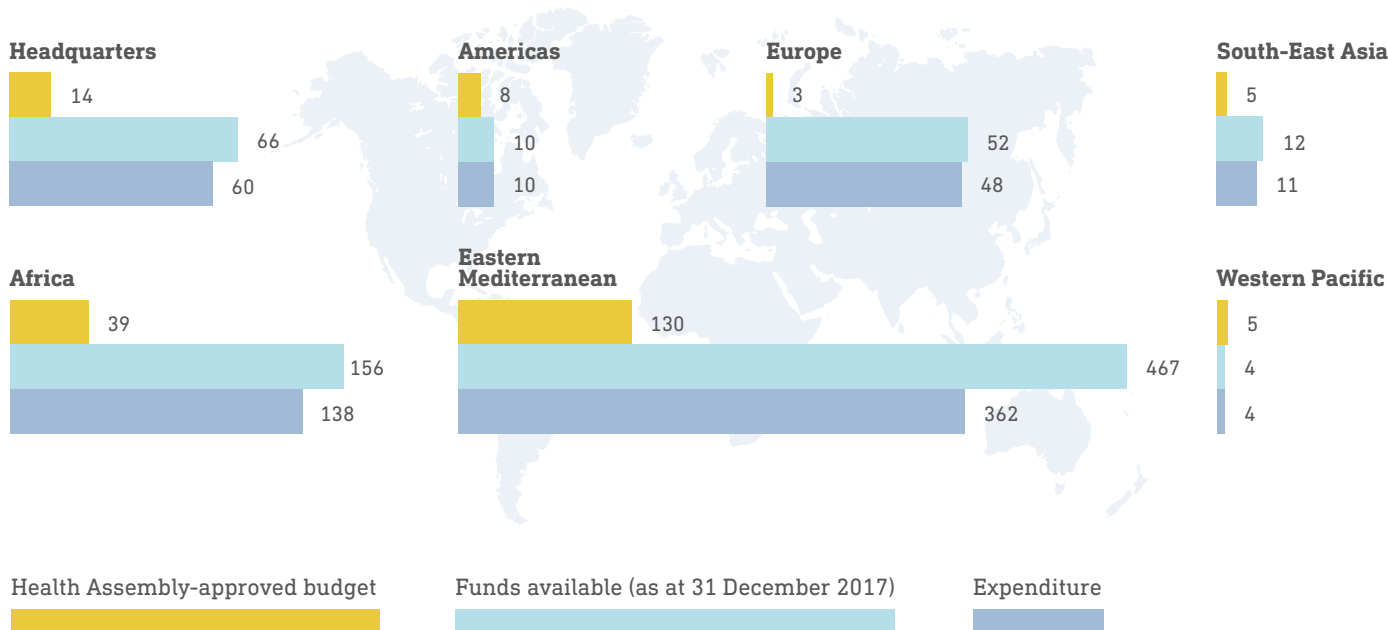
Key figures for 2016–2017 Outbreak and crisis response

Approved Programme budget: US\$ 205 million (event driven)

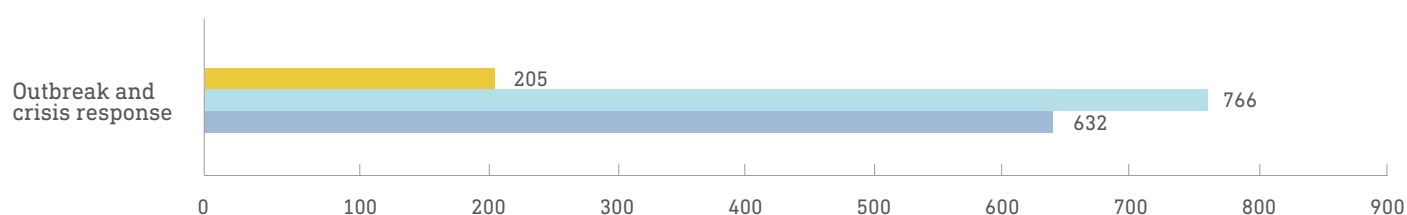
Funds available: US\$ 766 million (374% of Programme budget)

Expenditure: US\$ 632 million (308% of Programme budget, 83% of available resources)

Budget, funds available and expenditure by major office (in US\$ millions)



Budget, funds available and expenditure by programme (in US\$ millions)



Budget and financing

The budget approved by the Health Assembly for the Outbreak and Crisis Response segment stands at US\$ 205 million. Owing to the event-driven nature of this budget segment and the level of financing for responding to the different emergency events, the total budget allocation had been increased to US\$ 1033 million by the end of 2017. As at 31 December 2017, the total available resources amounted to US\$ 766 million, of which US\$ 633 million had been expended.

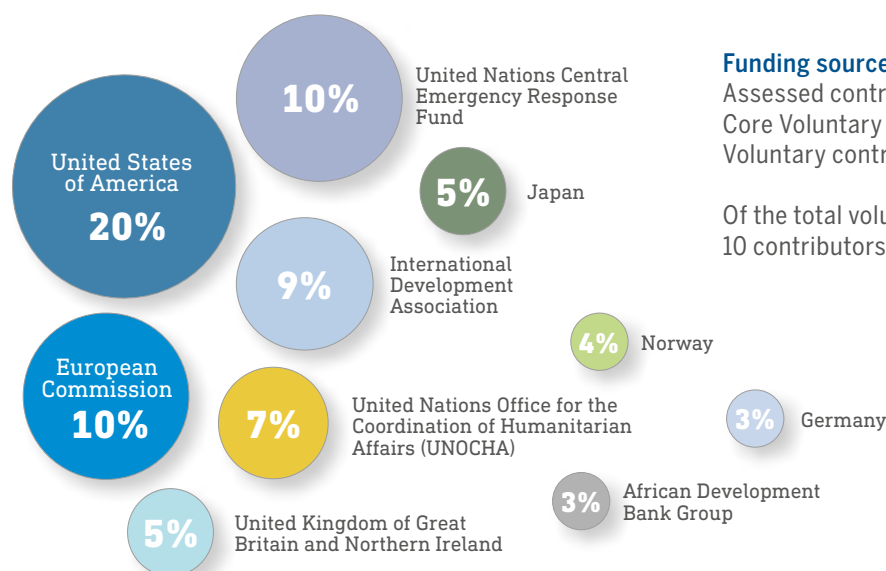
In order to facilitate the scale-up of WHO's initial response to outbreaks and emergencies with health consequences, the

Contingency Fund for Emergencies was established in May 2015. As at 31 December 2017, the Fund had received US\$ 44 529 731 from the following countries: Canada, China, Estonia, France, Germany, India, Japan, the Republic of Korea, the Netherlands, Sweden and the United Kingdom of Great Britain and Northern Ireland.

Ten donors account for 81% of outbreak and crisis response funding.



Top 10 voluntary contributors (specified)



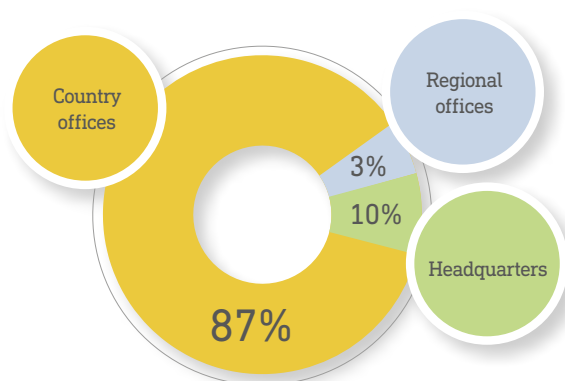
Funding source:

Assessed contributions: 1%
Core Voluntary Contributions Account: 1%
Voluntary contributions – specified: 98%

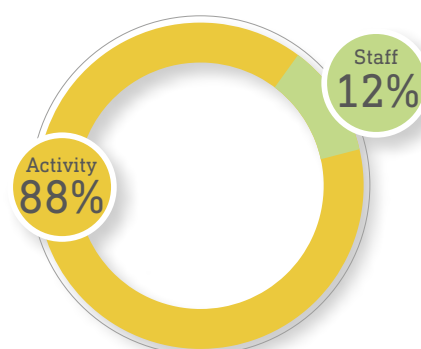
Of the total voluntary contributions specified, 76% were from 10 contributors (shown beside)



Expenditure by level



Expenditure: staff vs. activity



Expenditure

87% of expenditure on outbreak and crisis response was incurred at the country level, with support provided by WHO headquarters (10%) and regional offices (3%).

More than half of the expenditure is on medical supplies and materials (26.5%) and contractual services (29.8%), reflecting the fact that the short-term expertise often required to respond to crisis situations.

Most of the expenditure was in the Eastern Mediterranean Region (57.1%) and the African Region (21.7%), reflecting the distribution of outbreaks and emergencies worldwide.

PROMOTING HEALTH THROUGH THE LIFE COURSE

“

We must address the determinants of health — many of which have roots that stretch far outside the health sector. To address them, we must work across all sectors and settings. We must take collaboration and cooperation to new heights.

Dr Shin Young-soo

Regional Director for the Western Pacific, October 2017

”



Programme areas

**Reproductive,
maternal,
newborn, child
and adolescent
health**

**Ageing
and health**

**Gender, equity
and human rights
mainstreaming**

**Social
determinants
of health**

**Health
and the
environment**

Key objectives



To improve health at **key stages of life**, from pregnancy to birth to death



To consider various **factors that affect health** (including social, economic and environmental determinants, as well as equity, human rights and gender)



To ensure **adoption of these cross-cutting themes** across the Secretariat and in the work of Member States, thereby enabling an integrative and multisectoral approach

The day a baby takes that first breath on entering the world could be the day that the child's life is most at risk. A birth day may become a death day. In 2016, one million newborn babies died within the first 24 hours after birth. Unfortunately, most mothers and newborns in low- and middle-income countries do not receive optimal care during the critical labour, birth and postnatal periods.

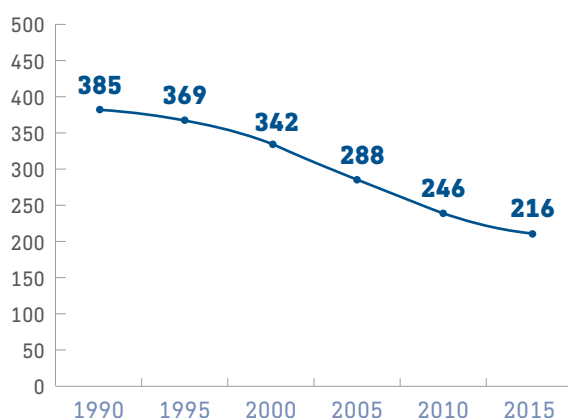
Of the 830 women who die every day from causes related to pregnancy or childbirth, 99% of the deaths occurred in low-resource settings and mostly as a result of well-known, preventable causes. Deep inequities in health care services lie at the root of the problem.

The life course approach recognizes the specific health concerns of different stages of life: early childhood development, women's

health during and beyond reproduction, adolescence, and healthy ageing, which is now the fastest-growing life stage.

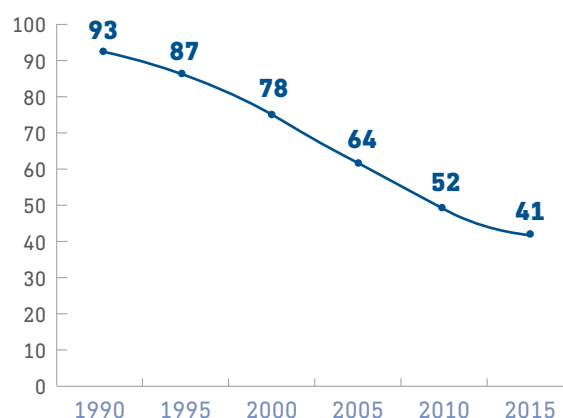
The approach also aims to identify the social, economic and environmental factors that impact health and lead to inequitable health outcomes, with the overall goal of promoting health equity, human rights and gender equality. The work, which promotes a multisectoral approach through its cross-cutting nature, helps Member States move towards attaining a number of related targets under the Sustainable Development Goals, including those for the health of women and children, key environmental determinants of health (such as air and drinking water quality) and reducing inequalities in health.

Maternal mortality ratio (per 100 000 live births)



Today, fewer women die during pregnancy and childbirth because they have better pregnancy care and access to services and facilities for delivery.

Under five mortality rate (probability of dying by age 5 per 1000 live births)



Today, more children live till their fifth birthday.

Key achievements

An ambitious roadmap

A decade ago, one of the starkest examples of inequity in health was the extremely high number of mothers and children under five dying needlessly in poor countries. Today, there has been a dramatic drop in the number of deaths. WHO recommended a life course approach to the problem and invested in research to identify cost-effective, impactful interventions, which were then promoted where needed, notably in the African Region. Yet inequalities persist, with the poorest most at risk, and much work remains to confront this.

30 million
more women using modern contraceptives
from 2012, in countries with the greatest
unmet family planning needs



In line with the Sustainable Development Goals, the **Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)** provides a road map for achieving ambitious targets. The Organization uses its funds in supporting Member States to implement the Strategy through the technical and in-depth knowledge it can bring to, and promote at, all levels. WHO is developing and updating effective interventions, and the best ways to deliver them, and supporting countries to implement and monitor them. Global standard setting has been adapted to regional requirements across WHO, with advice provided at the country level. Specific attention has been given to improving the quality of care and measurement in the areas of sexual, reproductive, maternal, newborn and child health, including equity and rights.

WHO has also helped pave the way in adolescent health, which was absent from national plans a decade ago, and the Secretariat is supporting Member States to implement a comprehensive framework for adolescent health.

68 low- and middle-income
countries showed reduced
inequalities in childhood
immunization coverage,
including no gender gaps



80% of estimated deliveries
attended by a skilled birth
attendant in 2017



Ensuring the best start to life in Viet Nam

Neonatal deaths in Viet Nam account for about 50% of deaths in children under the age of five. The use of outdated and harmful clinical practices by health workers during delivery and immediately afterwards contributed to higher risks for the newborn. Prior to the provision of WHO support, skin-to-skin contact between mother and child – a good indicator of uptake of improved newborn care practices – was rare.

In 2014, Viet Nam endorsed the WHO/UNICEF **Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014–2020)** and adopted early essential newborn care to improve the quality of childbirth and newborn care in health facilities. Three hospitals in the northern, central and southern parts of the country were selected to become centres of excellence, with staff coached on early essential newborn care and a team set up to monitor the quality of care. Selected staff members were trained to be regional coaching facilitators.

Today, half of all national and first-level referral hospitals in the country have adopted early essential newborn care and over 8000 staff have received coaching. Clinical practices have improved, with 94% of term babies receiving life-saving skin-to-skin contact, 56% remaining in sustained contact until the first breastfeed, and 80% being exclusively breastfed in the immediate newborn period. A detailed study by one centre of excellence found a one-third reduction in babies requiring intensive care and over a two-thirds reduction in sepsis.





Beating the “silent killer” of babies in Indonesia

It is known as a “silent killer” that often goes unnoticed by health services. Neonatal tetanus kills newborns at home. Often, these births and deaths are not recorded. Yet the disease is fully preventable with tetanus toxoid vaccines and hygienic birth practices.

In 1988, the disease was killing 800 000 neonates a year. By 2013, prevention efforts brought that figure down by 94%. Yet the risk remained high in remote parts of Indonesia.

The country invested in vaccinating pregnant women and “brides-to-be” in high risk areas, while also improving access to health services in remote regions. The WHO **Innov8** approach to “leave no one behind” led the way in health inequality monitoring.

Indonesia succeeded in eliminating maternal and neonatal tetanus in the last areas affected by the disease (primarily Maluku and Papua) in May 2016. (Elimination is defined as less than one case per 1000 live births in every district). WHO provided technical assistance at various levels and rapid coverage assessments to identify high risk areas. The **Health Equity Assessment Toolkit** (HEAT) helped Indonesia analyse inequality data and produce the first-ever WHO national report on health inequalities. Following this success, maternal and neonatal tetanus is no longer a major public health problem in the South-East Asia Region.

New approach to healthy ageing

Globally, the number of people aged over 60 years will double to two billion during the first half of this century. This massive demographic shift has profound implications for almost every aspect of society. In 2016, following the adoption of resolution WHA69.3, WHO released the **Global strategy and action plan on ageing and health 2016–2020**, which provides a comprehensive framework to guide country action. The Strategy spans the period of the Sustainable Development Goals and calls for a decade of healthy ageing between 2020 and 2030.

Significant progress has been made since its introduction, including:

- 83 countries now with formal national plans on ageing and health;
- guidelines issued for integrated care of older people in primary care settings;
- guidance provided on establishing long-term care systems in sub-Saharan Africa;
- continued development of the WHO **Global Network for Age-friendly Cities and Communities**; and
- significant steps taken towards identification of key indicators for healthy ageing and mechanisms to monitor them.

90 million
people will age in more supportive environments with 304 cities joining the WHO Global Network of Age-friendly Cities and Communities



Adolescent health programming improved substantially in many countries in all regions



In view of the constraints imposed by limited resources, WHO has concentrated its efforts on global research coordinated at headquarters. Consultations at the regional level have focused more sharply on those regions with the fastest ageing populations, but the lessons learned have formed the basis for the continued promotion of the global strategy at all levels. The real impact on ageing populations will depend on the adoption of the new approach by Member States, but WHO has ensured that the foundations for change are in place.

Raising environmental awareness

Unhealthy environments cause one in four deaths among children under five years. Those living in low- and middle-income countries are the worst affected. By investing significantly in research, WHO has drawn global attention to the importance of the problem through major global assessments of specific environmental health risks, such as the ongoing Global Analysis and Assessment of Drinking Water (GLAAS).

WHO's leadership has also helped raise awareness that many sources of air pollution, which causes 6.5 million deaths annually and presents the single greatest environmental threat to health, are also the drivers of climate change.

More than 10% drop in air pollution in one-third of monitored cities in low- and middle-income countries and almost half in high-income nations in the five-year period 2008–2014



WHO has worked to address both issues through:

- the **BreatheLife** campaign, which 40 cities globally have joined, to educate the public, encourage sharing of data and solutions, improve monitoring and help trigger alerts when air quality is dangerous;
- the **Second Global Conference on Health and Climate**, held in Paris in July 2016, which highlighted the role of the public health community in supporting the Paris Agreement;
- a **health, environment and climate coalition** between WHO, UNEP, WMO and other relevant bodies, launched at the twenty-second session of the **Conference of the Parties to the United Nations Framework Convention on Climate Change (COP22)**, held in November 2016, in Marrakesh, Morocco, and reaffirmed at the twenty-third session of the Conference of the Parties (COP23), held in November 2017, in Bonn, Germany.
- The catalysing of high-level political commitment through relevant regional inter-ministerial processes, for example, the **Ostrava Declaration** that resulted from the Sixth Ministerial Conference on Environment and Health, held in Ostrava, Czech Republic in June 2017.
- Raising awareness also depends on evidence, so the 2016 publication of **Preventing disease through health environments**, updating the evidence relating to 90 environment-related diseases, has made a crucial contribution in that regard.

Bringing water to rural Tajikistan

In Tajikistan, 32% of the rural population do not have access to basic drinking-water services (2015). In some areas, water is consumed from unsafe sources – such as unprotected springs and wells, irrigation ditches and canals – which may not meet sanitary requirements and pose a disease risk.

The WHO Regional Office for Europe is supporting a large-scale intervention on water safety planning and water quality surveillance in rural Tajikistan. The two-year project is co-led by the Ministry of Health and Social Protection and is supported by a high-level steering group.

Exceeding expectations, the project has led to a major policy achievement. Water safety planning approaches recommended by WHO have been integrated in a draft law – a milestone for the country and the Region.

Among other achievements of the project are:

- establishment of a national team of water safety plan trainers;
- building the capacity of the water and health sectors for water safety planning and risk-based drinking-water quality surveillance, with a focus on vulnerable rural areas;
- strengthening of the infrastructural and personnel capacity of laboratories for drinking-water supply surveillance and analysis of core drinking-water quality parameters; and
- collecting local experiences through closely monitored and guided pilot projects on water safety planning and risk-based surveillance.

The project is coordinated through the European Centre for Environment and Health and funded by the Finnish Ministry of Foreign Affairs.



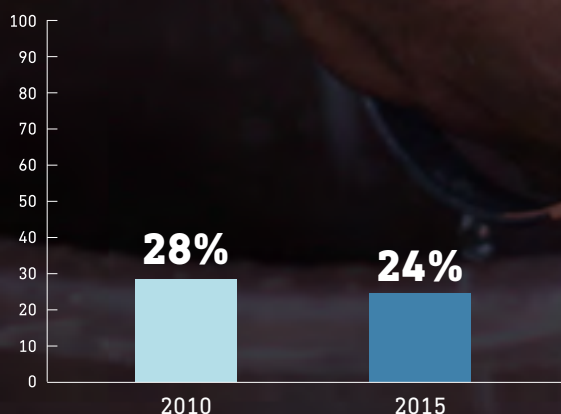


46 countries have adopted legislation in line with WHO guidelines on safe drinking water quality

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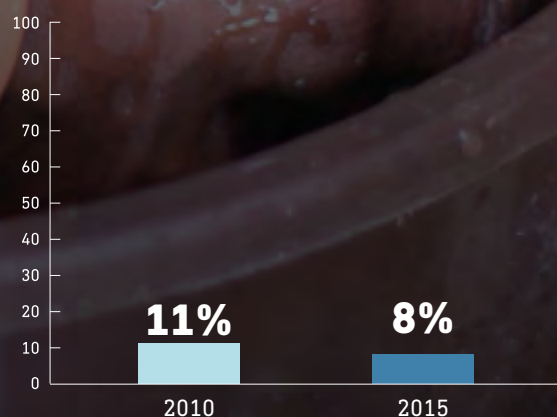
13 countries have developed health adaptation plans for climate change since 2015, increasing the total number of countries from **30 to 43**

Proportion of the population without access to improved sanitation



i Hygienic sanitation facilities are crucial for public health, yet some 2.3 billion people still do not have toilets or improved latrines.

Proportion of the population without access to improved drinking water sources



i Improving access to drinking water can have a significant effect on health

Cross-cutting work to leave no one behind

The ongoing, cross-cutting work to mainstream gender, equity and human rights into WHO's policies and programmes at the three levels of the Organization has been underpinned by a country support package, policy frameworks and a network of focal points. In 2016–2017, with considerable investment at the regional and country level, backed up by consistent support from headquarters, more than 70 countries were enabled to implement at least two WHO supported activities to integrate gender, equity and human rights into health programmes, policies and plans. That includes assessments of barriers to health services experienced by rural and/or disadvantaged populations, for example, the provision of preventive chemotherapy for neglected tropical diseases, and national reviews of diabetes programmes and maternal, child and adolescent health programmes. Health equity policy reviews at the country level have supported health ministries with evidence and policy options in order to engage the whole of government in dialogue on health equity.

16 countries, since 2015, have increased investment in human resource capacity for applying Health in All Policies, increasing the total number of countries from **21 to 37**



A realization of the value of health in all sectors of policymaking is the aim of the **Health in All Policies** agenda, which combines the forces of multiple stakeholders, and aims to improve policy coherence across government. By 2017, a total of 37 countries classified as low- and middle- income had received training to use the Health in All Policies approach, through the development of national road maps and strategies, and increased capacity and improved mechanisms for intersectoral work as a result of the establishment of the Global Network on Health in All Policies. The enhanced linkages with key sectors and global partners will help to attain the Social Development Goal targets. The impacts – such as increased public health promotion measures related to air pollution and other determinants, wider access to medical care for mothers and children, and the growth of age-friendly cities – are already starting to be felt.





Moving forward

The goal of addressing health inequities, often evident in the care of mothers and newborns in low-resource settings, will simultaneously address a wider goal of the Organization and global development: universal health coverage. Indeed, improvements in equitable care for women and children are a powerful indicator of overall equality and fairness in access to care. Thus, the essential work of this Category in overcoming persistent inequalities takes us forward in the march towards universal health coverage.

The life course approach – with its special focus on women, children and adolescents and providing what people need to thrive and survive at all ages – supports this goal. Interventions for the care of newborns, adolescent health and development, family planning and childbirth care will improve access to care services. The impact of such interventions goes beyond saving lives and improving health, yielding benefit-to-cost ratios of 10-to-1. Maintaining functional ability in older people can help reduce health care costs and promote well-being.

WHO will work to define a prioritized, integrated set of interventions to improve human potential. They will include stronger support for country offices and national health authorities to mainstream equity, gender and human rights, establishing mechanisms to measure impact, scaling up efforts to prevent diseases related to air pollution, and continuing to work on the interface between health, environment and climate change. The Organization will also work to advance international commitments to promoting the sound management of chemicals and workers' health.

Key figures for 2016–2017

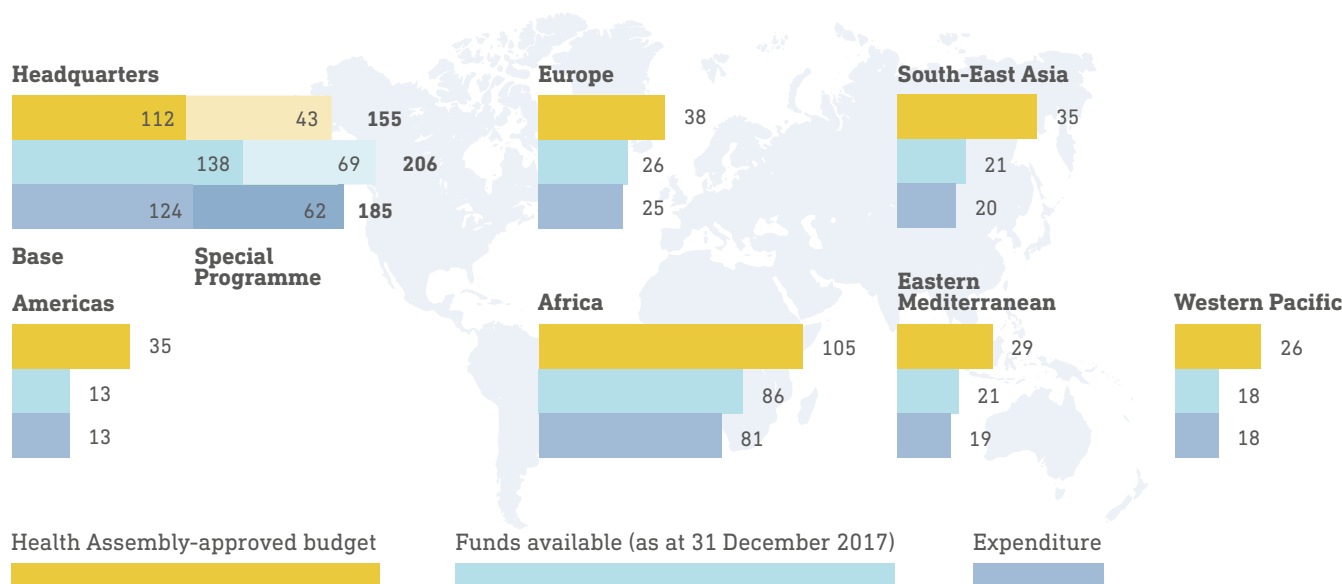
Base:

Approved Programme budget: US\$ 382 million
Funds available: US\$ 322 million (84% of Programme budget)
Expenditure: US\$ 300 million (79% of Programme budget, 93% of available resources)

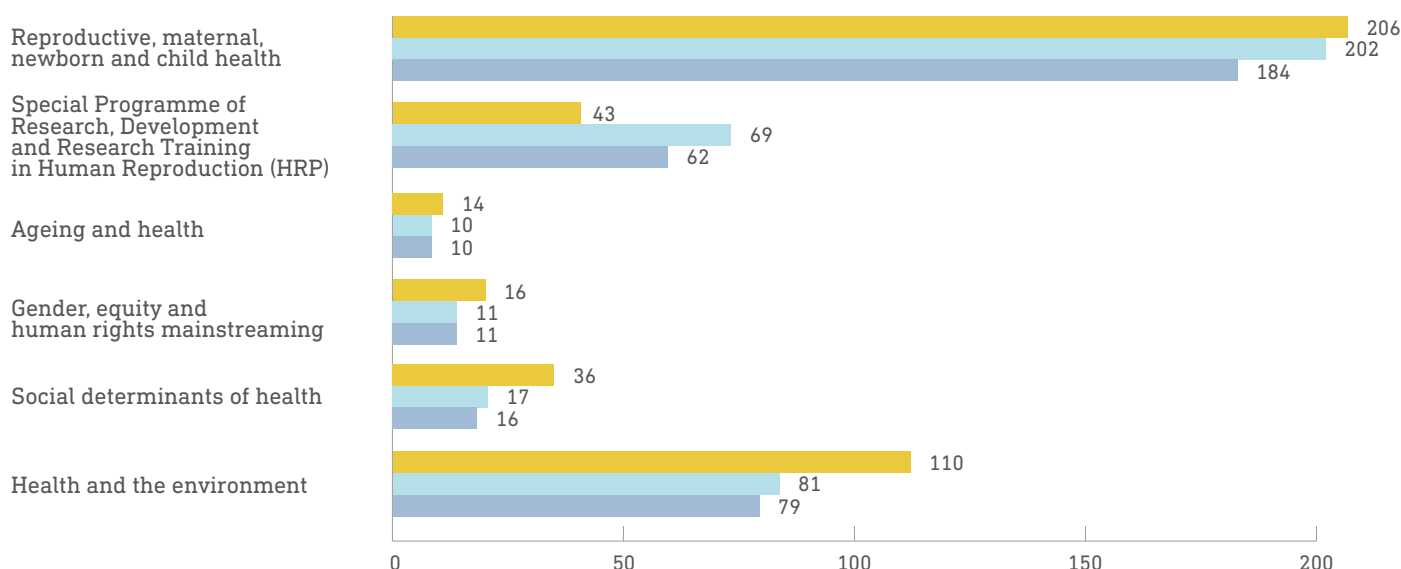
UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP):

Approved Programme budget: US\$ 43 million
Funds available: US\$ 69 million (160% of Programme budget)
Expenditure: US\$ 62 million (144% of Programme budget, 90% of available resources)

Budget, funds available and expenditure by major office (in US\$ millions)



Budget, funds available and expenditure by programme (in US\$ millions)



Budget and financing

Work in this area benefits from a large donor base that provides 90% of its funding through agreements under US\$ 1 million. Small projects of this type do pose a challenge to global strategy coherence and implementation.

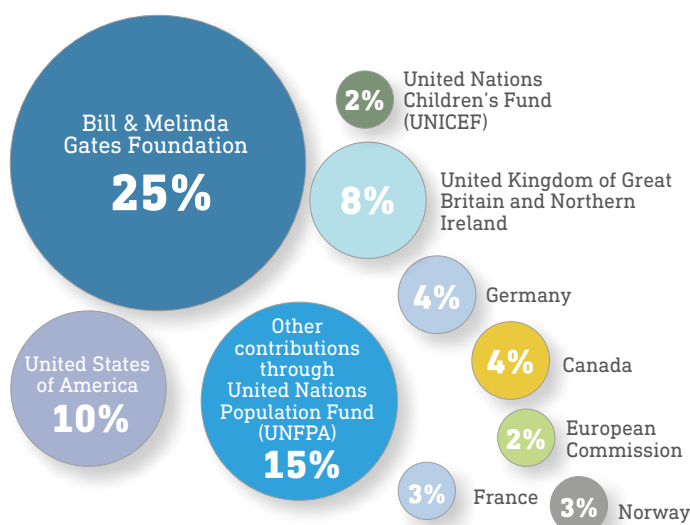
Reproductive, maternal, newborn and child health – A key component of the Sustainable Development Goals and a WHO priority area. Most of the voluntary contributors (for example, Bill & Melinda Gates Foundation, funds through the United Nations Population Fund or Luxembourg) fund this area. The available funds enabled WHO to conduct research at headquarters and implement initiatives at country level.

Health and environment – Voluntary specified funds from the Governments of the Netherlands, Norway, United Kingdom of Great Britain and Northern Ireland and United States of America, together with the Bill & Melinda Gates Foundation, and sourcing of funds through other United Nations agencies, enabled significant progress in this area.

Other programmes – Ageing and health, gender, equity and human rights mainstreaming, and social determinants of health are facing relatively bigger challenges in attracting funding. WHO is filling the gap from its flexible resources in order to deliver on its priorities in these cross-cutting areas, which will further strengthen work and ensure better delivery of results in other areas. A further reduction in flexible resources in these programmes remains a risk.



Top 10 voluntary contributors (specified, base)



Funding source

Base:

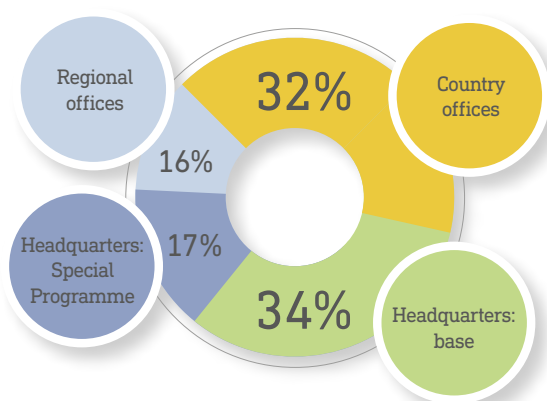
Assessed contributions: 27%
Core Voluntary Contributions Account: 8%
Voluntary contributions – specified: 65%
Of the total voluntary contributions specified, 73% were from 10 contributors (shown beside)

Special Programme of Research, Development and Research Training in Human Reproduction (HRP):

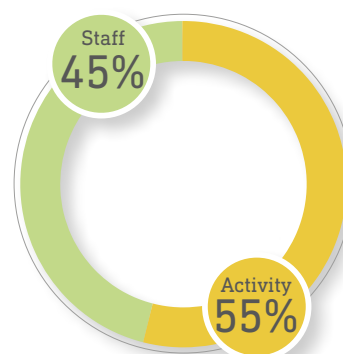
Voluntary contributions – specified: 100%
(25% of total voluntary contributions – specified)



Expenditure by level



Expenditure: staff vs. activity



Expenditure

A third of expenditure was invested directly at the country level to implement initiatives with national governments. A significant amount went on strengthening human resource capacity in programmes improving the health of women, children and adolescents, as well as on managing the health impacts of environmental risks.

WHO carries out much-needed normative functions and research and provides strategic support. It spends 45% of its funds on human resources to ensure that those functions are delivered. A significant proportion of expenditure is at

headquarters, where research, including research under the HRP, accounts for 33%. Although the expenditure is recorded at headquarters level, the actual work is delivered through partner research institutions and support for research on implementation in countries. The amounts of resources and expenditures against the budget are relatively high for reproductive, maternal, child and adolescent health, and for programmes on water, sanitation and hygiene (WASH), air pollution and urban health, masking the significant challenge that WHO continues to face in attracting sufficient resources to deliver capacity building and policy and technical support in countries.

NONCOMMUNICABLE DISEASES

“

More must be done to curb the death and disability toll from noncommunicable diseases. With our knowledge of what works, we cannot simply stand by while people die prematurely of preventable diseases. At least 80% of people affected by heart disease, stroke and diabetes and 40% of those suffering from cancer, would have remained healthy if the major risk factors, such as alcohol, tobacco, unhealthy diets and physical inactivity, had been tackled.

Dr Zsuzsanna Jakab
WHO Regional Director for Europe

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Programme areas

Non-communicable diseases

Mental health and substance abuse

Violence and injuries

Disabilities and rehabilitation

Nutrition

Food safety

Key objectives



To reduce **premature mortality** from noncommunicable diseases through prevention and treatment



To promote **mental health and well-being**



To reduce the number of **deaths and disabilities from injuries and violence**



To promote function and improve the lives of people living with disabilities



To end all forms of **malnutrition**



To respond to **foodborne disease threats**

The gravest threats to life in developing countries are no longer the sweeping plagues or pestilences that once ravaged continents. Today, noncommunicable conditions (including cardiovascular diseases, diabetes, cancers and chronic respiratory diseases) and injuries (including road traffic injuries and those caused by violence) are among the leading causes of premature death and contributors to disability in most countries.

Once called “diseases of affluence”, noncommunicable diseases actually hurt poor populations the most. Their chronic nature means they develop slowly, causing long-term suffering and disability over years, at a considerable cost to families, health systems and economies. Yet noncommunicable diseases are largely preventable by means of public policies that tackle four risk factors: tobacco use, harmful use of alcohol, unhealthy diets and physical inactivity. In addition, the management of noncommunicable diseases is essential in improving health care coverage for the four main conditions and mental health. Similarly, violence and injuries (which account for one in 10 deaths globally) exact their greatest toll in low- and middle-income countries, despite a considerable body of evidence on effective prevention strategies.

Other priorities in this Category include malnutrition in all its forms, foodborne diseases, mental health and neurological conditions, substance abuse, disability, rehabilitation, oral health, and eye and ear health. The work recognizes the common risk factors shared by many of these conditions, and the need to strengthen health systems for better outcomes, particularly given that multi-morbidities are the new norm. It promotes a multisectoral approach to influencing public policies in areas like agriculture, trade and finance, and helps countries move towards attaining a number of related targets under the Sustainable Development Goals.

Key achievements

Noncommunicable diseases, which account for 70% of deaths globally, are now recognized as one of the major challenges to development in the 21st century. Curbing them requires countries to develop whole-of-government and whole-of-society approaches and to implement packages of effective and

affordable public policies. That approach has helped countries to address capacity gaps and to support policy integration, data management, partnerships and financing.

Interventions range from taxation of tobacco, alcohol and sugar-sweetened beverages to good seat-belt laws which apply to all vehicle occupants. Such packages of “best buy” interventions are well aligned with the Sustainable Development Goals.

Leaders pledge action on noncommunicable diseases in Montevideo

To combat waning political action on noncommunicable diseases, WHO convened a high-level conference in Montevideo in October 2017 attended by representatives of all three levels of the Organization – country, regional and headquarters – and the Government of Uruguay, led by President Tabare Vasquez.

At the meeting, Heads of State and government ministers pledged further action to reduce by one-third – by 2030 – the 15 million global premature deaths (people under 70 years) from noncommunicable diseases. They also endorsed the Montevideo Roadmap 2018–2030 on Noncommunicable Diseases as a Sustainable Development Priority that will guide work in the lead up to the United Nations General Assembly third High-level Meeting on the prevention and control of noncommunicable diseases in 2018.

Focusing on high returns of investment

A decade ago, one of the starkest examples of inequity in health was the risk of dying prematurely from heart disease, stroke, cancer, diabetes or chronic respiratory disease, ranging from less than 10% in rich countries to more than 40% in poor countries. Remarkable progress has been made in an increasing number of countries. For example, all 53 countries in the European Region are expected to achieve the Sustainable Development Goal target for reducing premature mortality from four major noncommunicable diseases by 2030. WHO has recommended a whole-of-government approach to the problem and identified cost-effective, impactful interventions. However, there has been a persistent lack of progress with regard to the poorest, most at risk populations and much work remains to be done to remedy that problem.

The WHO Secretariat has a key role to play in supporting Member States to implement the “best buy” interventions and has developed related technical packages (**MPOWER**, the **SHAKE** technical package for salt reduction, **HEARTS**: a technical package for cardiovascular disease management in primary health care, **WHO PEN** (package of essential noncommunicable disease interventions for primary care in low-resource settings) and ways of delivering and monitoring those packages. Specific attention has been given to the taxation of alcohol, tobacco and sugar-sweetened beverages as an effective and impactful means of reducing consumption and health-care costs, as well as of providing a source of domestic revenue. WHO provides capacity-building support to countries in a range of areas, including violence and injury prevention (TEACH-VIP) and noncommunicable disease surveillance, notably through the country capacity survey, which facilitates the assessment of progress in developing national responses to such diseases.

A 9% relative reduction in the prevalence of tobacco use in persons aged 15+ years, between 2010 and 2016



100 countries have an operational policy, strategy or plan to reduce physical inactivity



101 countries have included essential noncommunicable disease medicines in the national essential medicines list



A trailblazer in tobacco control in Uruguay

Uruguay's bold political action to protect its people against tobacco has served as a model for other nations.

The small country of 3 million citizens made global public health history when it took on tobacco giant Philip Morris International – which tried to block the country's strong tobacco packaging and labelling laws – and won. In July 2016, after a six-year battle, Uruguay triumphed in a landmark case when an arbitration court run by the World Bank ruled in favour of Uruguay and ordered Philip Morris International to pay legal costs.

The decision represented more than a simple victory for the people of Uruguay: it set a precedent by showing that small nations can win against tobacco giants.

Uruguay has been a global leader in this area through its comprehensive implementation of the **WHO Framework Convention on Tobacco Control**. In 2006, it was the first country in Latin America to ban smoking in public places. Its tough tobacco control measures include taxes, price hikes, awareness campaigns and a ban on tobacco advertising and misleading marketing; national surveys on tobacco use are also conducted regularly. The success of such measures is reflected in the decline of tobacco use – the proportion of adults who smoked dropped by almost half between 2000 and 2015, from 40% to 22%.



Reducing risk factors in Sri Lanka

In Sri Lanka, noncommunicable diseases cause three out of every four deaths, or roughly 100 000 deaths annually. A rapid disease transition has followed lifestyle changes. Some 30% of Sri Lankans are physically inactive and a further 30% are overweight, while one in three men smoke. Salt consumption is high and one in three adults have raised blood pressure.

Despite limited resources, Sri Lanka has introduced many targeted interventions and bold policies in order to address the issue, with support from WHO. In 2016, the Government launched a national multisectoral action plan for the prevention and control of noncommunicable diseases in Sri Lanka, 2016–2020, which was endorsed by the Prime Minister. Some of the actions have already been initiated, for example, the Government has introduced tobacco taxes; its aim now is to introduce plain packaging for tobacco products and to end tobacco cultivation. In addition, a food “traffic light” labelling system has been introduced, in which red or orange dots on labels indicate higher sugar levels, thus encouraging and enabling people to make healthier choices. WHO and various stakeholders and organizations have been brought together within the framework of the NCD Alliance Lanka – a key recommendation of the **Global Action Plan for the Prevention and Control of Noncommunicable Diseases (2013–2020)**. It was one of the first such alliances in the Region. The opening hours of the approximately 800 “Healthy Lifestyle Centres” have also been extended until late evening to increase male participation. These centres, at the primary care level, provide screening services for conditions and risk factors such as hypertension, diabetes and cancer, while trained staff offer health advice to patients. Managing such diseases at an early stage can reduce the need for costly treatment later on.



Controlling hypertension in high burden countries

WHO has worked with partners to develop the HEARTS technical package which, in partnership with the Resolve to **Save Lives Initiative** and other stakeholders, will be rolled out in countries in order to scale up proven strategies for improving control of high blood pressure, including implementing practical treatment protocols and use of standardized indicators to monitor progress. Achieving control of hypertension would also involve scaling up implementation of the **SHAKE package** to reduce salt intake.

182 countries have policy and plans aligned with the **2025 global nutrition targets**



A decade of action on nutrition

Unhealthy diets, maternal and child malnutrition and obesity account for almost one quarter of all global deaths. In 2016, the United Nations General Assembly proclaimed 2016–2025 the United Nations Decade of Action on Nutrition. WHO, jointly with FAO, has developed a work programme calling for action in health, the food system, education and trade. Countries have made SMART commitments and established action networks to mutually inspire and support policy development on healthy food environments, nutrition labelling and school food procurement. WHO has helped pave the way in raising the priority given to reducing malnutrition in all its forms, including undernutrition, micronutrient deficiencies, overweight and obesity, which was absent from national nutrition plans a decade ago. WHO is supporting Member States to implement a common vision for ending malnutrition as an imperative for health and development.

33 countries introduced adequate mechanisms for preventing or mitigating risks to **food safety** between 2015 and 2017, increasing the total to 130



Ending childhood obesity

Almost three quarters of the 41 million children under five years of age who are overweight and obese live in Asia and Africa. The number of obese children and adolescents has increased more than tenfold in the past four decades, reaching 124 million in 2016. Actions to end childhood obesity include regulatory measures, integrated action across the field of maternal and child nutrition and physical activity as a component of primary health care and in schools. The implementation plan on the report of the Commission on Ending Childhood Obesity guides Member States in combining the strengths of multiple stakeholders to improve policy coherence across sectors, in order to advance these actions. The childhood obesity surveillance initiative within the WHO European Region covers 41 countries and close to half a million children.

Regular physical activity reduces the risk of heart disease, stroke, diabetes and some cancers and can improve mental health and quality of life. Globally, 23% of adults and 81% of adolescents are not active enough to benefit their health. The draft **global action plan on physical activity (2018–2030)** recommends policy actions across multiple settings and efforts to strengthen leadership, governance, multisectoral engagement, workforce capacity and information systems.

New approach in dementia plan

Dementia affects 47 million people worldwide (roughly 5% of the world's elderly population), a figure predicted to increase to 75 million in 2030 and 132 million by 2050. WHO estimates that, globally, nearly 10 million people develop dementia each year. Aware of the profound implications of these statistics, WHO is advocating a new approach to improving the lives of people with dementia, their carers and families, while reducing the impact of dementia on them, as well as on communities and countries, through a landmark strategy: global action plan on the public health response to dementia 2017–2025. Areas for action include: measures to reduce the risk of dementia; diagnosis, treatment and care; and research. The plan was developed through extensive consultations, including with Member States and partners; it will be monitored by the WHO Global Dementia Observatory, which is expected to collect data from 50 countries by the end of 2018.

Improving road safety

More than 1.3 million people die each year on the world's roads. Half of those people are vulnerable road users, namely: motorcyclists (23%), pedestrians (22%) and cyclists (4%). Under WHO's leadership, there is increased awareness that most traffic accidents are both predictable and preventable, and related policies and practices are being developed, including on trauma care. In 2017–2018, WHO contributed to the following areas:

3% lower suicide rate per year, per 100 000 population, between 2015 and 2017



- global performance targets for road safety risk factors and service delivery mechanisms: in November 2017, following extensive consultations and a discussion paper, Member States finalized a comprehensive set of 12 global road safety targets;
- the **Bloomberg Initiative for Global Road Safety**, aimed at reducing road deaths and injuries by strengthening national legislation and implementing proven interventions at the city level (WHO is providing technical support to this programme in China, Philippines, Thailand and United Republic of Tanzania), the United Nations Road Safety Collaboration to strengthen cooperation between United Nations agencies to promote road safety, and the **Fourth United Nations Global Road Safety Week, 8–14 May 2017**, which focused on speed, using the slogan Save Lives – #SlowDown;
- the global status report on road safety – published every two years – which contains country profiles on the burden of road traffic injuries and deaths, as well as key risk factors, and serves as a means of monitoring progress towards the Sustainable Development Goals and other global targets.

Preventing violence

Globally, it is estimated that up to one billion children aged 2–17 years have experienced physical, sexual or emotional violence or neglect in the past year. In addition to its immediate impact in the form of injuries and psychological trauma, exposure to violence is a major risk factor for negative health and social outcomes later in life. WHO has played a leading role in documenting those effects and disseminating scientific evidence about what works to prevent such violence. In 2017–2018, WHO:

- played a key role in establishing the **Global Partnership to End Violence against Children** and organizing the first Ending Violence Against Children Solutions Summit;
- released **INSPIRE: seven strategies for ending violence against children**, a technical package to support country implementation of evidence based prevention programmes and victim services; and
- provided technical support for the implementation of evidence-based prevention programmes and services for survivors in at least 20 countries.

Mental health care for refugees

WHO has been supporting the mental health of refugees. Turkey has a very large population of mainly Syrian refugees, many of whom have faced great adversity and have psychosocial needs. With assistance from WHO (especially the Gaziantep office), the Government has responded by building up human resources capacity in mental health care (using the **WHO mhGAP intervention guide**) and establishing mental health centres and other services for the refugee population.

Lebanon has received a massive influx of refugees fleeing the war in Syria. Some 1.5 million Syrian refugees are spread across the country; every village in Lebanon hosts some refugees. This represents a 30% increase in the population, placing a heavy burden on the health system. Primary health care services are not equipped to handle the high levels of depression and anxiety reported among refugees.

WHO has helped to develop a national mental health strategy, coordinated the development of national policies on mental health care and supported national awareness campaigns. It has also secured funding, helped with measures to update the Essential Drugs List to include more psychotropic drugs, and developed a mental health registry. The Organization has also helped train 2000 health care workers in diagnosing and managing people with mental disorders.

In 2017, a monthly average of 3500 mental consultations were provided to Syrian refugees. WHO saw the “opportunity in crisis” to improve mental health care in the country.



Moving forward

The WHO Secretariat will continue to work with Member States and other partners in scaling up efforts to implement high-impact and cost-effective measures to curb noncommunicable diseases and violence and injuries. It will work with civil society and all sectors to reduce the resulting burden and will cooperate with other relevant partners – through the Independent High-level Commission on Noncommunicable Diseases and the United Nations Interagency Task Force on the Prevention and Control of Noncommunicable Diseases – in order to persuade elected officials to make bold political choices in tackling noncommunicable diseases and mental health. The Secretariat will strengthen its leadership and technical capacity to support countries to implement the outcome of the third High-level Meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases, to be held in 2018.

The WHO Secretariat will continue to provide technical assistance to countries related to the “best buys” and other interventions. Evidence-based WHO guidance will support countries in reducing the use of salt and sugar; eliminating artificial trans-fats and reducing antibiotics in food; reformulating products so they are healthier; reducing tobacco use and the harmful use of alcohol; stopping the marketing of unhealthy foods and beverages to children; and reducing physical inactivity. In underpinning the management of noncommunicable diseases, the Secretariat will continue to support countries in implementing technical packages, notably the HEARTS package, and also through the WHO Package of Essential Noncommunicable Disease Interventions (WHO PEN) for primary care in low-resource settings.

The Secretariat will continue to provide technical assistance to countries to implement best practices in reducing road traffic injuries, through the Save LIVES package, and to reduce violence, with a focus on implementing strategies to reduce violence particularly against children, through the INSPIRE package. It will work with countries to identify gaps in emergency care systems and prioritize action.

The Secretariat's support to Member States will focus on four areas of commitment: governance, prevention and reduction of risk factors, surveillance, monitoring and evaluation, and health care. It will also strengthen the technical support it provides to address the mental health treatment gap and related human rights issues, implement high-impact health and social care services, and provide cost-effective interventions for common conditions.

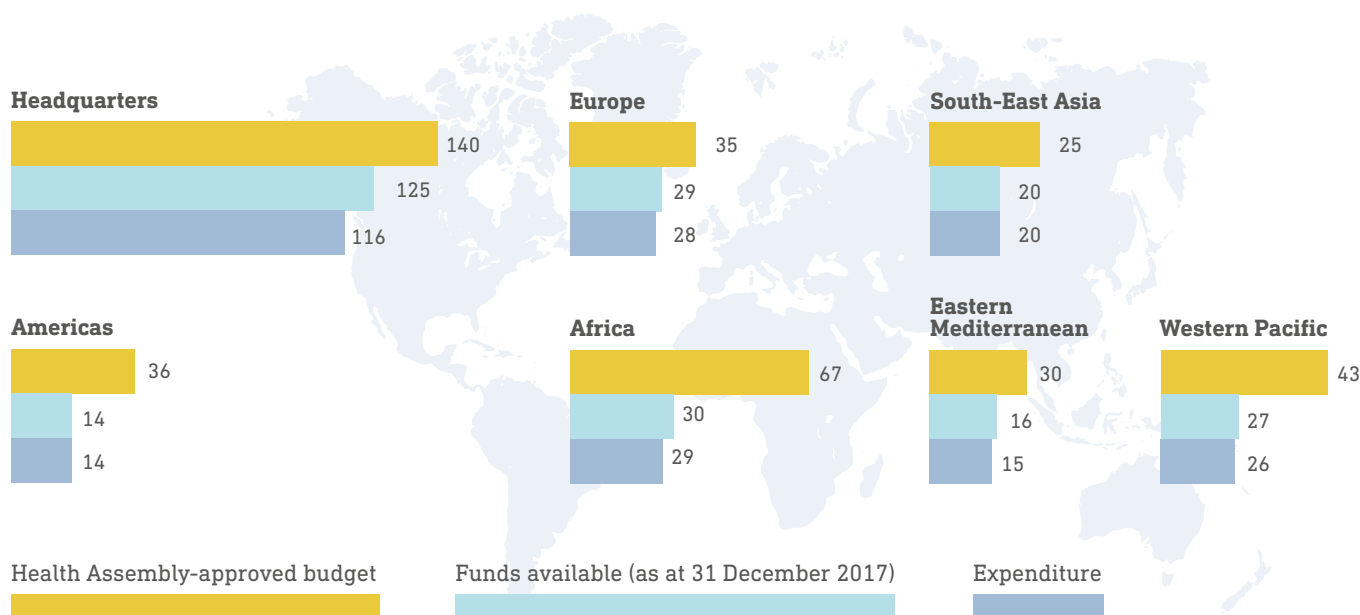
Key figures for 2016–2017

Approved Programme budget: US\$ 376 million

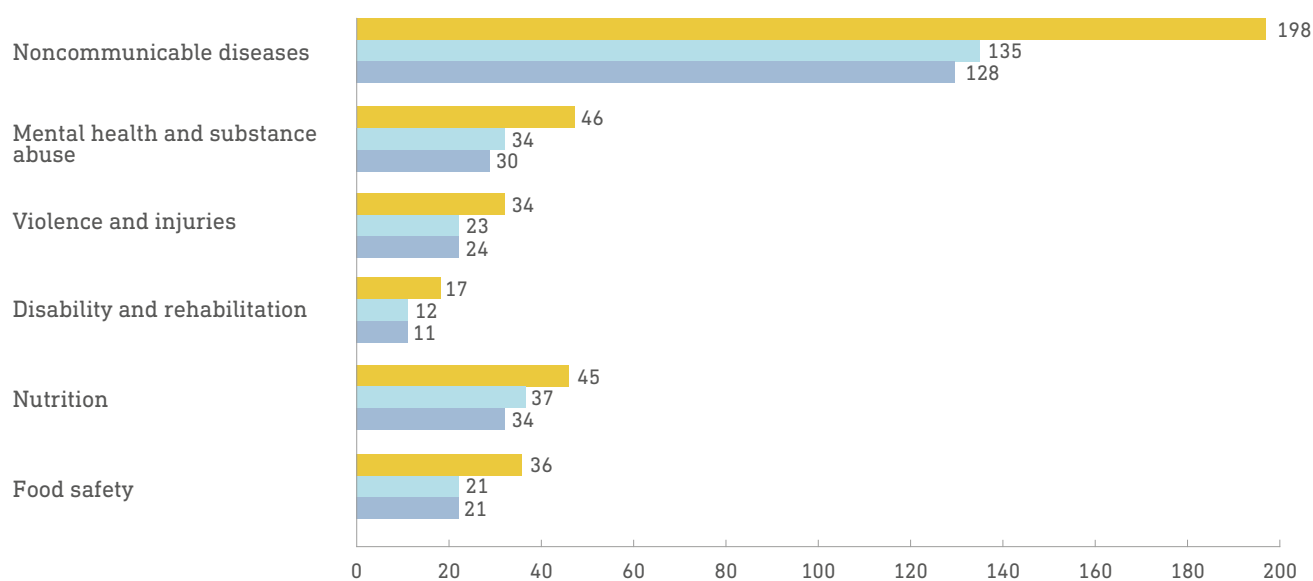
Funds available: US\$ 262 million (70% of Programme budget)

Expenditure: US\$ 249 million (66% of Programme budget, 95% of available resources)

Budget, funds available and expenditure by major office (in US\$ millions)



Budget, funds available and expenditure by programme (in US\$ millions)



Budget and financing

Noncommunicable disease programme areas remain among those that attract the least financing. This presents a huge challenge for implementing the strategies required. For example, during the biennium 2016–2017, only 70% of the total

approved Programme budget for the Category was mobilized. Noncommunicable disease programme areas are among those that have the largest financing gaps when compared with the programme budget, despite the fact that the programmes have

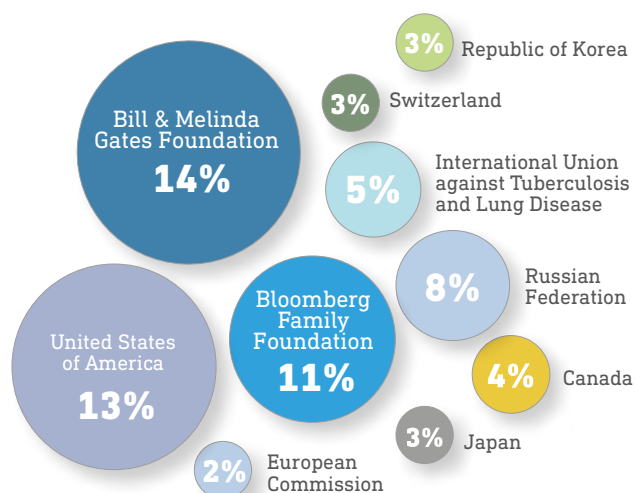
relatively lower budgets than other programme areas. However, it should be noted that implementation against available resources is very high.

Most countries make noncommunicable disease a priority for WHO support. Therefore, with less donor funding going

to this area, WHO provides funding from the core voluntary contributions account in order to ensure the implementation of the strategy and to achieve the expected results. Noncommunicable disease programme areas receive the largest share of the total flexible funds (54%).



Top 10 voluntary contributors (specified)



Funding source:

Assessed contributions: 38%

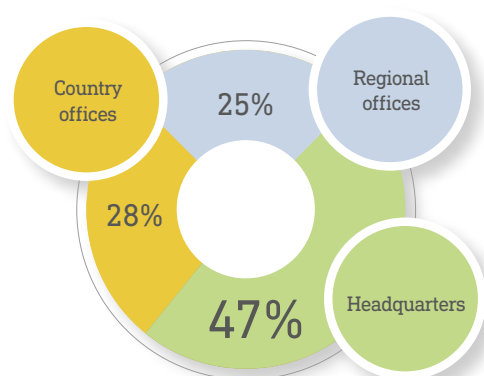
Core Voluntary Contributions Account: 13%

Voluntary contributions – specified: 49%

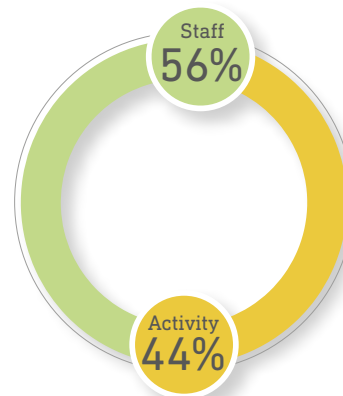
Of the total voluntary contributions specified, 66% were from 10 contributors (shown beside)



Expenditure by level



Expenditure: staff vs. activity



Expenditure

Almost half of all expenditure is at headquarters level. In the biennium 2016–2017, significant investments were made in the performance of normative functions, advocacy and research, and in the development of strategies and guidelines, including: the WHO nutrition strategy 2016–2020, guidelines on tobacco product regulation and guidelines on the mental health Gap Action Programme (mhGAP).

Almost one third of expenditure was for country-level delivery, including local capacity building, rolling out interventions at the

country level, especially those for implementing “best buys” and for supporting the development of relevant legislations. Expenditure of this type is expected to increase as countries are supported to scale. Significant investments have also been made at regional level in support of efforts to strengthen monitoring; these include the Global Adult Tobacco Survey (GATS) or the WHO STEPwise approach to surveillance survey (STEPS).

COMMUNICABLE DISEASES

“

All people have the right to good health no matter their age, sex and where they are born...

Dr Matshidiso Moeti

Regional Director for the African Region
(speaking on World AIDS Day, with a call to make sure “we leave no one behind”)

”



Programme areas

HIV
and hepatitis

Tuberculosis

Malaria

Neglected
tropical
diseases

Vaccine-
preventable
diseases

Antimicrobial
resistance

Key objectives



To **accelerate the elimination and eradication of high-impact communicable diseases** and reach all vulnerable and marginalized populations, thereby helping to advance equity



To support all countries in **delivering quality immunization services** as part of an integrated, people-centred platform for disease prevention



To **tackle antimicrobial resistance**, including by raising awareness, improving global surveillance, optimizing the use of antimicrobial medicines and promoting research and development

Communicable diseases have long devastated humankind, but today it is the poorest and most vulnerable segments of society that are hardest hit. These groups have limited access to prevention measures, diagnostic testing and treatment, and often face catastrophic costs when trying to access care.

In countries with high rates of extreme poverty, the burden of communicable diseases remains heavy, with high incidence rates of malaria and hepatitis, a heavy socioeconomic and human toll from HIV and tuberculosis, and persistent neglected tropical diseases and vaccine-preventable diseases.

Collectively, “diseases of poverty”, despite being preventable and treatable, kill over four million people each year, place a major burden on society and impede economic development.

The guiding principle of the category, “to leave no one behind”, which is also a founding concept of the Sustainable Development Goals, will be vital in combating those diseases and in achieving the Goals.

Despite being preventable and treatable, HIV/AIDS, tuberculosis, malaria, vaccine-preventable diseases, viral hepatitis and neglected tropical diseases continue to pose a major public health challenge in all WHO regions. The Sustainable Development Goals have brought

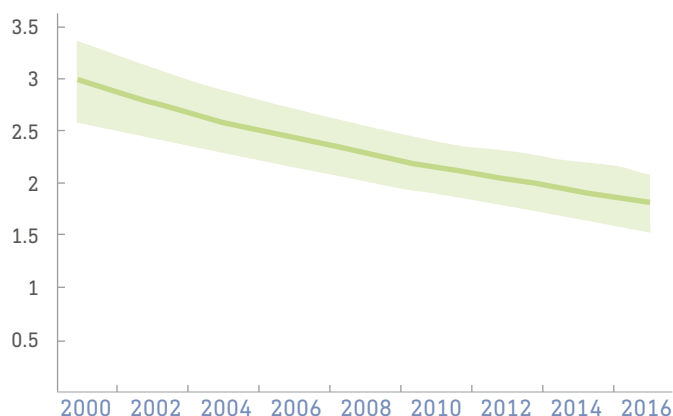
renewed urgency to fast-tracking the “unfinished agenda” of communicable diseases. Building on its strong record of combating communicable diseases, WHO is working with partners to deliver tangible and sustainable results in moving towards “ending the epidemics”.

Key achievements

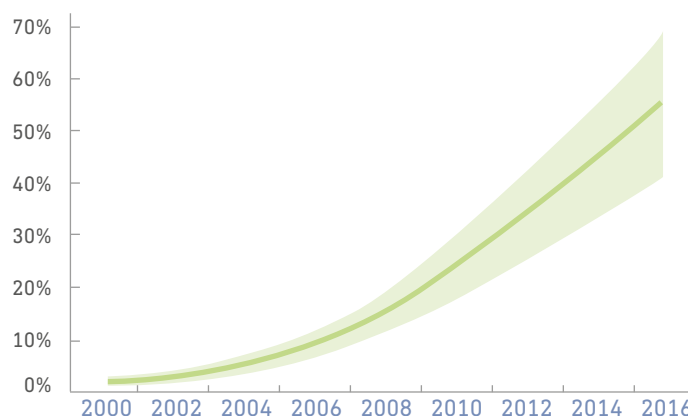
Reaching the most vulnerable people

The reduction of inequities in access has been systematically mainstreamed as a key element of the strategic approach to scaling up coverage of HIV and hepatitis prevention and treatment services. In HIV, the insufficient coverage of appropriate services for key populations, adolescent girls and young women, is being targeted with partners through various interventions. HIV testing is being scaled up to reach those who are most vulnerable and at risk through innovative testing strategies and approaches. Globally, a major new milestone has been achieved in HIV treatment with 21 million people living with HIV – more than half of all affected people – receiving recommended therapy.

Number of new HIV infections (in millions)



Coverage with antiretroviral therapy



New HIV infections fell by 39%, and HIV-related deaths fell by one third with 13.1 million lives saved through antiretroviral therapy between 2000 and 2016.

New guidelines, tests and cure

Work is under way to launch the pilot implementation of the world's first malaria vaccine in three countries in sub-Saharan Africa in 2018. The pilot programme will evaluate the feasibility of delivering the required four doses, the impact of the vaccine on lives saved, and the safety of the vaccine in routine use.

In 2016, in resolution WHA69.22, the Health Assembly adopted the global health sector strategies on HIV, viral hepatitis and sexually transmitted infections for 2016–2021. WHO also released, for the first time, a set of dedicated guidance documents on hepatitis, which include guidelines on surveillance, hepatitis B and C testing, and screening and care of chronic hepatitis C. WHO also prequalified its first rapid diagnostic test for hepatitis C virus, a tool that will aid diagnosis in low- and middle-income countries and improve access to treatment.

21 million people living with HIV now receive recommended therapy



A record **3 million** people were able to obtain treatment for hepatitis C over the past two years

More babies born free of HIV and syphilis

WHO certified eight countries or areas as having eliminated mother-to-child transmission of HIV and syphilis – Anguilla, Antigua and Barbuda, Belarus, Bermuda, Cayman Islands, Montserrat, Saint Kitts and Nevis and Thailand. The achievement is testament to a key factor – the integration of maternal and child health in sexual, reproductive health and HIV services. Integration underpins WHO's new health sector strategies on HIV, viral hepatitis and sexually transmitted infections.



Fighting the co-epidemics of tuberculosis and HIV

In 2016, almost 40% of all AIDS-related deaths globally were from tuberculosis. Cambodia, United Republic of Tanzania and Zimbabwe are examples of countries that have taken active steps to address their double burden of HIV and tuberculosis by scaling up recommended collaborative tuberculosis/HIV activities and by integrating services. Since 2004, Cambodia has seen an 85% reduction in HIV-associated deaths from tuberculosis, and Zimbabwe a reduction of more than 70%.

Preventing deaths from tuberculosis among people living with HIV requires preventive therapy, enhanced case detection and treatment interventions. In United Republic of Tanzania and Zimbabwe, over 95% of tuberculosis patients know their HIV status, and in Cambodia the figure is over 85%. Around 98% of notified HIV-positive tuberculosis patients have accessed antiretroviral treatment in Cambodia, 91% in United Republic of Tanzania and 86% in Zimbabwe. Those countries have all seen a considerable scaling up of isoniazid preventive therapy in recent years. For 2016, Zimbabwe has reported some 124 000 people living with HIV receiving isoniazid preventive therapy, a massive increase from 11 000 in 2013 and representing 73% of people newly enrolled in HIV care.



More than 50 million deaths averted through effective tuberculosis diagnosis and treatment between 2000 and 2016



80 million people successfully treated for tuberculosis since 1995. In 2016 alone, 6.3 million people were newly diagnosed and treated

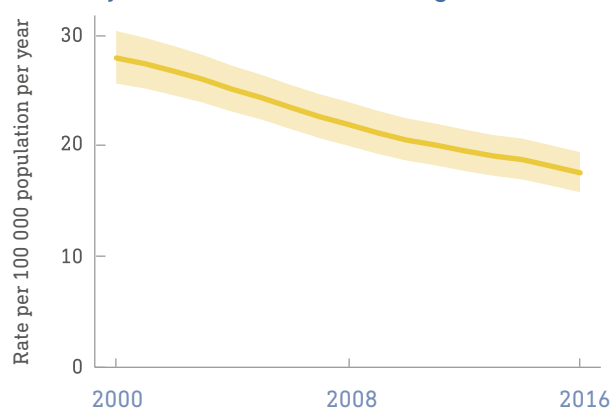


Building political momentum to end tuberculosis

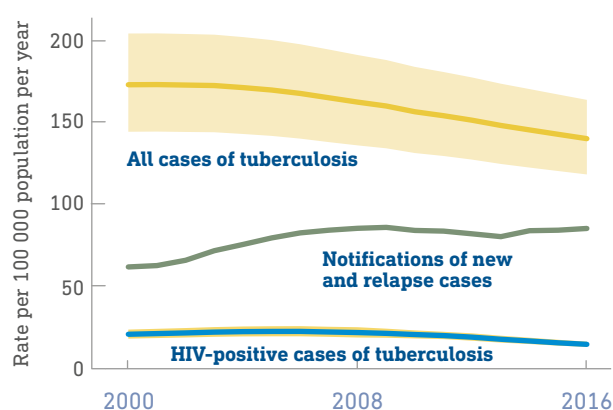
WHO's **Global tuberculosis report 2016** revealed that the pace of progress is insufficient to achieve Sustainable Development Goal target 3.3, to end the tuberculosis epidemic by 2030.

The Secretariat has therefore worked with Member States and partners to build political momentum around the fight to end tuberculosis. In 2017, commitment to ending tuberculosis was expressed at the highest levels by the G20 group of countries, the so-called BRICS countries comprising Brazil, Russia, India, China and South Africa, the Asia-Pacific Economic Cooperation forum, in communiques of the G7 group of countries, and at the first WHO global ministerial conference on **"Ending tuberculosis in the sustainable development era: a multisectoral response"**, held in Moscow, in November 2017. The conference brought together ministers and leaders from 120 countries and over a thousand partners encompassing representatives from civil society, development agencies, the corporate sector, academia and other partner organizations. Preparations are now under way for the **United Nations General Assembly high-level meeting on tuberculosis**, to be held in 2018, which will further raise the profile of the fight to end tuberculosis.

Mortality from tuberculosis (HIV-negative)



Incidence of tuberculosis



Globally, the tuberculosis mortality rate fell by 37% and the incidence rate by 19% between 2000 and 2016. Source: **Global tuberculosis report 2017**.

Protecting poor people with tuberculosis

Kenya, Mozambique, Namibia and Zambia are seeking to better address inequities in access and social protection, given the profound burden of poverty. Kenya now has a strong national social protection policy, and through its leadership in tuberculosis it is forging linkages with existing social protection schemes, including cash transfers for key vulnerable groups, and nutritional assessment and support.

Greater community engagement, transport reimbursement, income-generation efforts and nutritional support are included under Namibia's new tuberculosis strategic plan. Mozambique is initiating a representative national survey to assess patient and household costs associated with tuberculosis care, and define means of alleviating them. It is already expanding community-based tuberculosis care in two thirds of its districts and enhancing active case finding. In Zambia, the tuberculosis prevention and care services of the Ministry of Health have been linked with the social welfare and cash transfer programme of the Ministry of Community Development and Social Services, enabling the country to deliver better results in improving the livelihood of poor people while also improving access to good-quality tuberculosis services. This example points to the synergies that can be achieved through inter-programme collaboration.



Game-changer in vector control response

Today more than 80% of the world's population is at risk from a vector-borne disease, with half at risk from two or more diseases.

In 2016–2017, WHO spearheaded the development of a new strategic approach to vector control. A broad consultation tapped the experience of health ministries and experts, in a process steered by eminent scientists. The result was the **global vector control response 2017–2030**, which calls for improved public health entomology, a national research agenda, better coordination within and between sectors, community involvement, strengthened monitoring systems and effective novel interventions. The global vector control response aims to reduce mortality from vector-borne diseases by at least 75% and incidence by at least 60% by 2030.

Vector-borne diseases account for 17% of the estimated global burden of communicable diseases. They affect poor populations most and can impede economic development. Vector control can prevent most of these diseases. Key vectors and their diseases are:

- **Mosquitoes** – malaria, lymphatic filariasis, Japanese encephalitis and West Nile fever, dengue and other diseases.
- **Flies** – onchocerciasis, leishmaniasis and human African trypanosomiasis (sleeping sickness)
- **Bugs and ticks** – Chagas disease, Lyme disease and encephalitis.

The mortality rate for detected cases of **dengue** has **decreased by 28%** since the launch of the global strategy for prevention and control of dengue (2012–2020)

1 billion people protected from treatable neglected tropical diseases by receiving 1.5 billion treatments in 2017

Large-scale medicine donations

WHO's efforts to coordinate large-scale medicine donation* programmes for neglected tropical diseases – such as lymphatic filariasis, onchocerciasis, soil-transmitted helminthiasis, schistosomiasis and trachoma – resulted in the delivery of 1.5 billion preventive chemotherapy treatments to more than a billion people in 2017. This was an unprecedented global public health achievement attributable to the Secretariat's long-standing engagement with the private sector.

At the **Global Partners meeting on neglected tropical diseases**, hosted by WHO in April 2017, more than US\$ 800 million was pledged by governments, partners, philanthropists and industry representatives to eliminate and eradicate neglected tropical diseases over the next five years. This will mean several billion treatments for more than a billion people at risk in the developing world as part of an international push to eliminate and eradicate these ailments for good.

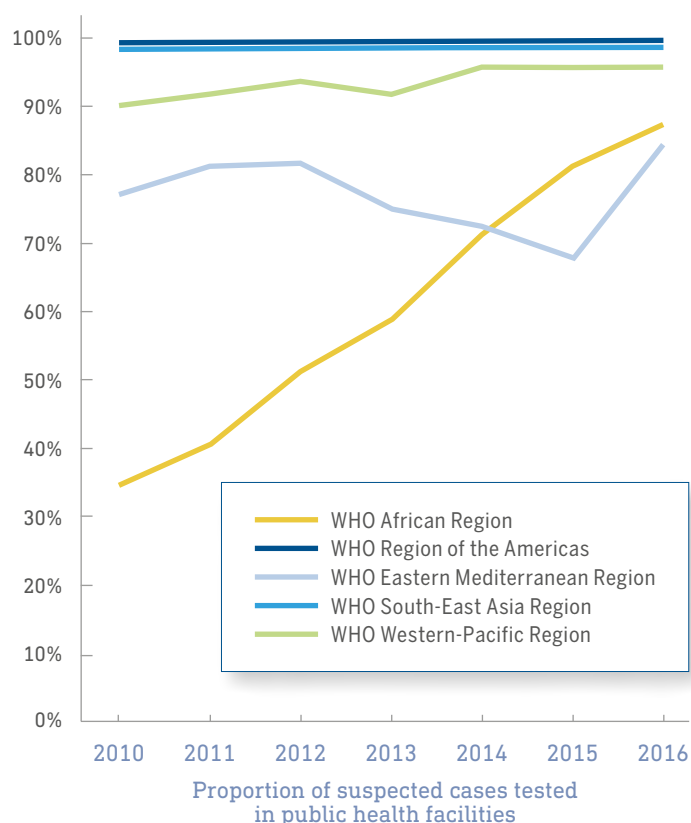
*Up to US\$ 173 million (cf to audited financial statements).

End in sight for two diseases of the poor as two or more neglected tropical diseases are set to be eliminated or eradicated by 2020

186 countries are certified free of transmission of dracunculiasis (commonly known as Guinea-worm disease)

A South Sudanese boy examines a cloth filter. Filtration of drinking water prevents Guinea worm disease.

Proportion of patients attending public health facilities and suspected to be suffering from malaria who received a diagnostic test by WHO Region, 2000–2016, Source: National malaria control programme reports



i Between 2010 and 2016, malaria incidence rates (new malaria cases) fell by 18% globally and by 20% in the African Region. Source: **World malaria report 2017**.

i Kyrgyzstan and Sri Lanka also had another success story to celebrate – being certified malaria-free.

Almost 1 billion
Cases of malaria averted since 2000



44 countries
in which malaria was endemic
in 2000 had fewer than 10 000
indigenous cases in 2016



Joint malaria and polio drive saving lives in Nigeria

In 2017, malaria claimed more lives than all other diseases combined in Nigeria's Borno state, where some 3.7 million people needed humanitarian assistance as a result of the eight year conflict.

In October 2017, WHO launched a special campaign in the state to rapidly reduce the malaria burden among young children, and, at the same time, protect them against poliomyelitis. The campaign was timed to coincide with the peak malaria transmission season, which typically runs through November. Roughly 1.2 million children received monthly rounds of antimalarial medicines. Community health workers are administering the medicines to all children in targeted areas, regardless of whether or not they show symptoms of malaria.

The campaign benefited from WHO's well developed network of polio vaccinators who have extensive experience in reaching vulnerable children, including in difficult to access areas. WHO health emergency teams also supported the effort by procuring, airlifting and distributing the monthly rounds of antimalarial medicines.

Beyond this time-limited campaign, WHO and partners are working to prevent malaria among at-risk populations through the distribution of bednets and the spraying of homes with insecticides. Boosting access to treatment and strengthening surveillance systems are other key areas of focus in the region. WHO is looking to apply a similar approach in South Sudan where 10 million people are at risk of dying from a combination of malaria, malnutrition and conflict.



#VaccinesWork

Routine immunization is a building block of primary health care and universal health coverage, offering every child the chance of a healthy start in life. To give immunization a boost, WHO and partners created compelling content for social and traditional media in 2016 and 2017. On Twitter alone, there was a sharp rise in the number of tweets using **#VaccinesWork** – driven in large part by key pieces of creative content and high-profile champions. In addition, several articles and editorials were published, highlighting the positive impact of immunization around the world. Those activities supported the call by the **global vaccine action plan 2011–2020** for greater action on immunization by highlighting its importance as a top global health priority.

Partners achieved this through linking immunization with many other issues, such as sustainable development and global health security, and promoting awareness of the actions required to achieve the vision of the global vaccine action plan. Such concerted efforts successfully increased awareness that vaccination is a vital tool to help save lives.

260 million
people in African countries affected
by meningitis A vaccinated with
MenAfriVac



By 2016, **130** countries
had reached at least 90% coverage
of **DTP3 vaccine**



Measles vaccination resulted in an
84% drop in measles deaths
between 2000 and 2016 worldwide



#VACCINESWORK

The Americas declared free of measles

In September 2016, the WHO Region of the Americas became the first region in the world to have **eliminated* measles**, a viral disease that can cause severe health problems, including pneumonia, brain swelling and even death. This achievement concludes a 22-year effort involving mass vaccination against measles, mumps and rubella throughout the Americas. Measles is the fifth vaccine-preventable disease to be eliminated from the Americas, following the regional eradication of smallpox in 1971, poliomyelitis in 1994, and rubella and congenital rubella syndrome in 2015.

Before mass vaccination was initiated in 1980, measles caused nearly 2.6 million deaths annually worldwide. In the Americas, more than 100 000 deaths were attributable to measles between 1971 and 1979. A cost-effectiveness study on measles elimination in Latin America and the Caribbean has estimated that through vaccination, 3.2 million measles cases will have been prevented in the Region and 16 000 deaths averted between 2000 and 2020.

* Elimination is defined as "the reduction to zero or a very low defined target rate of new cases in a defined geographical area."



All 11 countries in the South-East Asia Region achieved elimination of maternal and neonatal tetanus in 2016, making it the second WHO region to have achieved this **historic milestone**

Combating rising antimicrobial resistance

Antimicrobial resistance can occur whenever microbes (bacteria, viruses, parasites, or fungi) are exposed to antimicrobial medicines, including antibiotics and antivirals. It results in the drugs becoming less effective and infections more difficult to treat. At stake are the gains made against infectious diseases, advances in modern medicine, and the achievement of a number of the Sustainable Development Goals.

WHO has played a key role in building political momentum and raising awareness of the global threat posed by antimicrobial resistance. In 2015, the need for sustained action was highlighted with the adoption of the global action plan on antimicrobial resistance by the Health Assembly in resolution WHA68.7 and endorsement by the FAO and OIE governing bodies. Global consensus on the importance of multisectoral action was built through a series of high-level global and regional meetings, including at the United Nations General Assembly in New York, in September 2016 when Heads of State made a commitment to deal with the root causes of the problem across multiple sectors through a broad, coordinated approach.

In 2015 Member States committed to developing national action plans to address antimicrobial resistance within two years. By December 2017, 93 countries reported having an action plan, and 67 were in the process of developing one. That represents over 95% of the world's population.

The One Health approach to antimicrobial resistance has led to closer collaboration with FAO and OIE at global level in the development of tools, a monitoring framework and indicators, and on progress towards a framework on antimicrobial stewardship. There is also closer collaboration in supporting countries to implement their plans. UNEP is now also collaborating in support of action to understand and address environmental aspects of antimicrobial resistance.

Antimicrobial resistance is a major concern for programmes on tuberculosis, HIV, malaria, sexually transmitted infections and neglected tropical diseases. There is substantial activity to tackle resistance within these individual programmes, which links with work to build political momentum and stronger systems in order to combat antibiotic resistance.

Significant progress has been made in implementing the 2015 [global action plan on antimicrobial resistance](#), with work being scaled up at all levels of the Organization to meet the key objectives.

The Global Antibiotic Research and Development Partnership, a joint WHO and DNDi initiative, was established. The priority pathogens list was developed and analysis of the antibacterial pipeline was undertaken.

52 countries enrolled in the Global Antimicrobial Resistance Surveillance System (GLASS)

93 countries have developed a national action plan on tackling antimicrobial resistance

Updated WHO List of Critically Important Antimicrobials for Human Medicine (WHO CIA List) for public health and animal authorities to ensure prudent use of antimicrobials

Access, watch, reserve
Updated Essential Medicines List with syndromic guidance and grouping of antibiotics according to how they should be used

Looking forward

The Sustainable Development Goals have renewed the need to fast track the “unfinished agenda” of communicable diseases. But the 2030 target of ending the epidemics cannot be achieved and sustained without a strong universal health coverage framework that brings together disease-specific services, including those for HIV, viral hepatitis, malaria, neglected tropical diseases, vaccine-preventable diseases and tuberculosis. Reports published in 2017 revealed that progress has stalled in several areas. The pace of progress is insufficient to achieve Sustainable Development Goal target 3.3 to end the tuberculosis epidemic and achieve a malaria-free world. There are concerning signs of complacency and inadequate political commitment to immunization, and the global vaccine action plan targets are off course.

Hence, working with partners, WHO will build political momentum around the acceleration agenda, including for the upcoming United Nations General Assembly’s first high-level meeting on tuberculosis. WHO will also develop integrated guidance to replace strategies that are coming to an end, such as global strategies on HIV and hepatitis.

Strong emphasis is being placed on moving rapidly to achieving universal health coverage by strengthening health systems and improving access to people-centred prevention and care. Work on improving data and scaling up innovative new medicines, diagnostics and tools to improve cost-effectiveness and efficiency of interventions will continue. Priorities include:

- re-focusing efforts to stamp out malaria on the countries with the highest burden; significantly scaling up efforts against HIV infection in western and central Africa;
- finding missing tuberculosis cases, accelerating research and development, and developing a new accountability framework;
- scaling up integrated service delivery – for example, against HIV and tuberculosis and mother-to-child transmission of HIV, hepatitis B and syphilis;
- re-focusing technical assistance on the needs of the most affected groups (for example, supporting drug users with high-impact harm reduction packages for the prevention and care of HIV, hepatitis B and C and tuberculosis);
- strengthening efforts against vector-borne diseases and rolling out the new global vector control response 2017–2030;
- stepping up implementation research activities, including social innovation in health-care delivery, and supporting the shift from disease control to disease elimination, along with strengthening research capacity, especially in low- and middle-income countries and the creation of novel tools to enhance country preparedness for outbreaks.

The WHO Secretariat will continue to lead global action against antimicrobial resistance, promote policy dialogue, provide technical support to Member States, strengthen partnerships, and provide strategic action to tackle antimicrobial resistance. Despite the current momentum, gaps in action remain across all WHO regions. More needs to be done to support countries in implementing their action plans for the animal and human health sector, including: supporting education and raising awareness; strengthening laboratory and surveillance systems; improving infection prevention and control practices; and encouraging more appropriate antibiotic use and more effective regulation. This will require sustained investment of human and financial resource.

Some of the challenges preventing countries and the Secretariat from staying on track and advancing towards the Sustainable Development Goal targets include a lack of sustainable and predictable international and domestic funding, risks posed by conflict zones, anomalous climate patterns and the emergence of resistance to medicines. Furthermore, to reach the most vulnerable populations, some critical interventions need to be carried out in security-compromised areas or areas affected by United Nations sanctions.



Key figures for 2016–2017

Base:

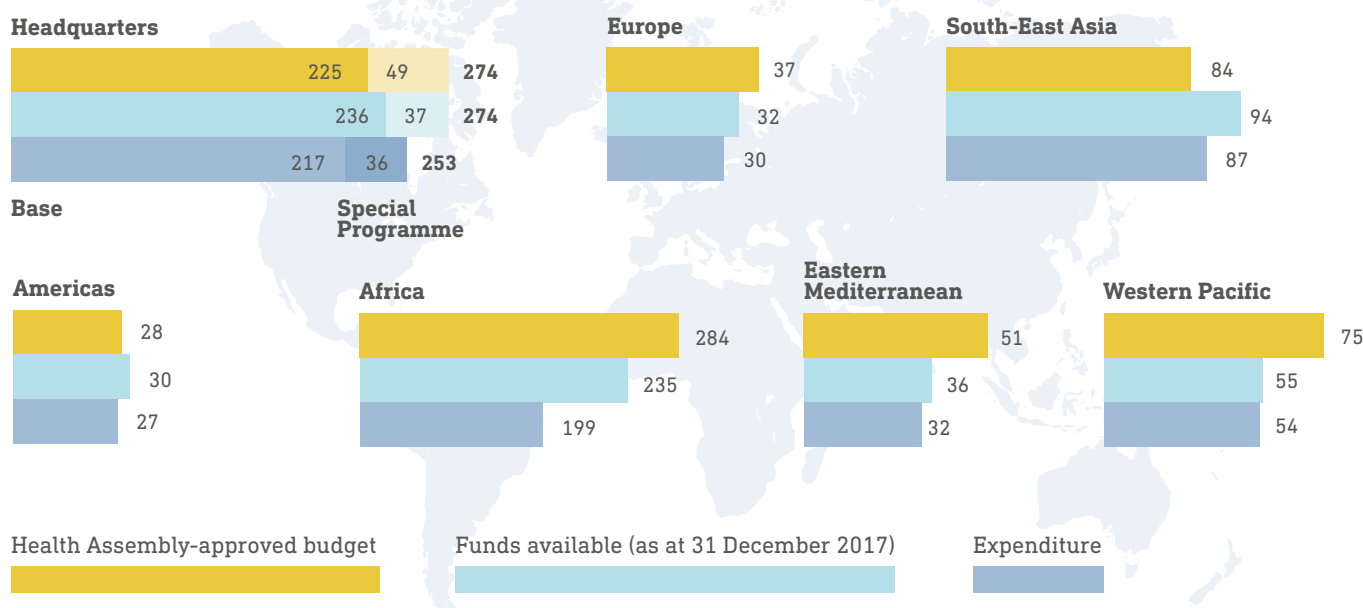
Approved Programme budget: US\$ 784 million
Funds available: US\$ 720 million (92% of Programme budget)
Expenditure: US\$ 645 million (82% of Programme budget, 90% of available resources)

UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases:

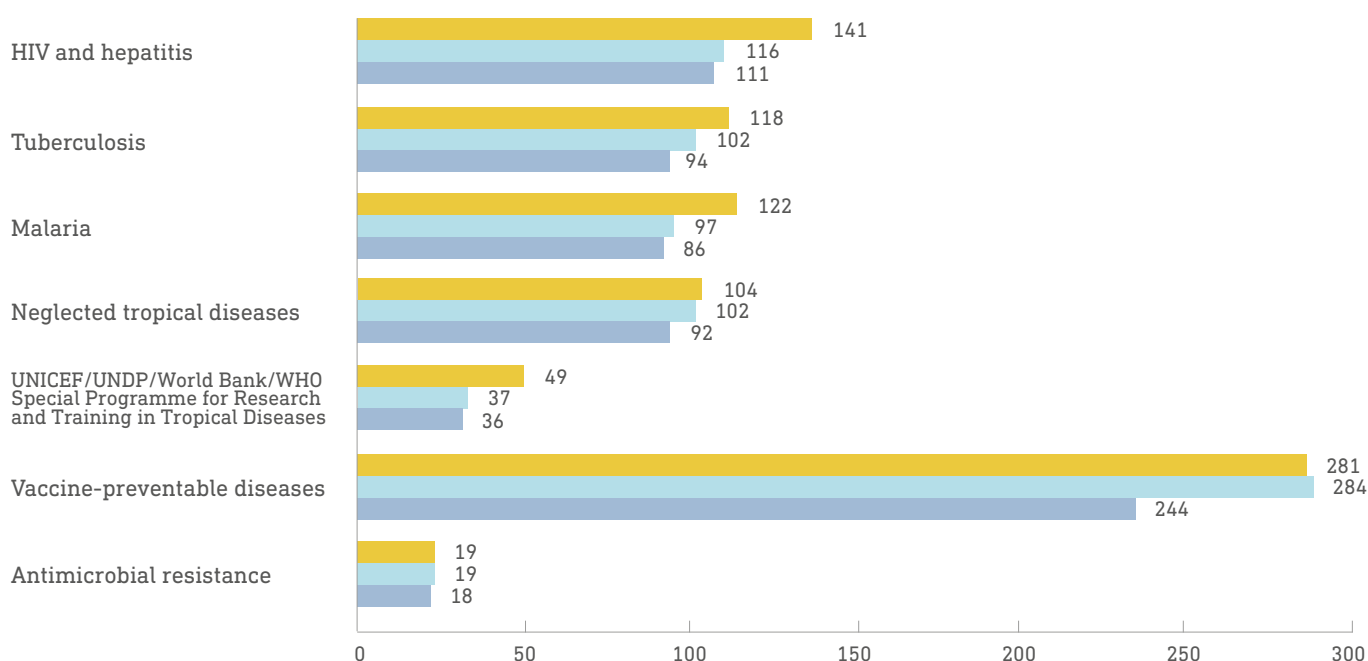
Approved Programme budget: US\$ 49 million
Funds available: US\$ 37 million (77% of Programme budget)
Expenditure: US\$ 36 million (73% of Programme budget, 95% of available resources)



Budget, funds available and expenditure by major office (in US\$ millions)



Budget, funds available and expenditure by programme (in US\$ millions)



Budget and financing

Although the 92% overall level of available resources compared to the approved budget level can be considered adequate for the biennium, some programme areas faced a more challenging

situation and were under-funded. The reasons include a significant reduction (50%) in UNAIDS/Unified Budget, Results and Accountability Framework (UBRAF) funding, which primarily affected staffing of the HIV programme and hampered

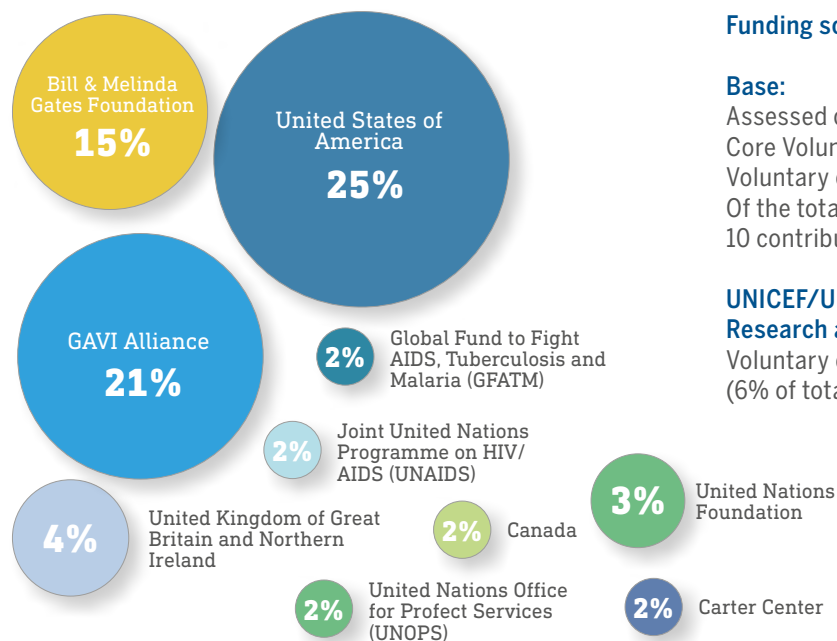
implementation support to countries and chronic difficulties in mobilizing resources for hepatitis activities and hampering implementation support to countries.

Only 15 % of the resources are funded from assessed contributions and about 77% come from heavily earmarked

funding from only 10 voluntary contributors. The flexibility to shift resources between programme activities and levels is therefore limited, making it difficult to act swiftly and scale up the response to countries' identified or emerging needs. Individual programmes are having to depend even more on a handful of donors for most of their contributions.



Top 10 voluntary contributors (specified, base)



Funding source

Base:

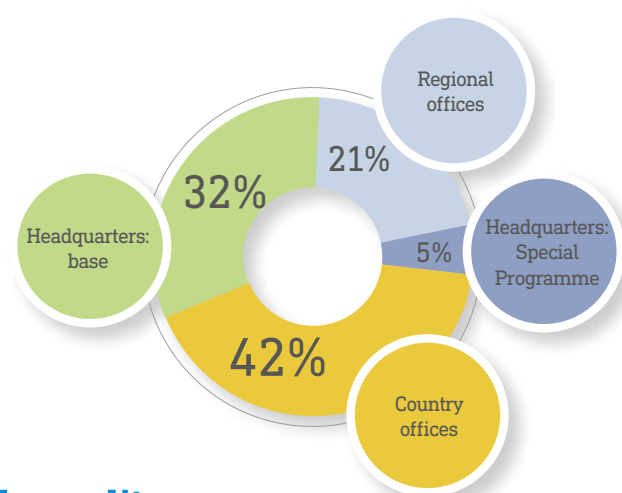
Assessed contributions: 15%
Core Voluntary Contributions Account: 4%
Voluntary contributions – specified: 81%
Of the total voluntary contributions specified, 77% were from 10 contributors (shown beside)

UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases:

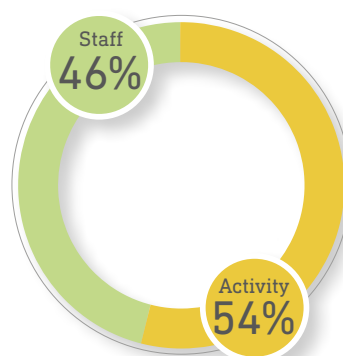
Voluntary contributions – specified: 100%
(6% of total voluntary contributions – specified)



Expenditure by level



Expenditure: staff vs. activity



Expenditure

Expenditures reached 90% on average of the available resources and 82% of the approved budget. Countries and regions implemented 42% and 21 %, respectively, of the expenditures, with a stronger focus on the African and South-East Asia regions providing capacity to countries for coordination of disease prevention, control and surveillance, and to guide effective interventions. Vaccine-preventable diseases and neglected tropical diseases registered half (52%) of the total expenditures.

Of the balance, 32% was implemented at headquarters level, focusing on science and evidence-based normative work and global public goods which are key enablers for guiding the effective implementation of programmes at country level, underpinning the unique position that WHO enjoys in global health. A further 5% was implemented by the Special Programme for Research and Training in Tropical Diseases.

THE GLOBAL POLIO ERADICATION INITIATIVE

“

We stand at a historic crossroads. Wild poliovirus transmission is at the lowest levels in history. Humankind is very close to eradicating from the face of the earth a disabling and killer disease – poliomyelitis.

Dr Mahmoud Fikri (1953-2017)

former Regional Director Eastern Mediterranean, March 2017

”

Polio vaccinators ensure that every child is vaccinated at the busy Torkham border crossing between Afghanistan and Pakistan, two of the three remaining countries in which polio is endemic.

Key objectives



Detecting and interrupting all poliovirus transmission



Phased withdrawal of oral polio vaccines (OPV)



Containment and certification



Transition and post-certification strategy

Ending polio once and for all

In 2017, polio was beaten back to the lowest levels in history. There were fewer cases reported in fewer areas in fewer countries than ever before. Thanks to an exceptional coalition, the world stands on the brink of being polio free.



Key achievements

In the Eastern Mediterranean Region, efforts are ongoing in the two remaining countries in the Region – Afghanistan and Pakistan – in which polio remains endemic, to tackle the remaining strongholds of virus circulation, much of which stems from cross-border transmission and leaves the two countries joined in a single epidemiological block. The commitment of both governments, across all levels, has forged a unique cross-border collaboration in eradication efforts.

In Africa, the emergency response to an outbreak detected in 2016 is continuing in Nigeria, and across the Lake Chad subregion, following detection of wild poliovirus in north-eastern Nigeria. The governments of countries across the subregion are to be commended for their response to this outbreak. No new cases have been identified since August 2016, which is encouraging, although difficulty of access leaves an estimated 160 000 children under five years at risk, and undetected circulation of the virus cannot be ruled out.

With wild poliovirus in fewer countries than ever before, responding to outbreaks of polio due to circulating vaccine-derived polioviruses is increasingly important to ensure that all types of poliovirus transmission are stopped. Outbreaks due to circulating vaccine-derived poliovirus type 2 confirmed in 2017 in the Democratic Republic of Congo and the Syrian Arab Republic highlight the dangers posed by this strain, and public health authorities in both countries have taken appropriate and urgent action to address the outbreaks. While tragic, the outbreaks were seeded before the successful and globally synchronized switch from trivalent oral polio vaccine to bivalent oral polio vaccine in April 2016, and validate the world's correct decision at the time to remove the type 2 component in oral polio vaccine.

>16 million
cases averted



>1.5 million
children's
lives saved



2.5 billion
children
vaccinated



Estimated cumulative achievement since the launch of the Global Polio Eradication Initiative in 1988

With polio on the brink of being eradicated, efforts are intensifying to ensure that it will remain eradicated. This means ensuring that polioviruses kept in laboratories – for important research work or to manufacture new vaccines – are not accidentally released back into the environment to cause outbreaks.

A global containment strategy is therefore being implemented with countries, laboratories, manufacturers and other experts. To sustain a polio-free world, a comprehensive “post-certification strategy” is being developed to ensure that other essential functions, such as ongoing immunization, surveillance and outbreak response (should it be needed) will remain in place. But more than that, planning is being accelerated to ensure that the infrastructure established to eradicate polio – which regularly detects and responds to natural disasters or outbreaks of other diseases – will continue to contribute to broader public health and development issues long after polio is gone, a process known as “transition planning”.

With generous commitments from partners, including new commitments made at the Rotary International Convention in June 2017, the Global Polio Eradication Initiative now has contributions, pledges and other commitments to fully fund the estimated US\$ 7 billion budget needed for the period through 2019. However, Member States are encouraged to convert their pledges and commitments into financial contributions in a timely manner to ensure smooth, uninterrupted programme operations. Every effort is being made to stretch the current US\$ 7 billion budget as much as possible into 2020, by ensuring the programme is managed and operates in the most cost-effective manner while responsibly managing risks. Budget reviews, risk assessments and prioritization are part of this process. Based on evolving epidemiology, the Global Polio Eradication Initiative will further refine or update the budget for 2019–2020 mid way through 2018.



Tens of thousands of vaccinators work in all weather and across all terrains every day to make sure no child gets left behind without polio vaccine. In Pakistan, where 60% of the population live in rural areas that may lack transport, vaccinators use camels to reach children.



A child is vaccinated against polio in the Syrian Arab Republic. Globally, more than 450 million children were vaccinated using more than 2200 million doses in more than 50 countries.

3

number of countries in which polio is endemic



2

number of countries experiencing outbreaks of polio



>2200 million

number of vaccine doses delivered



22

number of detected polio cases due to wild poliovirus



91

number of detected polio cases detected due to circulating vaccine-derived poliovirus



>450 million

number of children immunized



2017 situation summary

Looking forward

The focus for 2018 will be to build on the progress made to date, with a particular focus on interrupting the final chains of transmission for both wild and vaccine-derived poliovirus. Surveillance is being strengthened in key high-risk areas, and operations sensitized to ensure no child is missed during supplementary immunization activities. Preparations will continue to be intensified for the post-polio era, including by supporting countries in their laboratory containment activities, finalizing the post-certification strategy to ensure the essential functions needed to sustain a polio-free world, and planning the transition of significant polio assets to ensure they will continue to support broader public health initiatives after polio has been eradicated.

>100 000

**number of acute flaccid paralysis
("suspected polio") cases detected
and investigated**



20 million

**number of volunteers mobilised in
the global effort to eradicate polio**



2017 situation summary



Afghanistan expands environmental surveillance

Afghanistan is strengthening the drive to track and understand the movement of poliovirus by expanding environmental surveillance to all regions, for example, by collecting and testing sewage samples for poliovirus in the laboratory. At the end of 2017, a new environmental sampling site became operational in Kunduz province, becoming the twentieth site to be established since the collection and testing of sewage samples for poliovirus began in Afghanistan, with WHO support, in 2013.

In 2017, 317 sewage samples were collected from all sites, 30 of which contained poliovirus. That means that the polio eradication team knows where the virus is without relying on the identification of paralysed children. Given that for every polio victim there may be hundreds of "silent" cases – children infected but with no symptoms – improved environmental surveillance is akin to giving the programme x-ray glasses to find and track the virus. The expansion of the surveillance system began in the high-risk provinces of Kandahar and Helmand and was then expanded to nine provinces.

A sensitive surveillance system remains the cornerstone of polio eradication efforts. Environmental surveillance can determine possible routes of transmission and enable a swift response to stop further spread of the virus. It complements acute flaccid paralysis surveillance, which is currently carried out by a network of over 28 000 reporting volunteers and focal points, including health workers, teachers, religious leaders and traditional healers. Volunteers detect and report children showing signs of polio, such as floppy or weakened limbs.

Before each new site is established, WHO conducts a two-day training, demonstrating how samples are properly collected, labelled, packed, stored and transported to the laboratory for testing. After each sample is collected from a sewage site, it is frozen and sent to the regional laboratory in Pakistan for further testing and analysis.

Afghanistan's polio surveillance system is as strong as it has ever been. The country is closer than ever to stopping poliovirus transmission, with the virus currently cornered in small, security-challenged parts of the country.

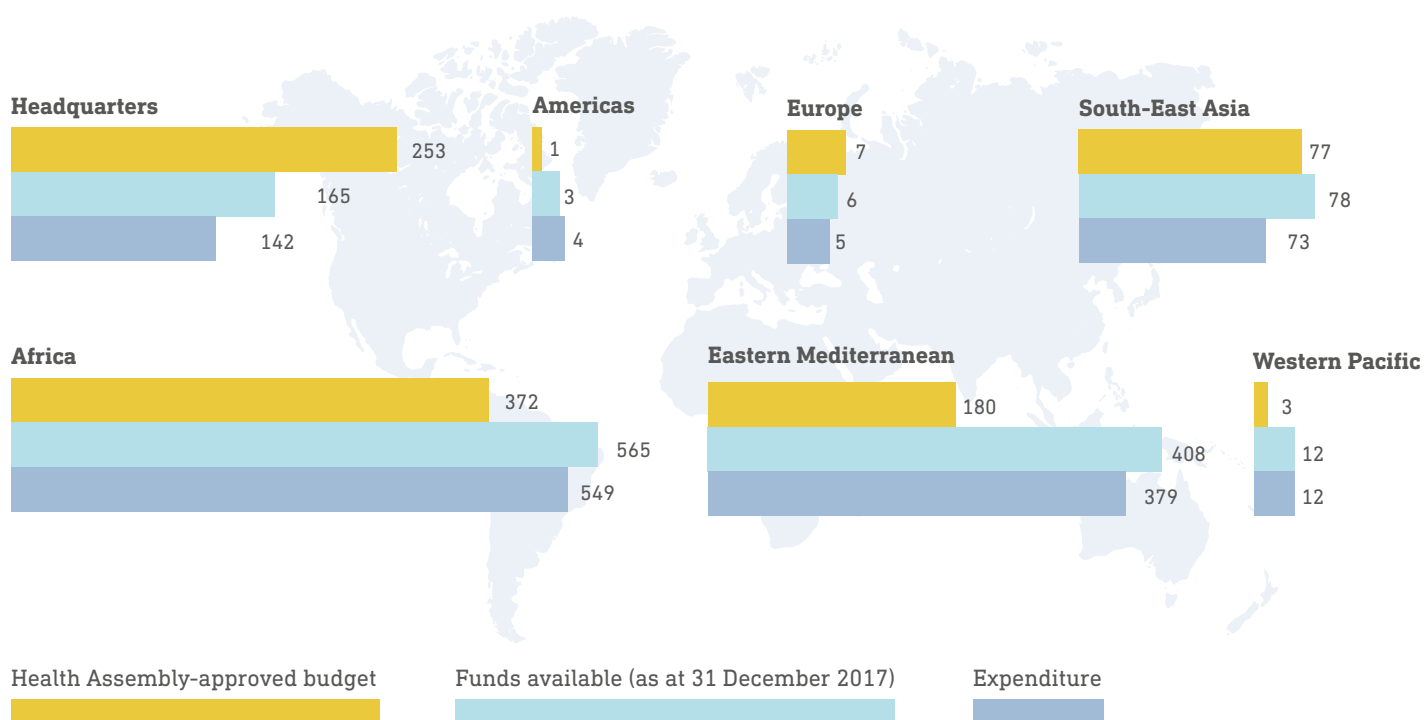
Key figures for 2016–2017

Approved Programme budget: US\$ 895 million

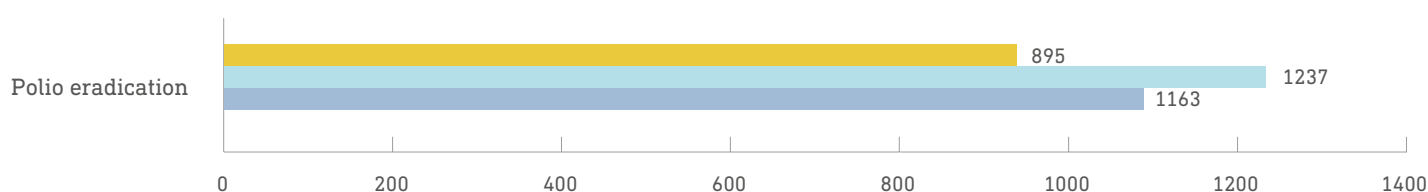
Funds available: US\$ 1237 million (142% of Programme budget)

Expenditure: US\$ 1163 million (138% of Programme budget, 94% of available resources)

Budget, funds available and expenditure by major office (in US\$ millions)



Budget, funds available and expenditure by programme (in US\$ millions)



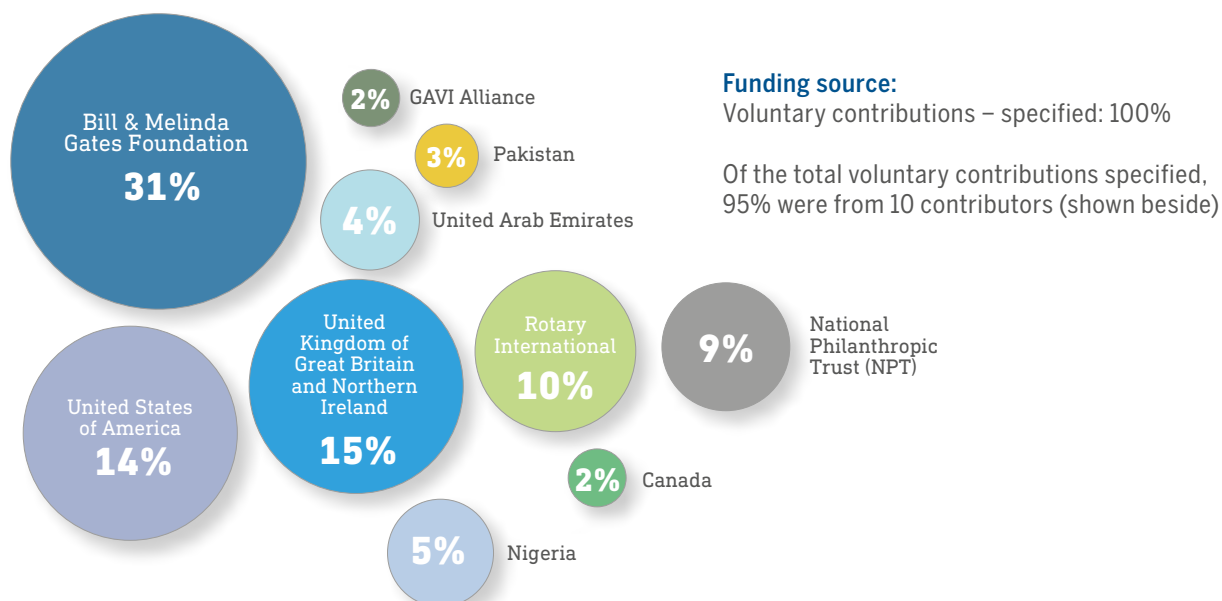
Budget and financing

The Health Assembly approved the budget increase for polio eradication for the biennium 2016–2017 in response to continued transmission of poliovirus in the African and Eastern Mediterranean regions.

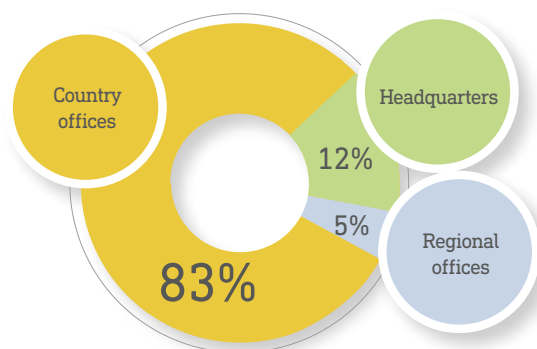
During the biennium, excess budget at headquarters was distributed to regions and countries, where nearly 90% of programme expenditures occur.



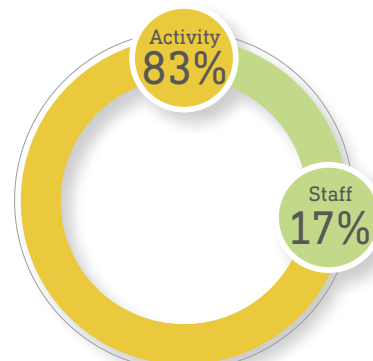
Top 10 voluntary contributors (specified)



Expenditure by level



Expenditure: staff vs. activity



Expenditure

About half of all expenditures occur in the three endemic countries, Afghanistan, Nigeria and Pakistan.

The highest cost activities are immunization campaigns in countries. Country costs also include payments for 6000 non-staff personnel in 63 countries. WHO staff account for less than one fifth of the overall programme costs.

The Global Polio Eradication Initiative has begun to scale down resources in the countries where polio is no longer endemic and this will continue into the biennium 2018–2019. As part of the process of transitioning away from polio resources, countries are defining and costing essential functions, such as disease surveillance, which will need to be sustained to ensure that the world remains polio free.

Special attention will be paid to ensuring that the potential financial liabilities associated with fixed-term staff of the polio programme are carefully monitored and provided for; and that country offices which are currently heavily reliant on polio funding will enjoy long-term sustainability in terms of both staffing and funding.

Similarly, priority areas in public health that have benefited from polio assets and infrastructure, such as outbreak response capacity, are being identified in order to find sources of support beyond the Global Polio Eradication Initiative partners, including governments.

LEADERSHIP AND ENABLING FUNCTIONS

“

We need a WHO – fit for the 21st century – that belongs to all, equally. We need a WHO that is efficiently managed, adequately resourced and results driven, with a strong focus on transparency, accountability and value for money.

Dr Tedros Adhanom Ghebreyesus
WHO Director-General

”



Programme areas

**Leadership and
governance**

**Transparency,
accountability and
risk management**

**Strategic
planning, resource
coordination and
reporting**

**Management and
administration**

**Strategic
communications**

Key objectives



to **lead and convene** decisions on public health issues between Member States and stakeholders



to give the Organization a sharper **results focus**



to ensure **adequate resources** and **good governance**, with the highest standards of integrity and oversight



to provide core **administrative services** that underpin the effective and efficient functioning of WHO

Key achievements

A time of transformation

The biennium 2016–2017 was historic, marked by bold leadership and far-reaching governing-body decisions, which, far from routine, demonstrated WHO's clarity of vision and the willingness to act pragmatically. This could prove to be a turning point for the Organization.

Two major events that carved out a fundamental new course for WHO were the devastating Ebola outbreak in West Africa and the adoption of the ambitious Sustainable Development Goals. The hard lessons learned from the Ebola outbreak propelled WHO's governing bodies into establishing the Health Emergencies Programme in 2016, marking a profound shift in the Organization's history. The Organization-wide changes to incorporate at all levels the 2030 Agenda for Sustainable Development, which calls for universal health coverage, presented considerable challenges.

In May 2017, Dr Tedros Adhanom Ghebreyesus was appointed Director-General of WHO. He introduced a clear mandate to prioritize health emergencies and universal health coverage, along with the Sustainable Development Goals.

Turning vision into reality

The election of Dr Tedros was the most inclusive and transparent election process in WHO's 70-year history. Shortly after being elected, Dr Tedros put in place a diverse leadership team, ensuring exceptional gender and geographic balance.

The Organization also moved swiftly to set its strategic priorities for the next five years, which highlight health emergencies, the Sustainable Development Goals and universal health coverage.

The draft thirteenth general programme of work, 2019–2023, is being prepared with Member States one year in advance to ensure a proper transition that encompasses the Organization's new strategic direction and priorities. It will also have an increased impact at the country level and will address the Sustainable Development Goals by incorporating them into all operational plans for the next biennium.

The new Director-General has set aside 5% of the Organization's budget to ensure that the universal health coverage agenda is incorporated in WHO's activities in 2018.

The new direction complements work achieved throughout the previous biennium. WHO has used its global voice and technical expertise to champion a range of critical health issues, including the growing health inequities in urban populations, global action to halt the rise of diabetes and to improve care for diabetics, and promoting research and development related to new antibiotics, whilst addressing the growing global resistance to antimicrobial medicines.

A new direction for WHO

The draft thirteenth general programme of work, 2019–2023 sets out a bold new vision for WHO. It summarizes WHO's mission to:

- Promote health
- Keep the world safe
- Serve the vulnerable

It outlines a grand plan to achieve the "triple billion" goal through three strategic priorities:

- 1 billion more people benefiting from universal health coverage
- 1 billion more people better protected from health emergencies
- 1 billion more people enjoying better health and well-being

Focus on countries

The first report on the performance of WHO in countries, territories and areas, presented to the Health Assembly in May 2017, highlighted selected country achievements.

Soon after, experiences from 106 countries informed the draft thirteenth general programme of work, 2019–2023. The priorities set out in the draft general programme of work were confirmed using an analysis of 64 country cooperation strategies dating from 2012 to 2017, which showed that 84% of the countries listed universal health coverage as their priority, and half of the countries listed as priorities Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and health-related goals.

The quality of Heads of WHO Offices in countries, territories and areas has been enhanced by using four merit-based assessment centres to identify a new cohort of potential candidates. Global induction for new Heads of WHO Offices was based on the draft thirteenth general programme of work and included strategic guidance from the Global Policy Group and capacity development through United Nations Country Team leadership training.

By the end of 2017, two thirds of 149 countries, territories and areas had valid country cooperation strategies or biennial collaborative agreements with their Member States. Fifteen more are in development and 30 are being initiated.

Improving transparency and accountability

WHO is continuing to improve transparency and has become a member of the International Aid Transparency Initiative. It has developed the programme budget web portal, which is open to the world and provides access to budget, financial, planning, funding allocation and country operations information with real-time results.

During the biennium, WHO carried out rigorous internal control assessments based on its internal control framework. Corporate risk management has been strengthened through enhanced risk training and reporting, the development of a new risk management tool and the establishment of a WHO Risk Committee.

By the end of the biennium, 80% of the Organization's critical risks had response plans that had been approved and implemented.

Efforts to foster a culture of evaluation throughout the Organization continued through the implementation of an evaluation policy, and the conduct of corporate and decentralized evaluations as per the Organization-wide evaluation work plan for 2016–2017 approved by the Executive Board. WHO also worked to establish a management-

Post-Ebola WHO Sierra Leone office improved

Following its experience during the severe Ebola outbreak of 2014–2015, the WHO Country Office in Sierra Leone implemented its workplan for the biennium 2016–2017, "From Ebola to Health", moving from emergency standard operating procedures back to normal office operations.

Staff numbers and budget needs far exceeded the pre-Ebola level, and the transition required adequate management structures and solid staff competencies. To facilitate effective workplan implementation, WHO reorganized the Country Office to strengthen management and accountability.

A senior management office was set up to lead on planning, budgeting, monitoring, resource mobilization and communication, thus allowing technical officers to focus on technical work.

To ensure programmatic coherence, quarterly management team retreats were held for in-depth discussions on cross-programme priorities. Together with enhanced information flow and regular peer recognition, the initiatives helped to increase technical effectiveness and accountability, with the results apparent in the strong performance recorded in the compliance review of the Country Office in 2016.



led mechanism to track implementation of recommendations from audits, evaluation and other assessments.

Efforts to promote good ethical behaviour, develop staff capacity and manage conflicts of interest continued with the strengthening of WHO's ethical framework. The new system of internal justice and a new policy on mediation were introduced, with increased emphasis placed on the role of the Ombudsman.

Supporting Kyrgyzstan through all levels of WHO

The WHO Country Office in Kyrgyzstan was strengthened. Through the strong leadership and coordination by the WHO Country Office, various teams from all three levels of the Organization (from human resources to country support, strategic planning, communications and partnerships) converged to provide support in areas where they were most needed.

An internal, but widely consulted, long-term vision for WHO's collaboration with Kyrgyzstan was developed, leading to a more focused country programme for 2018–2019.

Under WHO's convening role, policy dialogue and engagement of development partners led to the drafting of a new health sector strategy for Kyrgyzstan in a collaborative manner under the leadership of the Ministry of Health.

WHO is proving that the Organization can deliver results in a more efficient way through this type of initiative, which shows how WHO regional offices, in collaboration with headquarters, can converge to provide support through a country office.

Growing use of business intelligence service

696 unique users in December 2017 compared with 23 in January 2016

ISO 9001:2015 certification

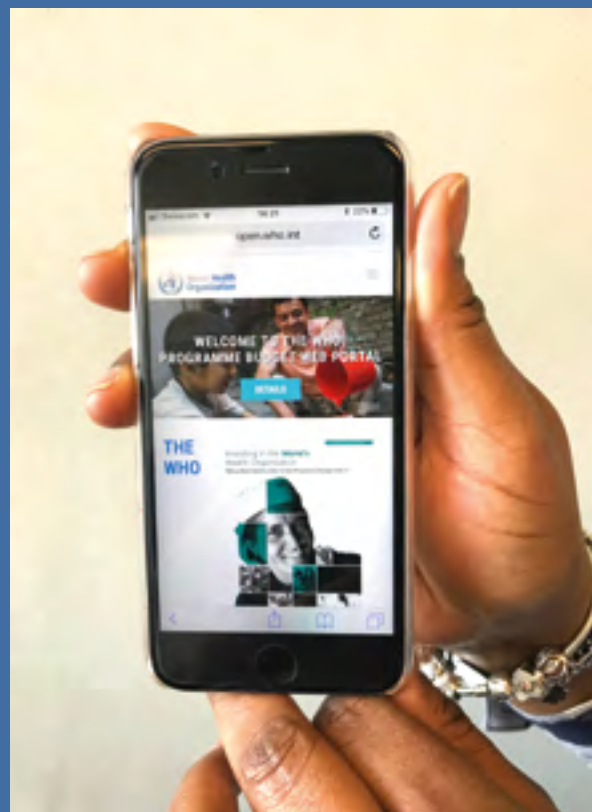
WHO's Global Service Centre achieved ISO certification for its standard of effective data quality management

Web portal opens WHO to the world

Since 2013, WHO has published budgets and expenditure figures (including by donor at the country level), results, key stories and documents. In 2016, transparency was enhanced through a re-designed programme budget web portal. In line with the newly-launched information disclosure policy, details of programmatic and budgetary results and achievements have been published on the web portal. The portal meets the International Aid Transparency Initiative compliancy commitment and allows stakeholders to have access to information on all WHO's achievements, including the resources involved.

The web portal makes programmatic and financial data more accessible. It has also led to an increase in the number of country-level documents, including Country Cooperation Strategy briefs.

WHO's programme budget web portal has been presented as a model for other United Nations agencies.



Framework for better engagement with donors and partners

The increasingly complex global health landscape involves a wide number of actors who play a significant role in advancing public health. WHO regularly engages with non-State actors (nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions).

A new external relations cluster has been created, bringing together the functions of governing bodies, resource mobilization, communications and partnership engagement. Additional health diplomacy functions will be built up in this integrated external relations function, covering the three levels of the Organization.

The ground has been laid for a revised engagement model with donors and partners. During the current biennium, 27% of voluntary contributions came from non-State actors. The goal is to increase WHO's engagement with partners and donors who can help achieve the triple billion goal of the draft thirteenth general programme of work. WHO cannot "go it alone". To achieve the ambitious goals, WHO is aiming at "thinking outside the box" on how it engages with donors and partners.

The Framework of Engagement with Non-State Actors, which was adopted by the Health Assembly in May 2016 after long negotiations, aims to strengthen and deepen WHO's engagement with non-State actors, while protecting its work from potential risks, such as conflict of interest and reputational risks.

The Framework provides WHO with a comprehensive policy and is also one of the strongest transparency and accountability systems employed by international organizations in their external engagements. Implementation of the Framework is under way and information about such engagements will be made publicly available online in a register of non-State actors.

Plans and budgets focused on achieving results at the country level

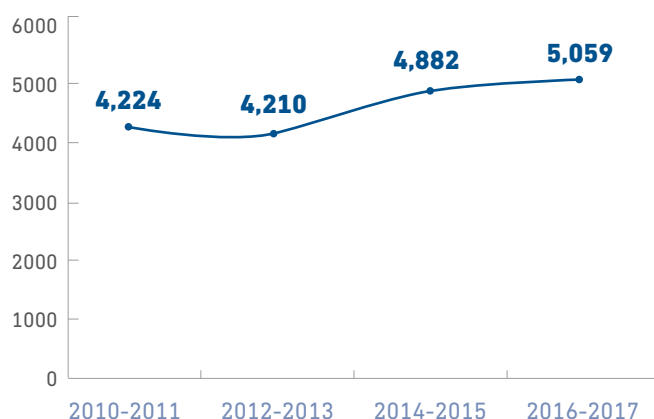
During the biennium 2016–2017, the Secretariat completed a significant shift to a bottom-up process, with the focus of work and identification of priorities at the country level. Most country offices prioritized their work and budgets to ensure that 80% of resources were in line with a limited set of country priorities. For the first time, the programme budget followed a bottom-up prioritization, after extensive consultations with Member States during regional committees and the Executive Board.

The Health Assembly endorsed the strategic budget space allocation model in 2016, and this has already guided the budgets for 2016–2017.

The bottom-up process has also meant that the Organization needed to introduce working mechanisms to achieve coherence between the levels of the Organization, such that global, regional, and country priorities are aligned. During the biennium, the category and programme area networks were established with the aim of achieving coherence in programme work across the Organization's three levels and better coordination of planning and monitoring.

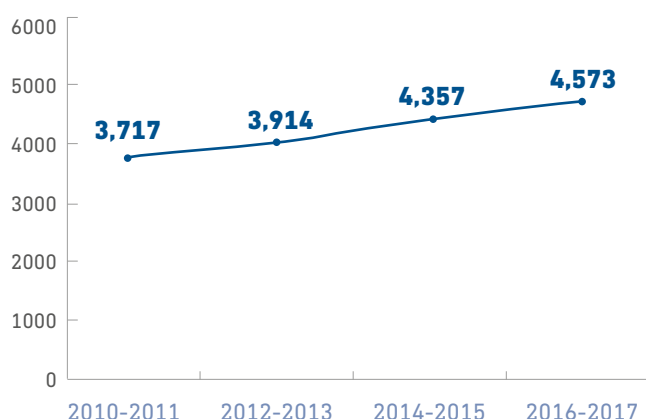
To better coordinate planning, budgeting and monitoring across the entire Organization, the Secretariat introduced more innovative and user-friendly tools. The small investments in these tools have improved the efficiency of the corporate business process.

WHO available resources for programmatic work (in US Millions)



i Rising available resources for WHO's work

WHO expenditure levels for programmatic work (in US Millions)



i Increasing WHO expenditure on public health interventions

A new way of working in the Eastern Mediterranean Region

Inspired by the strong push for intersectoral collaboration in order to achieve the Sustainable Development Goals, the Eastern Mediterranean Region launched an innovative way of increasing effectiveness and efficiency in programme implementation by means of cross-programme collaboration. The initiative sets out to strengthen cross-programme work at the regional office level by generating new avenues for technical collaboration. With strong leadership backing, the initiative garnered 60 innovative proposals for fostering intersectoral collaboration. A process for selecting the best proposals is now in place; the interest raised should further stimulate implementation. Lessons learned from this innovative regional approach will cascade down to the country level during the next planning cycle to further encourage the intersectoral collaboration needed for success with the Sustainable Development Goals.

Delivering value for money

Among the first initiatives of WHO's new leadership was the launching of a comprehensive, value-for-money approach to all actions undertaken by the Secretariat, and the fostering of an organizational culture driven by results and impact.

Value-for-money is not only about saving money. It is much broader. Simply put, it is to make the best use of available resources to achieve the greatest sustainable impact.

The approach is central to the draft thirteenth general programme of work, which moves beyond looking at processes or outputs and focuses instead on its impact on people.

The Secretariat presented a strategy note and an implementation plan to the Executive Board. The plan is aimed at ensuring a rigorous, single-minded focus on outcomes and impacts, through measurement and reporting of achievements.

An investment case underpinning the draft thirteenth general programme of work and the work of the Organization will be developed, and a set of concrete efficiency savings targets established in order to guide staff members towards operating in accordance with the value-for-money concept.

WHO Budapest Centre: demonstrating value for money

On 13 December 2016, the newly-established WHO Budapest Centre, an outpost of headquarters, opened in the Hungarian capital. Its current functions include:

- administration of internal justice, including the management of administrative reviews and the Global Board of Appeal
- management of long-term agreements and procurement catalogues

WHO conducted a comparative analysis of various locations that had the potential to offer cost-effective support in order to strengthen the WHO internal justice system, following the recommendations of an independent panel of experts.

Budapest emerged as the best option in terms of security, cost, skilled local workforce, quality of the premises offered and connections to and from Geneva.

Out-posting the functions to Budapest allowed WHO to substantially strengthen internal administration of justice without additional cost.

The experience of the Budapest Centre has been taken further with the creation in 2017 of a new administrative services platform for the African Region in Pretoria, South Africa. Cost savings should be seen as of 2018.



Management and administration that facilitates results delivery

In the biennium 2016–2017, management and administration focused on maintaining credible operations, maximizing available resources to meet increasing demands from Member States, and initiatives, through helping programmes to deliver intended results better by eliminating bottlenecks to processes, operations and administrative requirements at all levels. All processes and systems were examined, from the area of human resources to that of information technology.

The biennium saw a strong push for efficiency, with the Organization meeting increasing demands without a rise in budget levels.

Cost control combined with efficiency gains brought demonstrable results. Strengthened oversight of travel led to a 17 % reduction of the average cost of travel during 2016–2017.

In keeping with the policy, geographical mobility was pursued in 2017 and valuable lessons were learned. In the area of human resources management, the biennial target of a male:female staff ratio of 55:45 was almost reached at 55.6: 44.4 in the internationally recruited professional and higher categories. That represents a further step towards gender parity compared with the ratio of 57.2:42.8 scored in December 2016.

The Organization invested in information technology to provide improved support for WHO technical programmes. The results were evident in better project management and business intelligence. A new human resource system (Stellis) has simplified and accelerated WHO's recruitment processes.

The Organization was, for the first time, able to issue a Statement of Internal Control, as part of its annual financial statements – considered to be a best practice of enhanced financial control. That was complemented by the achievement by WHO's Global Service Centre of ISO 9001:2015 certification for effective data quality management, which also helps to strengthen internal controls and increases efficiency.

Security and premises management protocols were further developed with the refurbishment and reconstruction of the Regional Office for the Western Pacific, the headquarters campus, and the improved security requirements for several country offices. Efficiencies were achieved through engagement with United Nations Country Team partners. Meetings of governing bodies, including a Special Session of the Executive Board in November 2017, were conducted at the same time as extensive re-building works were in progress.

US\$ 115m

added to flexible funds in 2016–2017 following sound investment performance

Indicators to measure the performance of the Regional Office for Africa

In 2015, the Regional Office launched its ambitious, results-focused Transformation Agenda 2015–2020. Key performance indicators, with a focus on managerial/administrative and programmatic functions, were developed to measure results in the Region.

The capacity of WHO country offices to integrate and align with the key performance indicators in programmes, national goals and sustainable development goals was strengthened. Such indicators help to demonstrate WHO's performance, contribution, capacity and work towards achieving an accountable, strategic technical and programmatic focus. An online tool will facilitate reporting, transparency and accountability. The annual performance report on the key performance indicators for 2017 will be published in May 2018.

The above demonstrates the commitment of WHO's regions to innovative performance management, through a focus on individual accountability based on shared results.

62% decline in outstanding Direct Financial Cooperation (DFC) reports

Number of outstanding DFC reports dropped from 1116 at the end of 2015 to 430 by the end of 2017

Rising female–male international staff ratio

Biennial target of male:female staff ratio of 55:45 holding long-term appointments in the international professional and higher categories almost reached

Web dashboard shows real-time health threats

.....

Data spread across different sources and managed by different teams were making it difficult for the WHO Health Emergencies Programme to show a picture of an unfolding emergency. The process was time-consuming and prone to human error. In order to inform strategic decisions and align all teams behind the same “common operational picture,” the WHO Health Emergencies team had a critical need to have data on public health situations of concern that was unified and available through a single, intuitive dashboard.

A six-week project was conducted to deliver a secure, stable and flexible map-enabled interactive web dashboard, bringing together signals about new threats, events being studied and graded emergencies where WHO had committed resources.

For the first time, decision makers at headquarters, in regions and countries had a full, near-real-time view of the world’s emergency health situation, on their computers and mobile devices.



Bringing services closer to the people we serve

.....

The Division of Pacific Technical Support supports 21 Pacific island countries and areas, bringing WHO closer to those it serves. For example, emergency supplies were strategically repositioned in order to reduce the time required to deliver relevant supplies following natural disasters.

When a series of disasters struck Pacific island countries, WHO was able to deploy supplies during the disasters, particularly in isolated areas. Moreover, having a subregional platform for procurement is more efficient and responsive as technical programmes can better support countries through streamlining and can build capacity for procurement close to where it is needed.

Moving forward

The focus of leadership and enabling functions in moving forward is on ensuring implementation of the strategic and organizational shifts as envisioned in the draft thirteenth general programme of work.

WHO will:

- provide leadership on matters critical to the health of all people, engaging in partnerships where joint action is needed
- place countries at the epicentre of its work by driving public health impact
- focus its global public goods on delivering tangible impact at the country level
- monitor its performance, and establish an independent accountability mechanism to monitor outcomes of the implementation of the Thirteenth General Programme of Work
- reshape planning, including the operating model, so that country level impact is driving the work at all levels of the Organization
- strengthen critical systems and processes to optimize organizational performance by developing a workforce that is fit for purpose, highly competent, motivated and empowered

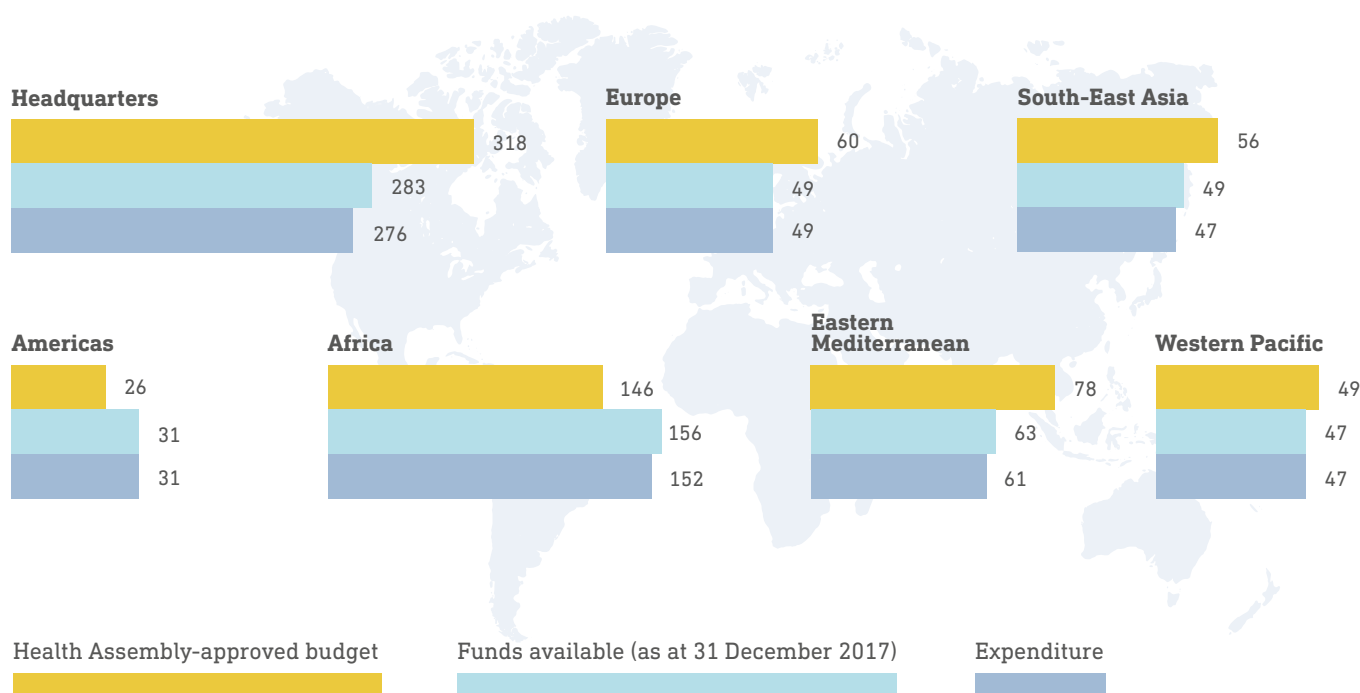
Key figures for 2016–2017

Approved Programme budget: US\$ 734 million

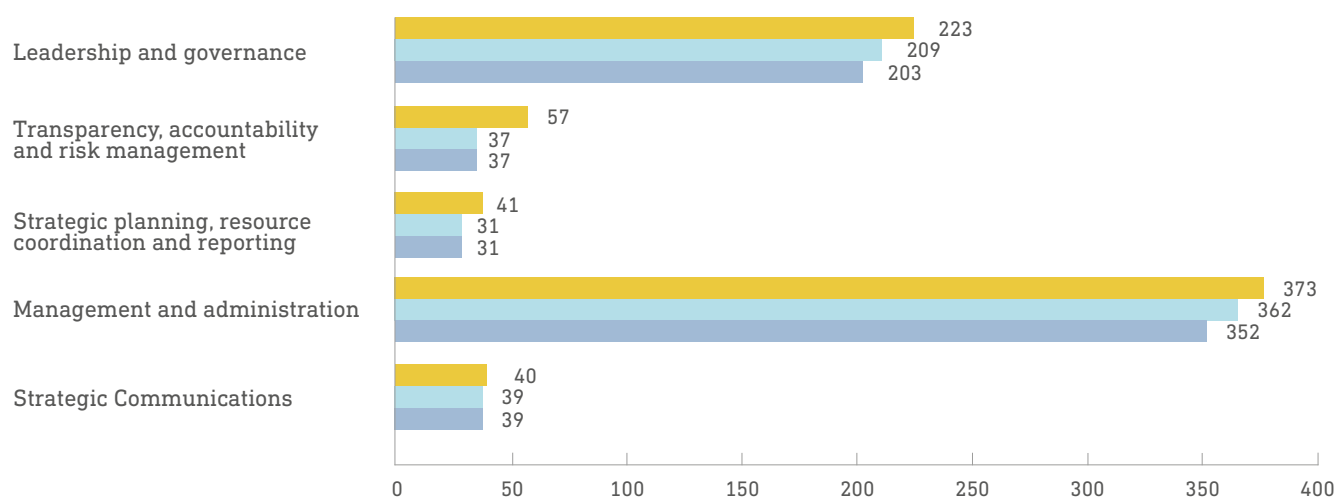
Funds available: US\$ 678 million (92% of Programme budget)

Expenditure: US\$ 661 million (90% of Programme budget, 98% of available resources)

Budget, funds available and expenditure by major office (in US\$ millions)



Budget, funds available and expenditure by programme (in US\$ millions)



Budget and financing

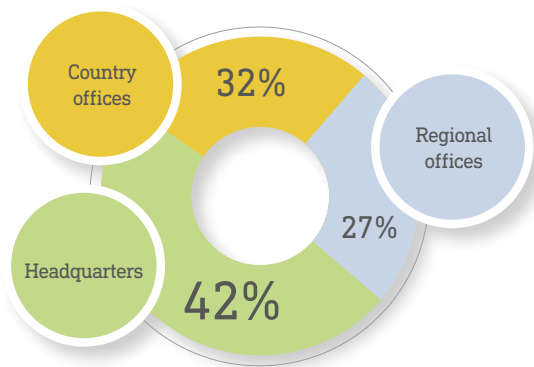
The category of work is resourced mainly from assessed contributions and administrative support costs (about 96%). The small amount of funding from voluntary contributions was intended to implement distinct projects managed within the framework of leadership and governance, as agreed with the donor, and contributed to the transformation work of the Regional Office for Africa during the biennium.

With a large portion of governance and corporate services being delivered from the headquarters budget, 41.7% of available resources was allocated to headquarters level. A significant portion is allocated in countries (32.2%) to maintaining an

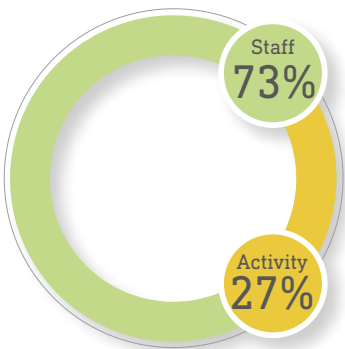
effective presence in 148 countries, including financing the salaries of Heads of WHO Offices in countries, territories and areas, and running these offices.

Governance and enabling functions do not attract donor support, yet they remain essential to the functioning of WHO as a whole. This makes the Organization very vulnerable to any major reduction in flexible funding or increase in requirements without increased funding. WHO is managing this risk by continuing to seek economies of scale and efficiency savings in administration and management.

Expenditure by level



Expenditure: staff vs. activity



Expenditure

A significant portion of expenditures (73%) is to ensure sufficient staffing at all levels of the Organization, not only for managerial and administrative staff, but for the entire senior management across all three levels. About 32% of expenditures have been dedicated to country level operations.

A total of 42% of expenditures was incurred at headquarters level (including WHO's Global Service Centre), since a significant part of the operations are corporate in nature or tend to be centralized for efficiency purposes and to gain

economies of scale. The 32% of total expenditures devoted to countries is for maintaining around 150 offices, including financing the salaries of the heads of country offices and immediate staff.

The significant expenditure on staff levels (73%) reflects the need for human expertise to maintain and utilize governance and enabling functions.

