

Driving impact in every country



The WHO Results Report, Programme Budget 2018–2019 (document A73/24) will be submitted to the Seventy-third World Health Assembly. This e-book version represents the document unchanged.



Front cover painting:

'Health workers for the triple billion goals' – painted by delegates of the Seventy-second World Health Assembly, under supervision of the artist. It aims to capture the pivotal role played by health workers in the delivery of the WHO's Thirteenth General Programme of Work to promote health, keep the world safe and serve the vulnerable.

Each panel represents one of the triple billion goals.

Dairo Vargas is a contemporary fine artist, who is passionate about health care. He is involved in improving health and mental well-being through global initiatives, as well as local community and charity work.

Photo credits, in order of appearance:

Director-General's foreword

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Executive summary

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Leadership and enabling functions

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DIRECTOR-GENERAL'S FOREWORD



As I write this, the COVID-19 pandemic has the world in its grip, and shows little sign of relenting. In less than five months, more than 4 million people have been infected and nearly 300 000 people have lost their lives – and counting. This new virus has taken a terrible toll on lives and livelihoods around the world, exploiting the gaps in health systems and magnifying inequalities. Its political, economic and social effects will be felt for years to come.

Already, immunization campaigns against polio, measles, cholera, and other vaccine-preventable diseases have been suspended, and hard-won gains against HIV, malaria and TB are at risk. The total number of deaths resulting from the public health disruptions caused by COVID-19 could be many times greater than the death toll caused directly by the disease.

The pandemic is a graphic illustration of the vital interconnections of the work of WHO across each of the “triple billion” targets: emergency preparedness and response, universal health coverage, and healthier populations. As COVID-19 reminds us, the Organization’s areas of work are interdependent, and none can exist without the others.

This Results Report lays out the vital work that we do, and shows how, even as we are responding to one public health event or crisis, we are also working to support countries in meeting the health needs of their populations, strengthening their systems, and planning for the unexpected.

With the pandemic dominating the headlines now, it is easy to forget that WHO is simultaneously taking on multiple other health threats, both ancient and modern.

As we work on responding to this pandemic, we must also prepare for the next one. Now is an opportunity to lay the foundations for stronger and more resilient health systems around the world.

The pandemic is a stark reminder of the need for urgent and sustained investment in health workers and health systems, as the best defence against health crises – both major, large-scale crises and those occurring at an individual level that millions of people face every day.

Health is a political choice. We face shared threats and we have a shared responsibility to act. If we learn anything from COVID-19, it must be that investing now saves lives – and money – later.

WHO’s commitment is not only to bringing countries together to end this pandemic, but also to building a healthier, safer, fairer world for everyone, everywhere.

EXECUTIVE SUMMARY

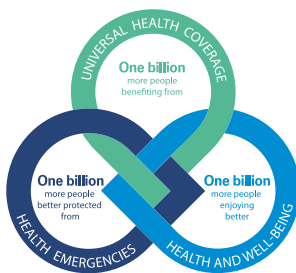
DRIVING IMPACT IN EVERY COUNTRY

Exactly 70 years after the founding of WHO, driven by the changing global health landscape of the 21st century, the Organization underwent a transformation across all six regions and 149 field offices. In 2019, WHO adopted a new strategy and mission and new priorities and targets with the overarching objective of delivering impact in every country.

The **Thirteenth General Programme of Work 2019–2023** (GPW 13) articulated a mission of what the world needs WHO to do: Promote health, keep the world safe, serve the vulnerable.

The yardstick of success for the new data-driven strategy is impact in countries. The ambitious “triple billion” targets, aligned with the Sustainable Development Goals, were set around 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 living with **better health and well-being**.



The GPW 13 emphasizes strategic shifts by stepping up leadership, focusing global public health goods on impact in countries and delivering an integrated approach that avoids programme silos.

Although the results presented in this report are aligned with commitments in the biennium 2018–2019 under the previous strategic plan – which defined how work was planned and budgeted – this report looks at WHO’s achievements and challenges through the lens of the new strategy. This will help set the baseline of where we are with respect to the new “triple billion” targets.

Many stories describe the contribution of WHO’s longer-term work to driving impact in every country. WHO’s work includes every country, large and small, even fragile and conflict-affected States; spans all conditions and diseases; and serves all people, young and old.

This report shows the results of a bottom-up process – starting at the country level – for monitoring progress and reporting on achievements and challenges in implementing the Programme budget 2018–2019, before the crisis caused by the outbreak of coronavirus disease (COVID-19).

An enormous challenge lies ahead, but the world is better positioned than ever before to face this unprecedented public health crisis. WHO will continue to lead countries not only to defeat COVID-19 but also to change the trajectory of global health and build a healthier, safer, fairer world for everyone.

ACHIEVING 1 BILLION MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE

WHO has transformed the definition of universal health coverage from a goal to a movement, advocating that it is a moral, economic and security imperative. A lack of access to affordable health care causes poverty and hinders economic growth, while weak health systems can be fault lines for diseases to spread.

WHO's leadership in this area has led to historic firsts. Countries approved a political declaration that includes comprehensive health commitments at the United Nations General Assembly in 2019. WHO also advocated on the issue for the first time at the G20 summit held in Osaka in June 2019 and at the Inter-Parliamentary Union Assembly held in Belgrade in October 2019.

Several countries have now made progress on the road to universal health coverage, with WHO's support and expertise. Greece, India and Kenya have rolled out ambitious programmes to expand coverage, while China, Egypt, and the Philippines have adopted important legislations to promote universal health coverage and the Government of Ukraine has increased its share of the financing of primary health care.

Although access to health services has expanded, the world is still far short of the 1 billion target and financial protection has weakened, as indicated in WHO's *Global Monitoring Report on Financial Protection in Health 2019*. In 2015, 930 million people spent 10% of household consumption on health and that number is growing. WHO's response has been to create a special programme on primary health care and provide more broad-based support to countries.

A key component of universal health coverage is the availability of accessible, affordable medicines, which WHO advances through prequalification. WHO prequalified 213 products in 2018–2019, including pioneering game-changers in a biosimilar life-saving drug for breast cancer, an Ebola vaccine critical for response efforts and a biosimilar insulin for diabetics.

The dramatic price reductions of antivirals, which WHO has supported, has enabled more people to afford hepatitis B and C medicines and more countries to strive for hepatitis C elimination, while also enabling countries such as China to include them in universal insurance coverage. A pilot programme for the world's first malaria vaccine may save many children's lives in future; some 200 000 children have now been vaccinated in Ghana, Kenya and Malawi.

Access to quality essential health services is key to reducing maternal and child mortality, which has declined significantly since 2000, in part due to more health facility births and greater political will. Expanded coverage and access have also helped several countries (Egypt, Ghana, Iran (Islamic Republic of), Kiribati, Mexico, Nepal and Yemen) reach elimination goals in a neglected tropical disease in 2018–2019. Malaysia, Maldives and Sri Lanka also achieved mother-to-child elimination of HIV and congenital syphilis.

Significant work is needed to further expand coverage to end the epidemics of leading communicable diseases. Recent gains include the expansion of HIV self-testing, a higher level of treatment for tuberculosis than ever before, the expansion of hepatitis C curative treatment to low- and middle-income countries, and the provision of treatment for at least one neglected tropical disease to 1 billion people; however, reaching isolated pockets of coverage so that no one is left behind remains a formidable challenge. Although 116 million more children received a basic set of vaccines in 2018, it is unlikely that the global targets for measles, rubella and maternal and neonatal tetanus elimination will be achieved by the end of 2020.

Significant progress has been made in ramping up the capacity to embed interventions for noncommunicable diseases within primary health care, in particular those for hypertension, heart disease, childhood cancer and mental health. The scale-up of the HEARTS package has resulted in more than 700 000 people receiving treatment for hypertension. Yet progress is still insufficient to meet targets, while the prevalence of diabetes, overweight and obesity continues to increase.

ACHIEVING 1 BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES

To “keep the world safe”, WHO battled outbreaks and responded to health needs in humanitarian crises in 2018–2019, including natural disasters and conflicts such as those in Mozambique, the Syrian Arab Republic and Yemen. WHO has recently taken a more hands-on approach to emergencies, putting boots on the ground in challenging crises.

WHO also works to detect, assess, communicate, prevent and prepare for public health emergencies. During 2018–2019, WHO picked up thousands of public health threat “signals” every month, of which more than 980 (in 140 countries) were assessed to be emergency events and responded to, where necessary.

Following the outbreak of Ebola virus disease in the Democratic Republic of the Congo, WHO coordinated a huge and complex operation, made more difficult by violence, a mobile population and a dearth of health facilities. After 18 months of operation, the Democratic Republic of the Congo achieved a zero-case level of Ebola virus disease. Thousands of front-line responders braved considerable risks to defeat the virus, as COVID-19 responders are doing today. Sadly, WHO lost five responders.

Despite fears that the disease would spread to neighbouring countries, that never happened. Strong preparedness efforts contained the outbreak at a cost of US\$ 18 million in Uganda, which was a fraction of the total response cost of US\$ 1 billion.

As is evident with the COVID-19 pandemic, a disease outbreak can bring a nation to its knees, particularly if the resilience of the health system is weak. All too often, the world responds with panic rather than epidemic preparedness to an outbreak. Investing in preparedness saves lives and money.

In November 2019, the Global Preparedness Monitoring Board published its first report, which warned that the world was dangerously unprepared for a “very real threat of a rapidly moving, highly lethal pandemic of a respiratory pathogen” – a risk that remains very real. Fifteen years ago, the International Health Regulations (2005) were ratified and have never been more relevant. The world must do more to prepare against pandemics by fully implementing them. Many countries still need to strengthen their core capacities to prevent, detect and respond to threats. In 2018–2019, WHO completed its 100th joint external evaluation, a preparedness exercise in countries. The International Health Regulations (2005) constitute the only international legally binding framework for protecting against, and responding to, the international spread of diseases.

Some crises never made the headlines due to successful prevention efforts. Case numbers fell in major cholera hotspots such as Somalia, South Sudan and Yemen. Globally, cholera cases declined by 60% in 2018 thanks to the delivery of 18 million doses of the vaccine. Mass vaccination against yellow fever protected more than 100 million people from the disease in 2018–2019. Some 500 million people were also vaccinated for seasonal influenza in 2019.

For some diseases, vaccination programmes need to be strengthened. Multiple measles outbreaks have occurred in the last two years. Polio eradication has also faced challenges. The 175 cases of wild poliovirus detected in 2019 in Afghanistan and Pakistan were the most since 2014.



ACHIEVING 1 BILLION MORE PEOPLE LIVING WITH BETTER HEALTH AND WELL-BEING

WHO advocates the promotion of health rather than merely the treatment of disease, especially among vulnerable populations. This involves looking beyond the biomedical view of health to identify the root causes of health outcomes, including determinants such as equity, gender, rights, education and the environment. As these often lie outside the health sector, multisectoral collaboration is needed to address them.

Cleaner, safer and more supportive societies promote healthier populations. WHO's leadership has helped secure political commitments from countries to meet WHO air quality guidelines, address climate change and improve health. At the United Nations Climate Action Summit held in 2019, 50 countries – representing more than 1 billion people – answered WHO's call to provide citizens with clean air by 2030, committing to achieve WHO's recommendations. The number of cities monitoring air quality measurements through a WHO air quality database has quadrupled since 2011, reaching 4300 in 2018. Thirty countries have already made significant progress in meeting their commitments to improve safe water, sanitation and hygiene (WASH) in health facilities.

WHO's Framework Convention on Tobacco Control has protected more and more people against the harms of tobacco since it was ratified 15 years ago. Currently, about two thirds of the global population are covered by at least one tobacco control measure under WHO's "MPOWER" package.

A historic agreement was reached between WHO and the International Food and Beverage Association, which has committed to eliminate industrially produced trans-fats from the global food supply by 2023. Fifty-four countries have established legislations to eliminate industrial trans-fats from the food supply following WHO's REPLACE package. With the support of WHO, 60 countries now have a tax on sugar-sweetened beverages.

A new tool has been launched to analyse the strengths and weaknesses of national food safety systems and prioritize interventions with the Food and Agriculture Organization of the United Nations (FAO). WHO has also worked with FAO and the World Organisation for Animal Health in a tripartite arrangement to strengthen action against antimicrobial resistance. Alliances with civil society and other partners have helped improve road safety in Chile, Kazakhstan, Malaysia, Slovenia and Trinidad and Tobago.

Work to promote health and well-being faces a significant challenge, however, in attracting the attention and investments that it deserves based on its impact on morbidity and mortality. Although WHO has a proud history of advocating for health promotion and prevention, it is only now consolidating its strategy to address these determinants of health in line with GPW 13.

ENABLING WHO TO BETTER SERVE COUNTRIES

In view of the changing global health landscape over the last two decades, WHO is deeply conscious that it needs to be agile, innovative, responsive and fit-for-purpose in the 21st century. Through the leadership of the Director-General, supported by the Regional Directors, WHO has strengthened its voice, advocating for accelerated progress in key health issues. It has elevated its health diplomacy to the highest levels of government at national and global levels and in international and regional political bodies, such as the G20, G7 and the Africa Union, resulting in concrete commitments in promoting the health agenda within and beyond the health sector.

WHO is finding innovative ways of engaging with non-health sectors and partnerships. Under the Global Action Plan for Healthy Lives and Well-Being for All, WHO partnered with 11 other global health agencies to align and focus support to countries. Innovative health partnerships have widened WHO's influence: it has partnered with FIFA on projects targeting children and young adults and with Google to produce GoogleFit, an app that monitors physical activity.

The need to be guided by science and evidence in addressing urgent, new problems such as COVID-19 grows ever more important in an era of fake news and misinformation.

The new Science Division at headquarters reflects WHO's commitment to being at the forefront of science and producing world-class, evidence-based norms and standards. The COVID-19 pandemic shows how the Science Division could play a pivotal role in a science-based response to the crisis. The new Data and Delivery Division at headquarters and the aligned structures in the regional offices demonstrate WHO's sharpened focus on delivering impacts and the capacity to measure them through its new results framework and measurement system.

WHO has developed effective digital management tools to support emergencies, including the Go.Data outbreak investigation tool; e-SPAR, a platform to support countries in their annual reporting for the International Health Regulations (2005); and EMS2, a system to provide information flows.

To best support countries, processes have been redesigned and global public health goods have been prioritized for impact in the first-ever review of fit-for-purpose staff capacity to best align WHO's workforce at the country level.

Providing support for countries is and will remain paramount among WHO priorities in the long road ahead to fight COVID-19. No country can solve the crisis alone and WHO will continue to share experiences, expertise, resources and technical support with countries. The virus will be beaten through solidarity across countries and globally.



THE **PROGRAMME BUDGET 2018–2019** WAS THE LAST AND THE **LARGEST** OF THE THREE PROGRAMME BUDGETS (2014–2019) OF THE TWELFTH GENERAL PROGRAMME OF WORK, 2014–2019

BUDGET IMPLEMENTATION SUMMARY

The Programme budget 2018–2019 was last and the largest of the three Programme budgets (2014–2019) of the Twelfth General Programme of Work, 2014–2019. The Health Assembly-approved Programme budget 2018–2019 totalled US\$ 4422 million and was presented in two distinct segments:

US\$ 3.4 BILLION



Base budget

US\$ 1.02 BILLION



Polio eradication; Special Programme for Research and Training in Tropical Diseases; and Special Programme of Research, Development and Research Training in Human Reproduction

Compared with the first two Programme budgets of the Twelfth General Programme of Work, the approved Programme budget 2018–2019:

- was the largest budget;
- did not include a planned budgeted amount for the Outbreak and crisis response and scalable operations;
- fully integrated the WHO Health Emergencies Programme into the base segment.



IN 2018–2019 WHO IMPLEMENTED PROGRAMMES WORTH OVER US\$ 5.3 BILLION

Considering all the operational segments of the Programme budget 2018–2019 (base, Polio eradication, Special programmes, Outbreak and crisis response and scalable operations), WHO implemented programmes worth over US\$ 5.3 billion. When considered in the light of the overall trends across the period of Twelfth General Programme of Work, the levels of absolute funding and implementation of the Programme budget 2018–2019 were the highest of the three bienniums (Figure 1).

Implementation of base programmes in 2018–2019 represented 57% of total implementation. The Outbreak and crisis response and scalable operations segment was the second largest level of operation, representing 22% of total implementation, while the Polio eradication segment represented 19% and the Special programmes segment only 2% of total implementation (Figure 2). In the African and the Eastern Mediterranean regions, the Outbreak and crisis response and scalable operations segment and the Polio eradication segment represented more than 50% of total implementation and as much as 77% for the Eastern Mediterranean Region. It therefore became clear that the lack of an approved Outbreak and crisis response and scalable operations budget segment in 2018–2019 led to about 20% underrepresentation of the WHO level of operation when compared to the approved budget. As stipulated in Health Assembly resolution WHA72.1 (2019), the Programme budget 2020–2021 will include an estimated budget for the Humanitarian response plans and other appeals segment.

FIGURE 1: OPERATIONALIZATION OF THE PROGRAMME BUDGETS OF THE TWELFTH GENERAL PROGRAMME OF WORK, BY BIENNIUM (IN US\$ MILLION)

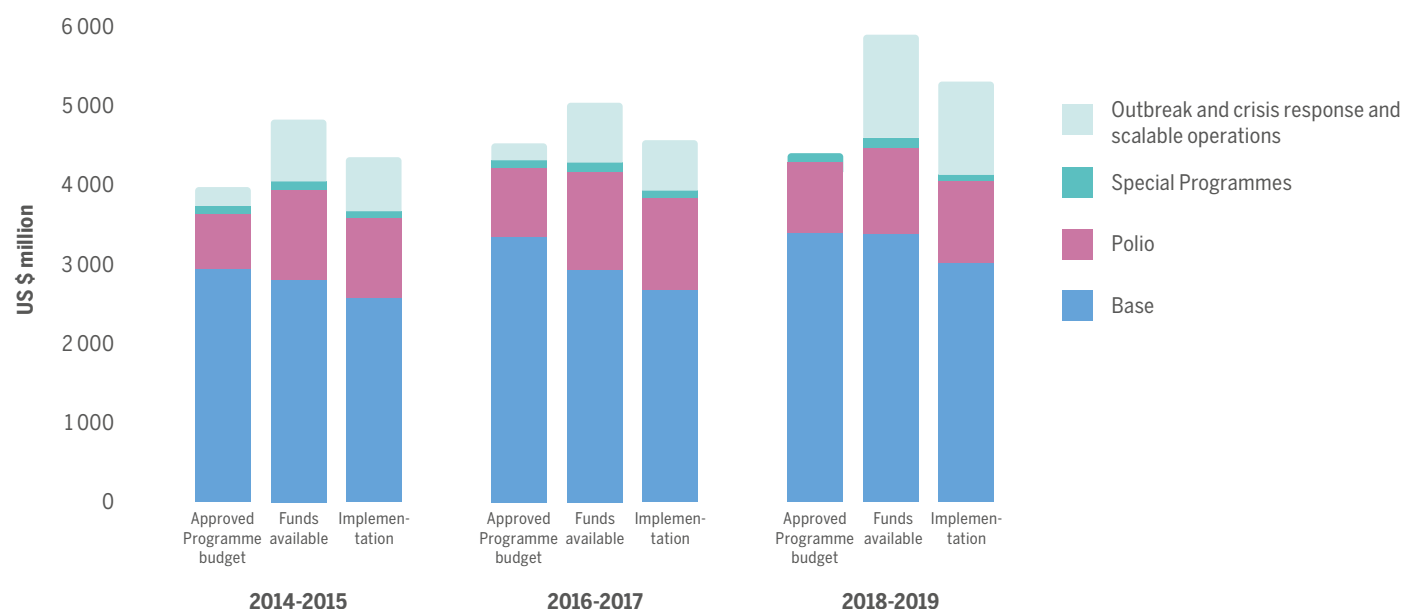
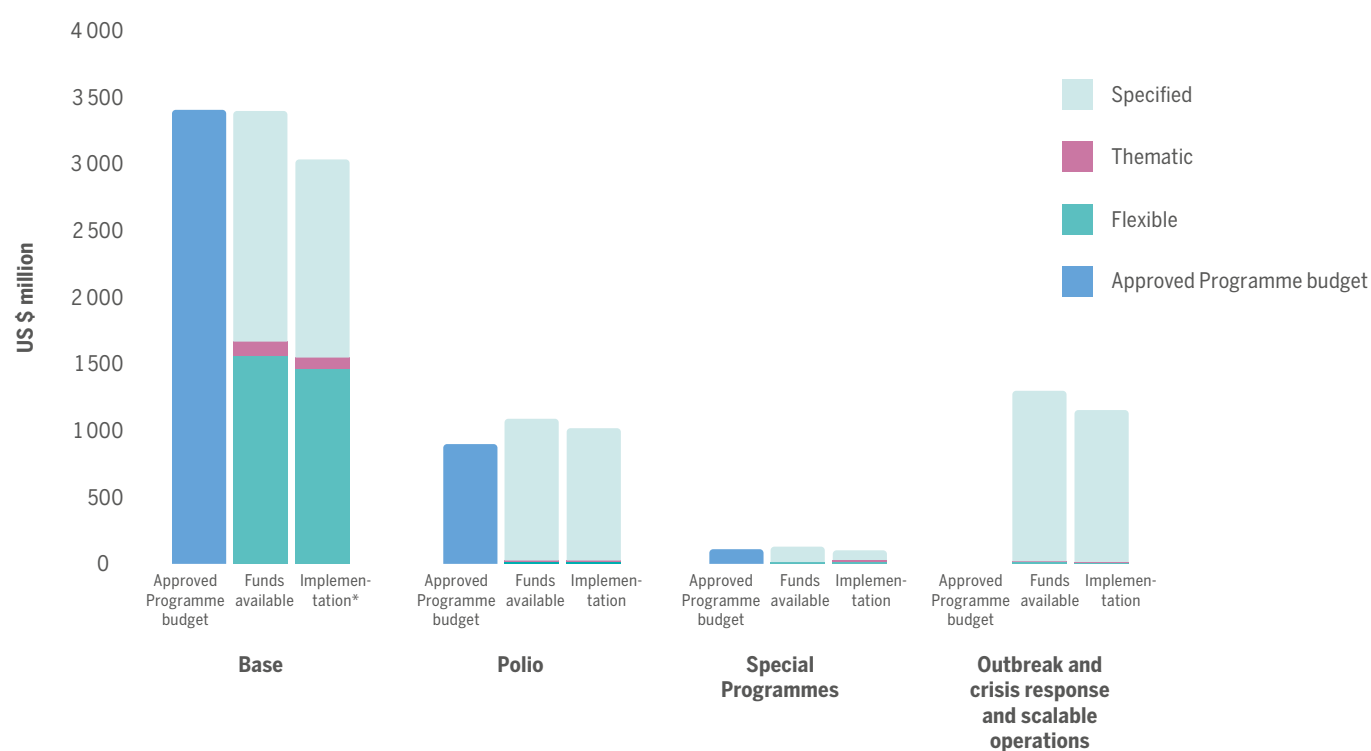
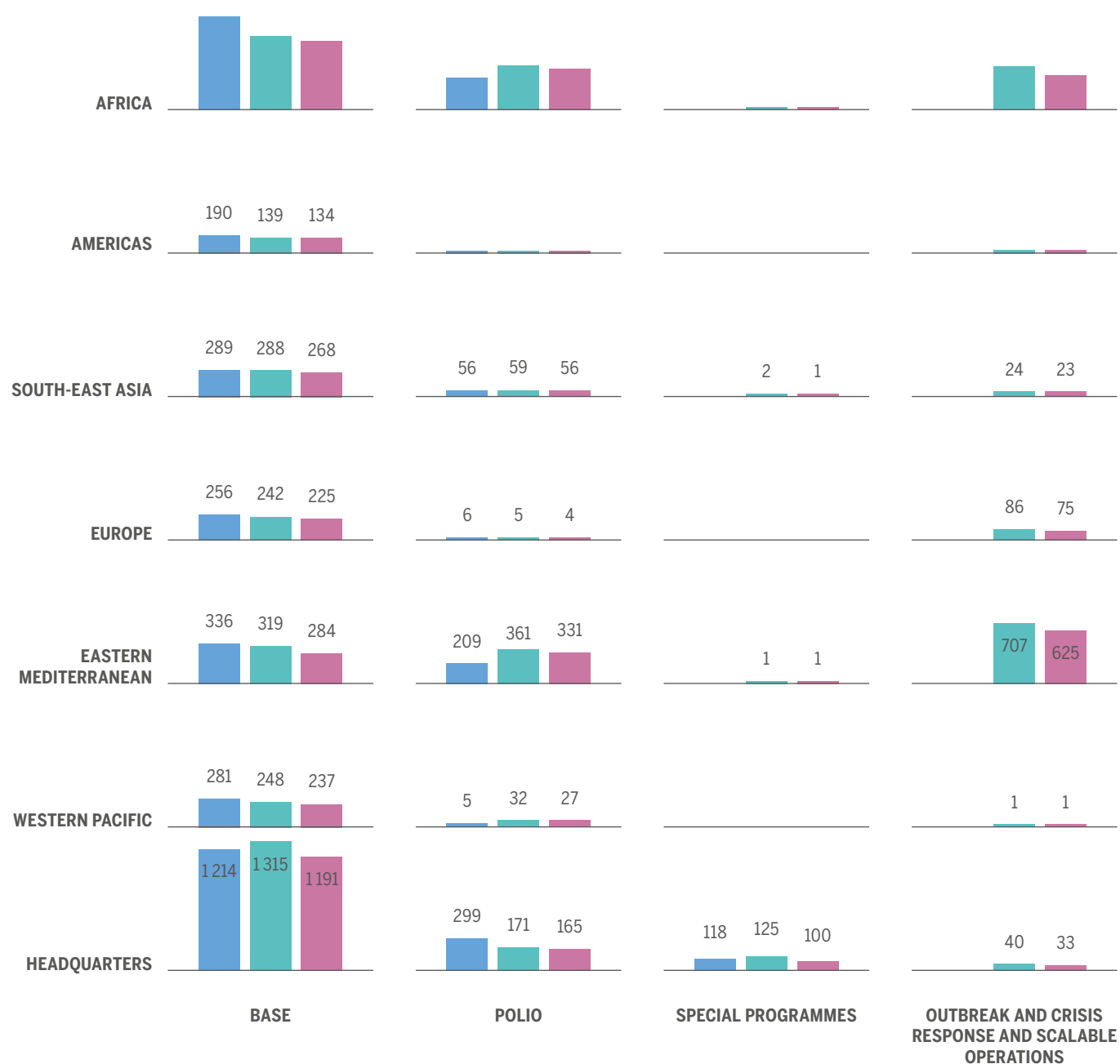


FIGURE 2: OPERATIONALIZATION OF PROGRAMME BUDGET 2018–2019, BY SEGMENT (IN US\$ MILLION)



* US\$ 1.3 million difference with the Audited Financial Statement (A73/25) due to the manual correction of a negative expenditure.

FIGURE 3: OPERATIONALIZATION OF PROGRAMME BUDGET 2018–2019, BY MAJOR OFFICE (US\$ MILLION)



■ Approved Budget
 ■ Funds available
 ■ Implementation

All major offices, with the single exception of the Regional Office for the Americas,¹ had their total approved Programme budget 2018–2019 close to fully funded – the European Region had the lowest level, at 94% (Figure 3). There was also a close alignment in the level of funding among the major offices. Similarly, the implementation of the approved Programme budget was well aligned among the major offices, with an exception of the Regional Office for the Americas, while in all cases the level of implementation in 2018–2019 was higher than in 2016–2017. The implementation of available funds was above 90% for all major offices without exception.

In 2018–2019, WHO had the highest funding level of the period of the Twelfth General Programme of Work, with respect to both the approved Programme budget and the Outbreak and crisis response and scalable operations segment (Figure 4). The base budget was 49% funded from corporate flexible funds² and thematic voluntary contributions (funds earmarked at a high level to priority areas but within which there is considerable discretion for deployment according to need³) and 51% funded from specified voluntary contributions. The Organization also benefited in 2018–2019 from a 3% higher amount of assessed contributions as compared to previous bienniums, in keeping with resolution WHA70.5. In addition, the absolute level of thematic funds increased nearly 2.5 times compared with 2014–2015.



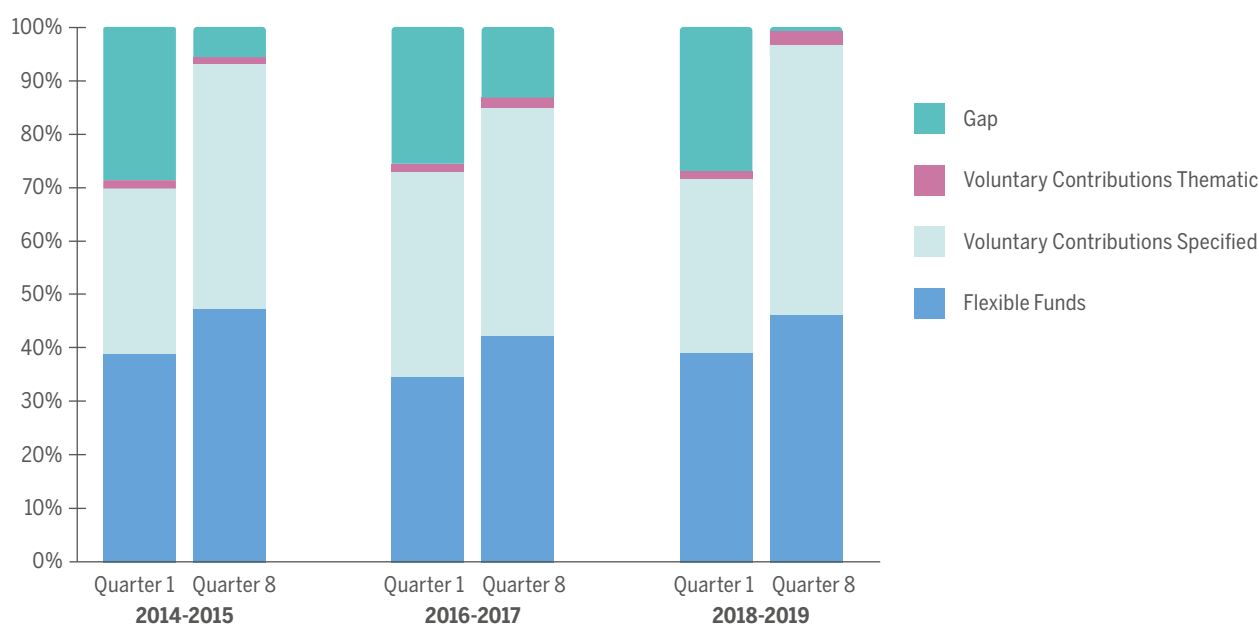
IN **2018–2019**, WHO HAD THE **HIGHEST FUNDING LEVEL** OF THE PERIOD OF THE TWELFTH GENERAL PROGRAMME OF WORK

¹The funding modality of the WHO Regional Office for the Americas differs from that of the other regional offices; while the resources of the other regional offices are either mobilized globally or by regional and country offices, its resources are mobilized entirely at the WHO global level.

² Assessed contributions, core voluntary contributions and programme support costs.

³ Referred to as voluntary contributions – core in the audited financial statement (document A73/25).

FIGURE 4: PERCENTAGE OF PROGRAMME BUDGET FUNDED ACROSS THE THREE BIENNIA, BY FUND TYPE AT THE BEGINNING AND END OF THE BIENNIUM



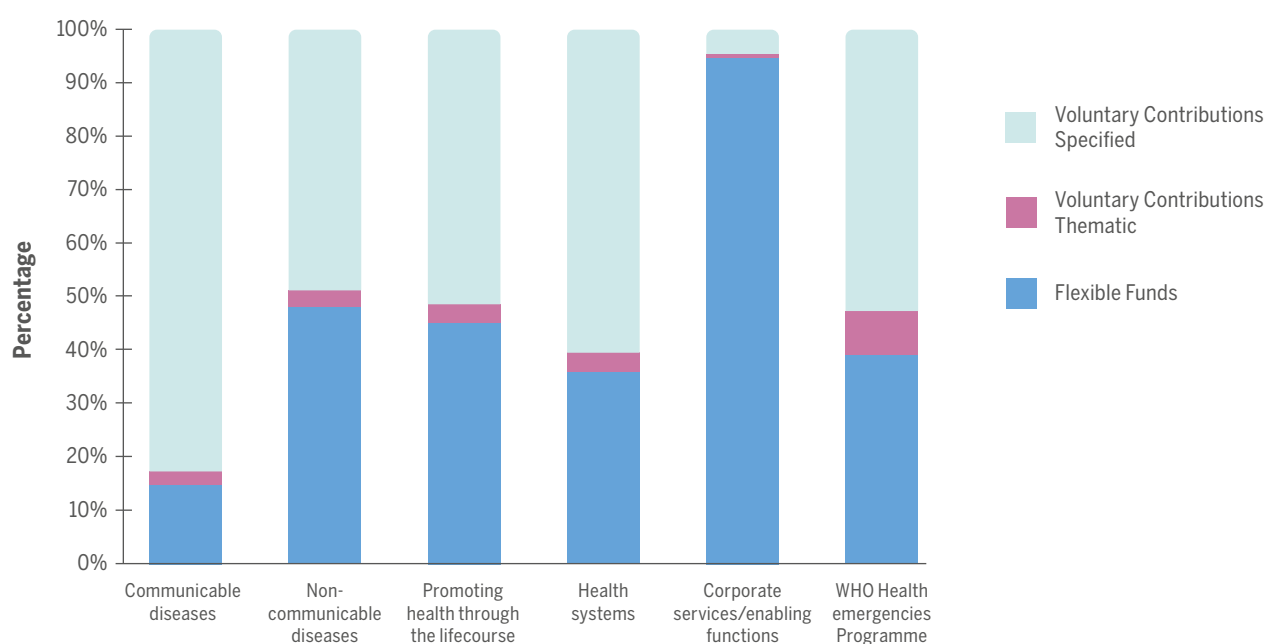
The flow of funding throughout the biennium was more evenly distributed in 2018–2019 when comparing the first and eighth quarters of the biennium; as the biennium unfolded, the increased level of specified and thematic voluntary contributions led to about 90% financing of the base budget by the end of the first year and to full financing of the budget at the end of the biennium”.

Corporate flexible funds represent an important source of funding that allows WHO to ensure operational capacity for staff costs and critical activities within the approved Programme budget. The Secretariat continued to implement the principle of strategic allocation of flexible funds in order to improve an equitable balance of the funding of programme areas across all categories in all major offices. As a result, in 2018–2019, a higher dependency on flexible funding was seen in the Noncommunicable diseases category, the Promoting health through the life course category and in the WHO Health Emergency Programme among technical categories (Figure 5). This demonstrated the Organization’s commitment to support efforts in these important areas, which did not have sufficient specified voluntary contributions. On the other hand, the Communicable diseases category received the lowest level of flexible funds because it had a sufficient level of voluntary contributions.

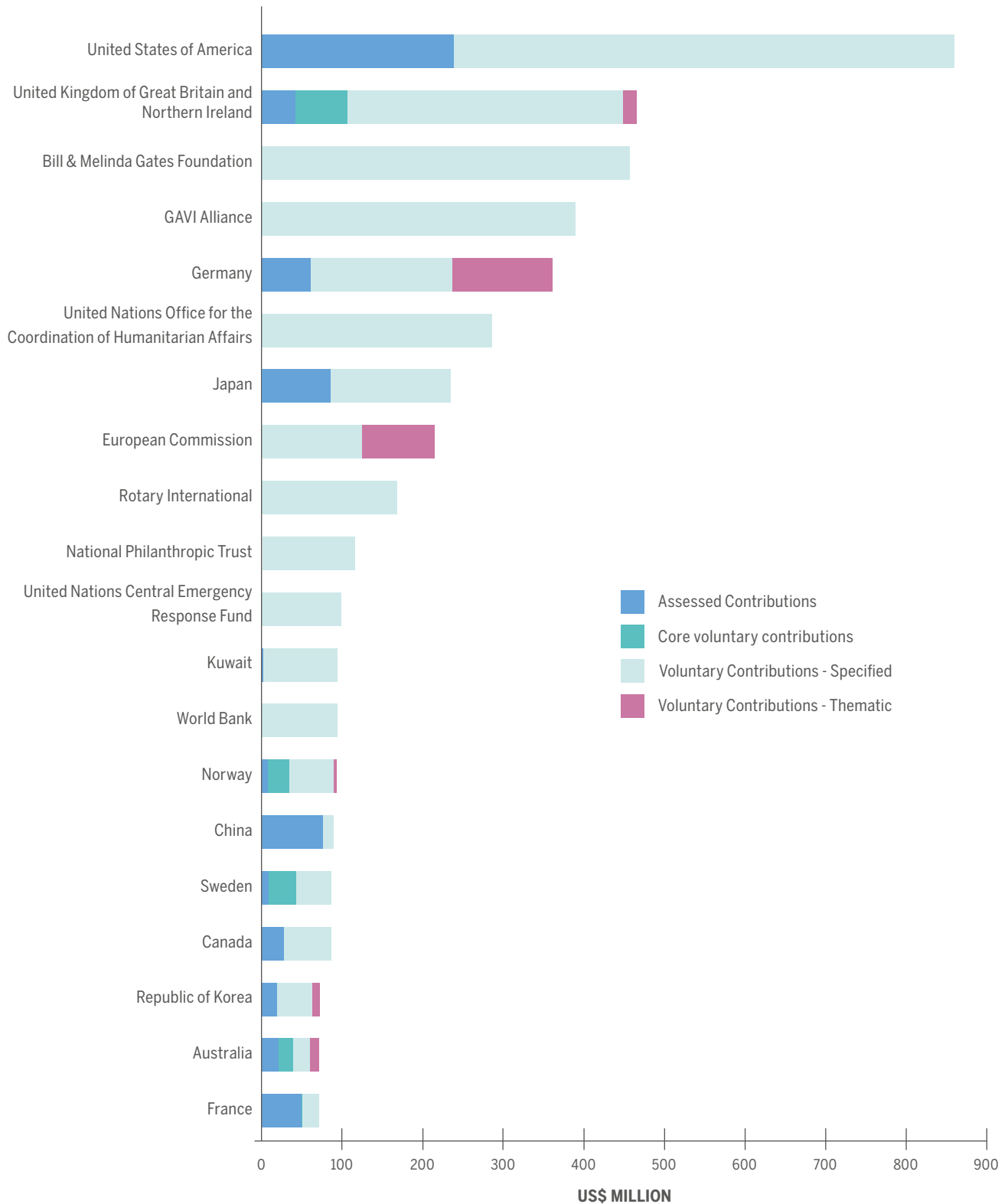
WHERE DOES WHO FUNDING COME FROM

There are two major sources of financing for the Programme budget: voluntary contributions and flexible funds, comprising assessed contributions, programme support costs and core voluntary contributions. The top 20 contributors, whose contributions account for 77% of total revenue for 2018–2019, are summarized in Figure 6. These are largely the same main donors of the WHO Programme budget as in the previous biennium with exception of Kuwait. The ranking of the donors has, however,

FIGURE 5: SHARE OF FUND TYPE IN FINANCING PROGRAMME BUDGET 2018-19, BY CATEGORY (IN PERCENTAGE)



**FIGURE 6: TOP 20 CONTRIBUTORS TO THE PROGRAMME BUDGET 2018-2019,
(IN US\$ MILLION)**



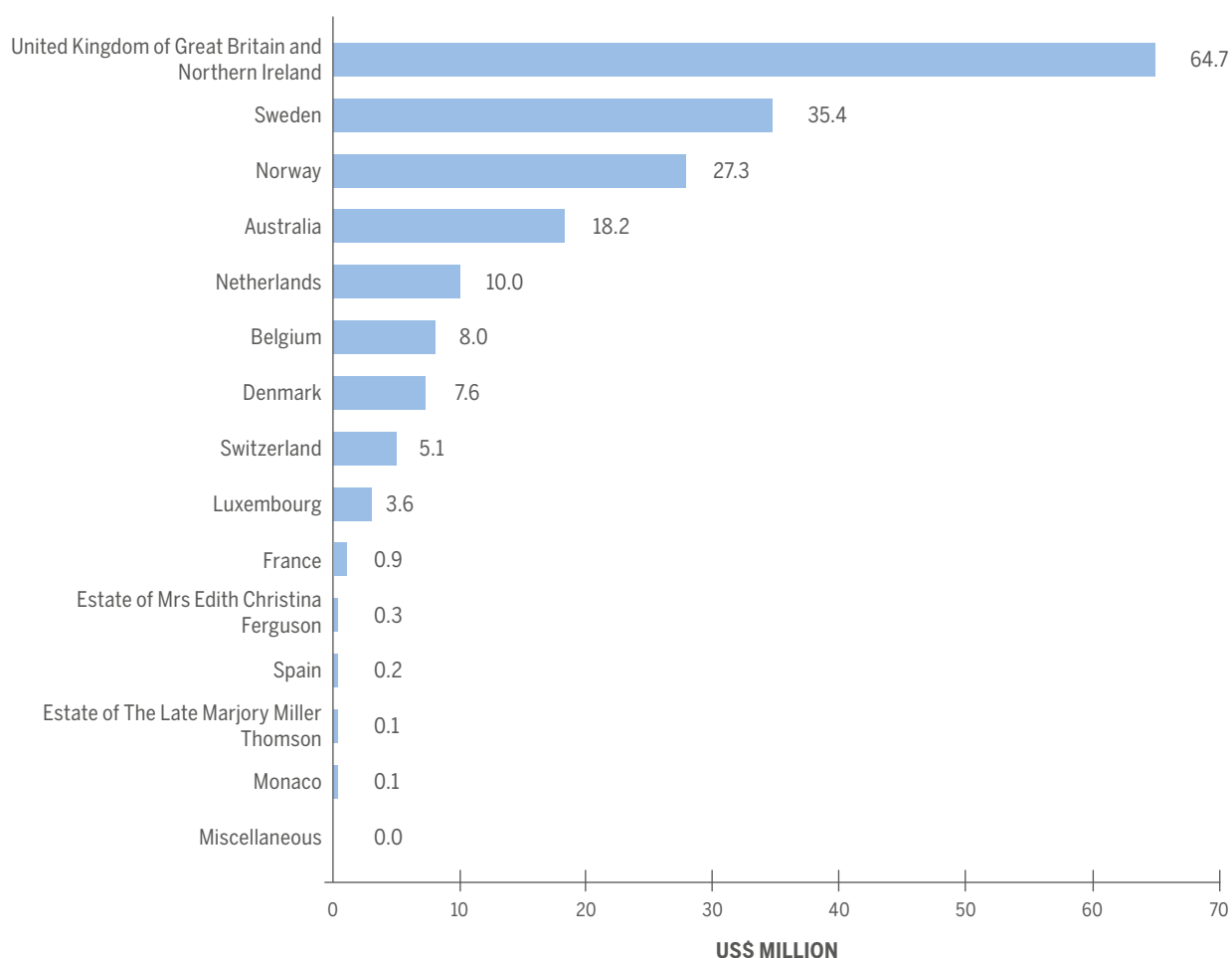
changed compared with 2018-2019 as well as the composition of their funding with a noticeable increase in thematic voluntary contributions. Detailed analyses of the WHO revenue for 2019 can be found in the Audit financial statements⁴; information on the WHO contributors and funding flow from a contribution to results are detailed in the WHO Programme budget Web portal.⁵

Of the total voluntary contribution funding for 2018-2019, US\$ 181.5 million is for the Core Voluntary Contributions Account. Figure 7 summarizes its funding by donor. Funding to the Account has increased this biennium by US\$33.5 million or 23% with several important contributors increasing their contributions. Core voluntary

⁴ A73/25

⁵ <http://open.who.int/2018-19/home>

FIGURE 7: CONTRIBUTORS TO THE CORE VOLUNTARY CONTRIBUTIONS ACCOUNT FOR PROGRAMME BUDGET 2018-2019 (IN US\$ MILLION)



contributions together the thematic voluntary contributions provide important flexible funding, which enables the Organization to advance its efforts in improving the balance in financing of Programme budget results.

In summary, in 2018–2019, with the support of its donors, WHO succeeded in achieving a better alignment of resources across categories and major offices, higher financing of the Programme budget and higher levels of implementation. Many structural improvements were put in place that enabled a stronger budget implementation performance, such as better quality and predictability of resources, largely due to the development of thematic funding; an increased focus on the global distribution and implementation of funds; and a focus on strategic allocation of resources. However, many challenges remain:

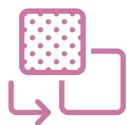
- Full financing and full implementation of the approved budget of certain categories in some major offices indicated that budget levels, if not adjusted, will provide little flexibility to respond to any emerging needs or priorities in the future.
- Although the funding of historically underfunded categories, such as Noncommunicable diseases, improved in 2018–2019 and demonstrated a better alignment of the financing and implementation levels of their programme areas, further efforts will be required to continue that trend.
- There is a need to continue striving towards more equitable funds distribution between major offices. Headquarters continues to be the best funded major office, especially in the base segment. Mechanisms need to be put in place to ensure that globally mobilized voluntary contributions are timely and equitably distributed among all major offices. This in turn will lead to redirecting flexible funds to most underfunded areas.
- The high dependency of several technical areas on corporate flexible funding remains. As long as such dependency persists in an environment of limited flexible funding, there will be a disparity in funding at a lower level, such as between outputs or budget centres.
- A potential significant gap for polio eradication activities in 2020–2021 could result in a need to advance the timing of transitioning the essential public health functions funded by the polio programme into the base WHO budget and base funding, drawing on the same finite flexible resources of the Organization.

Based on the experience of 2018–2019, various solutions have been put into place to learn from and to address such challenges in future. Although this work is ongoing, the more significant ideas have been advanced to date are:

- In the Twelfth General Programme of Work and the Programme budget 2020–2021, WHO moved away from disease-specific results towards an integrated results structure. Among various elements, it is hoped that this will allow greater levels of cross-cutting planning and alignment of both budget and resources – that is, better



IN 2018–2019, WITH THE **SUPPORT OF ITS DONORS**, WHO SUCCEEDED IN ACHIEVING A BETTER ALIGNMENT OF RESOURCES ACROSS CATEGORIES AND MAJOR OFFICES, **HIGHER FINANCING OF THE PROGRAMME BUDGET** AND HIGHER LEVELS OF IMPLEMENTATION



TRANSPARENCY

HAS BEEN CRUCIAL TO BUILDING TRUST WITH MEMBER STATES AND OTHER DONORS. WHO CONTINUOUSLY PROVIDES DETAILS OF THE ORGANIZATION'S WORK, FINANCING AND IMPLEMENTATION PROGRESS ACROSS ITS PROGRAMME BUDGET ON THE WHO PB WEB PORTAL: [HTTP://OPEN.WHO.INT/2020-21/HOME](http://open.who.int/2020-21/home)

leverage of underutilized budgets or overfunded programme areas to achieve common objectives

- Organizational structures, especially at headquarters, have been adjusted to foster a more flexible approach to resource management in support of cross-cutting and interprogrammatic delivery of results.
- The WHO resource mobilization strategy, presented to the Executive Board in January 2020,⁵ aims to strengthen WHO's approach to resource mobilization, which is essential if the Organization is to fulfil its mandate and achieve its goals. One of the major objectives of the strategy is to improve the quality of the funding that WHO receives. In 2019, there was a much more specific focus on encouraging greater flexibility and more predictability, with more emphasis placed on thematic and strategic funding. The 2018–2019 increases in thematic funding were a good early indication of the increasing momentum.
- A more centralized approach to corporate grants management is being put into place to ensure a more consistent and coherent organizational approach to the full grant management cycle – from conception to completion – in order to further improve WHO's credibility, transparency and efficiency.
- Senior management across regions and headquarters will be more proactively engaged in determining resource allocations at all levels and across strategic priorities down to the level of outputs. This is intended to ensure a more equitable and timely distribution of funds, in line with determined needs and based on the principle of strategic allocation of resources.
- As part of polio transition work, a more integrated interaction between base programmes and the polio eradication programme are being fostered to allow a fuller and more strategic consideration of all the elements that will need to be advanced by WHO as part of its core work in future.

Finally, it is important to note that transparency has been crucial to building trust with Member States and other donors. This in turn was reflected in improved level of funding of the Programme budget. WHO has continued to provide more details on its Programme budget portal.⁶ Through this and other reporting, its work has been shared on a broader scale, which has enhanced its profile, accountability and credibility.

⁵ Document EB146/29.

⁶ <http://open.who.int/2018-19/home>

HEALTH EMERGENCIES PROGRAMME

1 IN 3 STATES PARTIES have limited prevent and response capacities

45 STATE PARTIES have reported **NO DOMESTIC MECHANISM** to finance IHR implementation

EVERY YEAR, **MORE THAN 200 MILLION PEOPLE** ARE AFFECTED BY EMERGENCIES

ONLY 50% OF THE STATE PARTIES studies had "operational readiness capacities" to enable an **EFFECTIVE RESPONSE** to emergencies

CHOLERA: 20.8 million doses of oral cholera vaccine shipped to 10 countries

CHOLERA CASES FELL BY 60% IN 2018 (including in Haiti, Somalia and the Democratic Republic of the Congo)

EBOLA VIRUS DISEASE: 300 000 people vaccinated during response operations in the Democratic Republic of the Congo

ZERO-CASE LEVEL OF EBOLA VIRUS DISEASE achieved after 18 months of operation

YELLOW FEVER: 108 million people vaccinated

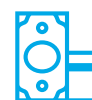
WHO responded to **55 EMERGENCIES** in more than **44 COUNTRIES** and territories in **2019**



Approved Programme budget:
US\$ 554 million



Funds available:
US\$ 455 million
(82% of Programme budget)

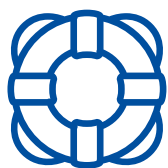


Expenditure:
US\$ 423 million
(76% of the approved budget;
93% of available resources)



"Every health crisis requires an all-of-society response. This includes all partners. United and leveraging our different strengths, we can save lives and safeguard health security."

DR MATSHIDISO REBECCA MOETI
WHO Regional Director for Africa



THE WHO **HEALTH EMERGENCIES PROGRAMME** BRINGS TOGETHER THE ORGANIZATION'S ASSETS AT **HEADQUARTERS, REGIONAL AND COUNTRY OFFICES** TO SUPPORT COUNTRIES TO PREPARE FOR, PREVENT, RESPOND TO AND RECOVER FROM ALL HAZARDS THAT CREATE **HEALTH EMERGENCIES**. NEW CRISES ARE ARISING FROM CLIMATE CHANGE AND DISPLACED POPULATIONS, WHO NUMBER NEARLY 70 MILLION TODAY. WORKING WITH PARTNERS, WHO HAS A CRITICAL LEADERSHIP ROLE TO HELP ENSURE A SWIFT INTERNATIONAL RESPONSE.



EVERY YEAR, **MORE THAN 200 MILLION PEOPLE** ARE AFFECTED BY EMERGENCIES, OF WHOM 130 MILLION **NEED HUMANITARIAN ASSISTANCE**

"There is a very real threat of a rapidly moving, highly lethal pandemic of a respiratory pathogen killing 50 to 80 million people and wiping out nearly 5% of the world's economy. A global pandemic on that scale would be catastrophic, creating widespread havoc, instability and insecurity. The world is not prepared."

Global Pandemic Monitoring Board report, September 2019

KEY ACHIEVEMENTS

In 2019, the WHO Health Emergencies Programme investigated 500 events in 140 countries and territories, of which 66% were infectious events, 14% were natural disasters and 7% were events related to chemical, radiological or nuclear products or food safety events.

In its short lifespan of less than four years, the WHO Health Emergencies Programme has made a considerable impact in the world. Tremendous progress was made in its leadership in health emergencies despite the simultaneous challenges of enacting the transformation agenda and the increasing numbers of global crises. In successfully coordinating complex and protracted crises and taking a stronger operational role, WHO strengthened its lead in health emergencies.

PREPARING FOR EMERGENCIES

Epidemics and pandemics threaten health security, increasing risks for the world, regardless of economic status. The depth of devastation that may result from a pandemic has been made plain in 2020. The toll of COVID-19 has been paid not only in terms of the human lives lost but also the livelihoods destroyed, the health workers overwhelmed and the disruption of the global economy. It is thus imperative that countries fully invest in preparedness to minimize the impact from epidemics and pandemics. Only a few countries had invested enough in pandemic preparedness to pre-empt the impact of COVID-19.

PREPAREDNESS PAYS AHEAD OF A PANDEMIC

In 2019, world leaders were alerted to the urgent need to invest and "build strong systems" to prevent devastating health threats in the first annual report of the **Global Preparedness Monitoring Board**, an expert panel convened by the World Bank and WHO. They warned of an "acute risk" of a pandemic and they made it clear that the world was not prepared.

Today, as the world reels from the enormous human, economic and social devastation of the COVID-19 pandemic, the need to ramp up preparedness is urgent. A virus has unleashed more death and damage than recent wars and terror attacks.

Previously, countries and donors have shown little interest once the momentum of an outbreak is over and the panic and fear have receded. For example, the Ebola response received positive support from donors, but Ebola regional preparedness a very low response – WHO had received only 10% of the funds needed as of early December 2019.

Targeted spending on preparedness is a highly cost-effective investment. Studies show that every US\$ 1 spent on preparedness is worth more than US\$ 2 during an emergency.¹ The Executive Board at its 146th session in February 2020 adopted resolution EB146.R10 on strengthening preparedness for health emergencies, recommending that the Health Assembly adopt a resolution that calls for a range of actions from stakeholders in order to improve preparedness.

¹ <https://reliefweb.int/sites/reliefweb.int/files/resources/Return%20on%20Investment%20for%20Emergency%20Preparedness%20Study.pdf>

INTERNATIONAL HEALTH REGULATIONS (2005):

A LEGAL FRAMEWORK INTENDED TO HELP THE INTERNATIONAL COMMUNITY PREVENT AND RESPOND TO ACUTE PUBLIC HEALTH THREATS

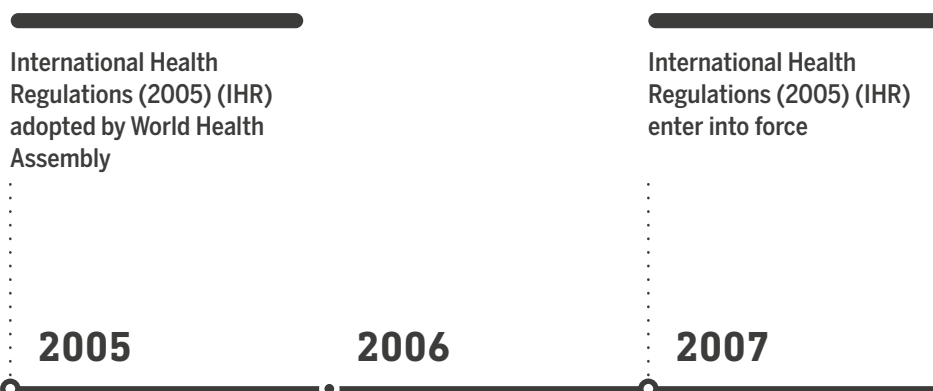
At the turn of the century, the threat of a pandemic was not high on the global agenda. Countries were not required to report any new pathogenic threat. Under the International Health Regulations (1969) State Parties were only required to notify cholera, plague and yellow fever.

The Severe Acute Respiratory Syndrome (SARS) epidemic in 2003, when WHO issued its first global alert, underscored the urgency of establishing a collaborative framework for health security in an era of globalization. Two years later, the Health Assembly, through resolution WHA58.3, adopted by consensus the **International Health Regulations (2005)** as the global instrument to prevent, protect against, control and provide a public health response to the international spread of diseases. In the wake of the COVID-19 pandemic, compliance with this legally binding international framework is critical for global health security and an effective global response

A DRIVING FORCE FOR GLOBAL HEALTH SECURITY

The International Health Regulations (2005) have led to a paradigm shift in global health security. 196 State Parties have committed to the global framework established through this legally binding instrument to address the international spread of diseases. The Regulations vest authority in WHO, giving it a mandate to coordinate a global response, ensure that critical information is shared and make recommendations, including in the context of a “**Public Health Emergency of International Concern**” (PHEIC).

“to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.”



The International Health Regulations (2005) require States Parties to report any event that may constitute a PHEIC occurring within their territories – not just for infectious diseases but for all hazards, including biological, chemical, radiological and nuclear threats and threats to food safety, as well as the health measures implemented in response to those events. Under the International Health Regulations (2005) States Parties shall develop, strengthen and maintain core capacities to detect, assess, notify and report public health events.

In 2018, close to 100% of States Parties reported on their core capacities. Details of the 2019 annual reporting by States Parties is published on WHO's e-SPAR Portal, the Strategic Partnership Portal for the IHR and the Global Health Observatory website. In accordance with the International Health Regulations (2005), all States Parties had designated or established a National IHR Focal Point to report on events. All 196 National Focal Points and 10 international organizations designated users of the Event Information Site, a platform through which IHR Focal Points report and exchange information. There are currently almost 900 users of the Event Information Site to provide information to WHO about events occurring within that territory.

Since the entry into force of the revised International Health Regulations in June 2007, the Director-General of WHO has convened an Emergency Committee for eight events: influenza pandemic H1N1 (2009), Middle-East Respiratory Syndrome Coronavirus (MERS-CoV) (2011–2012), international spread of poliovirus (2014–2020), Ebola virus disease in West Africa (2014–2016), Zika and neurological complications (2016), yellow fever (2016), Ebola virus disease in the Democratic Republic of the Congo (2018, and 2019–2020), and novel coronavirus COVID-19 (2020). For all but two of these events, a public health emergency of international concern was declared (the exceptions being MERS-CoV and yellow fever). In addition, under the Regulations, the Director-General has also convened a Review Committee on three occasions in order to get advice on the function of the Regulations: to review the response to pandemic influenza H1N1 (2011), to review requests on the second extensions of delay to implement core capacities under the Regulations (2014), and to review the functioning of the Regulations during the Ebola outbreak in West Africa (2016).

States Parties report progress on IHR implementation to World Health Assembly, including their capacity to:

- detect, assess, notify and report events
- respond promptly and effectively to public health risks and “public health emergencies of international concern”

A(H1N1) influenza

IHR core capacities monitoring framework introduced – self-assessment of 13 core capacities with indicators and a system for scoring

New era of accountability with the convening of the IHR Review Committee on the Functioning of the International Health Regulations (2005) and on Pandemic Influenza (H1N1) 2009



2008

2009

2010

2010

IHR CORE CAPACITY IMPLEMENTATION

By 2015, 34% of States Parties had met the IHR core capacity requirements. Although the International Health Regulations (2005) require States Parties, inter alia, to notify WHO of all events that may constitute a PHEIC within 24 hours of assessment of public health information, they do not include any enforcement mechanism.

In 2014, the national health systems of countries affected by the Ebola outbreak were unable to detect the threat early enough to mount an effective response. The outbreak demonstrated that the ability of the International Health Regulations (2005) to provide protection is conditional upon the capacity of States Parties to prevent, detect and respond to health threats.

The outbreak also underscored the importance of intercountry collaboration and helped ramp up laboratory systems, surveillance and community mobilization. WHO reassessed its own role, subsequently taking on a greater operational role through its Health Emergencies Programme. In a “never again” paradigm shift, States Parties also requested a stronger mechanism to monitor and evaluate their core capacities.

The success of IHR in ensuring global public health security depends on full application, implementation and compliance on the part of all States Parties; the potential consequences of non-compliance are themselves a powerful compliance tool.

Accelerate implementation of core capacities required by IHR ... focusing first on those countries that will have difficulty meeting the 2012 deadline for core capacities" – first recommendation of the IHR Review Committee

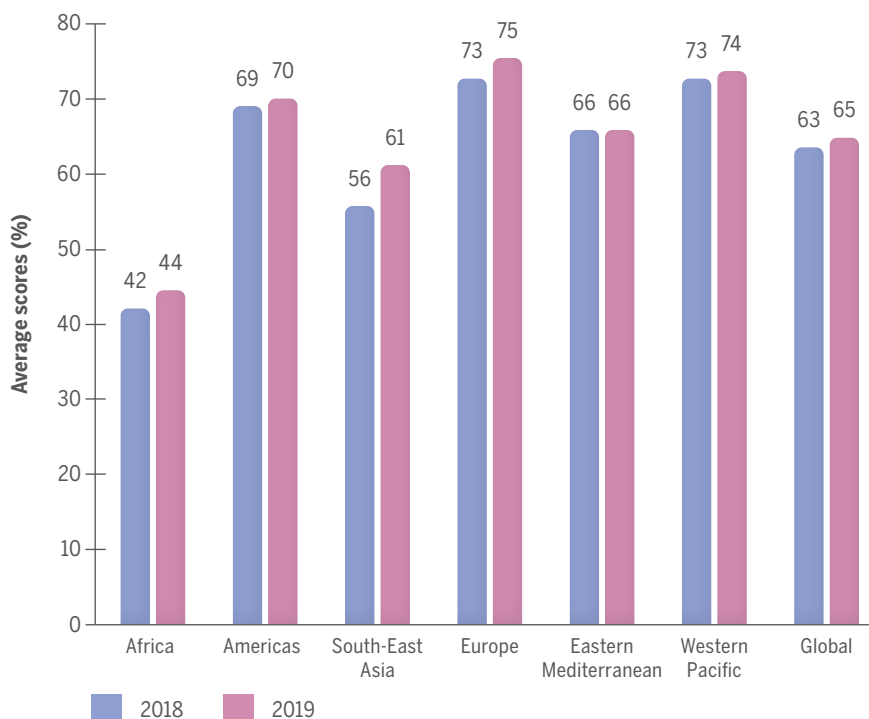
Deadline for all States Parties to have in place capacity to meet the surveillance and response requirements – extension to 2014

2011

2012

2013

INTERNATIONAL HEALTH REGULATIONS (2005): AVERAGE CORE CAPACITY SCORES* BY WHO REGION FOR 2018 AND 2019



* Based on information of 157 States Parties reporting in both 2018 and 2019. Scores are averages of 13 core capacities: C1 Legislation and Financing, C2 IHR Coordination and National IHR Focal Point Functions, C3 Zoonotic Events and the Human-animal Interface, C4 Food Safety, C5 Laboratory, C6 Surveillance, C7 Human Resources, C8 National Health Emergency Framework, C9 Health Service Provision, C10 Risk Communication, C11 Points of Entry, C12 Chemical Events, C13 Radiation Emergencies.
Source: SPAR tool (<https://extranet.who.int/e-spar>).

Extended deadline for all States Parties to have in place capacity to meet the surveillance and response requirements – second extension to 2016

IHR monitoring and evaluation framework extended – Self-Assessment Annual Reporting (eSPAR) tool to be created and complemented by 3 voluntary components

Third and final deadline for all States Parties to have in place capacity to meet the surveillance and response requirements

International spread of wild poliovirus

Ebola virus disease

Zika virus and observed increase in neurological disorders and neonatal malformations

2014

2015

2016

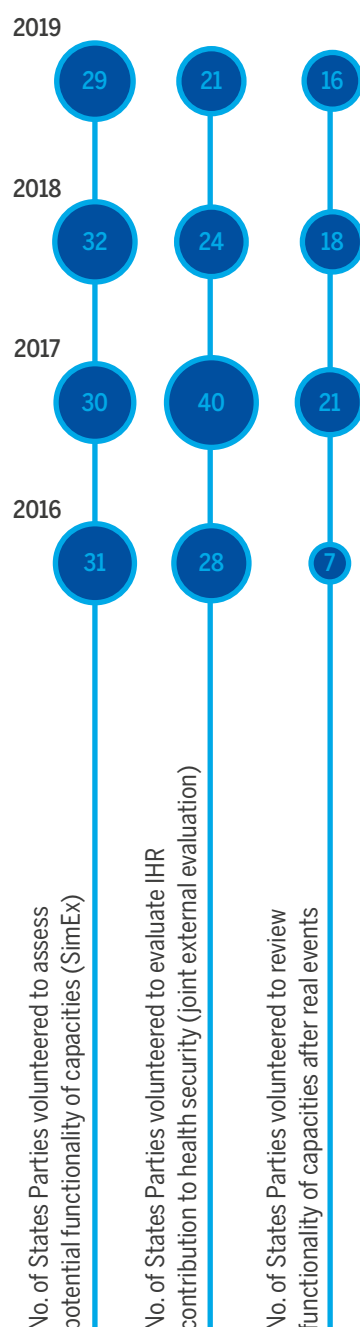
2016

No. of States Parties self-reporting core capacities for surveillance and response

127

Global average of core capacities reported using IHR monitoring questionnaires

78%



CORE CAPACITIES HAVE IMPROVED BUT NOT ENOUGH

In response, WHO developed various tools and processes – such as the **IHR Monitoring and Evaluation Framework, National Action Plans for Health Security** and **WHO Benchmarks** – to support States Parties to build their core capacities. Improvements have been made, but far more needs to be done.

By December 2019:

- 112 States Parties volunteered for a joint external evaluation
- 125 simulation exercises completed
- 65 national action plans for health security completed (31 in Africa)
- 31 national bridging workshops held on better detection and response at the human–animal interface

In the last biennium, the overall progress of implementation of core capacities improved by about 3%, according to 2018 data collected by the **States Parties Self-Assessment Annual Reporting** (SPAR) tool. The best gains, an average of about 5% in the “human–animal interface” capacity, reflect the need for improvement.

Progress was seen in other areas, such as disease detection. Yet most States Parties still had low to moderate levels of overall national preparedness, which also varied widely among them.

Further analysis of SPAR data by WHO, as presented in a recently published Lancet study, found that only 50% of the countries had “operational readiness capacities” to enable an effective response to emergencies such as COVID-19, while 17% had

All States Parties have reported core capacities at least once – but each should be reporting every year

eSPAR tool introduced – 13 revised capacities with 24 progress indicators and a new 5-level system for scoring.

Prepare indicator – mean of self-reported capacities – to contribute to measurement of GPW 13 target

International spread of wild poliovirus

Ebola virus disease in the Democratic Republic of the Congo

2017 2018

“limited” readiness² (the operational readiness index is based on 18 SPAR indicators). Approximately 20% of States Parties have limited capacities for legislation and 25% have limited capacities for risk communications.

Many other issues around preparedness were also lacking – in governance, investment, human capital, multisectoral work and technical capacities. The full reality of those gaps was made evident during the COVID-19 pandemic.

Based on 2018 SPAR data:³

- 1 in 3 States Parties have limited prevent and response capacities
- 52 States Parties have limited preventive capacities (zoonosis, food safety, infection prevention and control, risk communications, points of entry)
- 60 States Parties have limited response capacities
- 45 States Parties have reported no domestic mechanism to finance IHR implementation.

In the South-East Asia and the Western Pacific regions, the Asia Pacific Strategy for Emerging Diseases and Public Health Emergencies (APSED) has served as a regional strategic framework for action to advance the implementation of the International Health Regulations (2005). For more than a decade, countries have been making progress in strengthening their health security in the regions through the development and implementation of national action plans to strengthen core capacities under the International Health Regulations (2005).

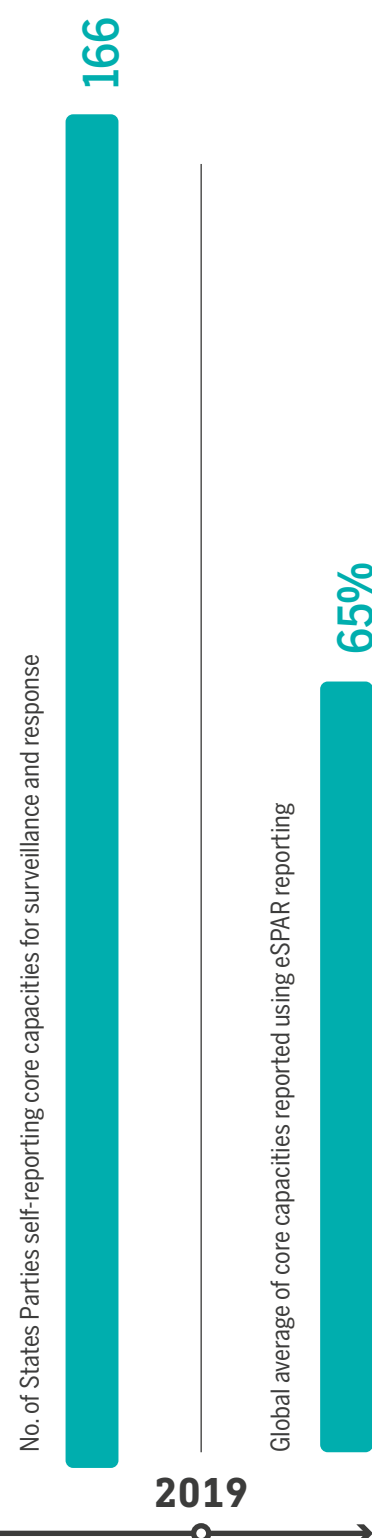
² Very little functional capacity available on an ad hoc basis with the support of external resources.

³ <https://extranet.who.int/sph/spar>.

eSPAR platform goes live for online reporting.

WHO benchmarks for IHR capacities support States Parties when developing national action plans for health security

2019



OPERATIONAL READINESS HELPS STOP SPREAD OF EBOLA

When an outbreak of Ebola virus disease was confirmed on 1 August 2018 in North Kivu, Democratic Republic of the Congo, there were concerns that it would spread to nine neighbouring countries, including Uganda. Given the regular cross-border movement of people and goods and the weaknesses of national health systems, the risks were very high.

Uganda has a long, porous border with the Democratic Republic of the Congo, with heavy cross-border trading. Some affected areas in the Democratic Republic of the Congo were just 30 km away. A rapid-risk assessment determined the regional risk to be high. It took into consideration the high population density of North Kivu and nearby

districts in Uganda. WHO deployed teams to support preparedness efforts, provide technical support, assess readiness using a WHO checklist, and help develop and implement national contingency plans. Surveillance for Ebola virus disease was heightened and rapid response teams were trained. Uganda's operational readiness for the disease increased from 53% to 84%, as assessed by multiagency dedicated missions between May 2018 and January 2019.

Work on the seven pillars of preparedness for Ebola virus disease began. An operations centre and at least one treatment centre were set up for the disease, with a team trained on safe burials. A rapid response team was trained in early case detection and front-line health workers were vaccinated. Essential supplies (such as protective equipment and surveillance tools) were provided. The risks were also mitigated by rapid communication and coordination among authorities

across jurisdictions and detection at points of entry, as well as subsequent response activities.

In Uganda, a total of US\$ 18 million was invested in preparedness against Ebola virus disease. Far more would have been spent on a response effort if an outbreak had occurred – at least US\$ 31 million, based on spending of US\$ 15 per capita over six months. In addition, a joint external evaluation conducted in Uganda in 2017 had been very useful in building operational readiness and identifying gaps.

In June 2019, three members of a family from the Democratic Republic of the Congo, who had entered Uganda seeking care, all died of Ebola virus disease. Some 108 exposed contacts were identified and followed up in Uganda. No spread of the disease followed this event or other events detected at border areas. This was testament to the work done by Uganda in improving its surveillance and response capacities. Preparedness efforts paid off to prevent an Ebola epidemic in the region and the world.

The International Health Regulations (2005) have never been more relevant. But their full potential needs to be realized and they remain to be fully implemented. The work to capacitate countries must be ramped up, for which strong political and financial commitments are needed. Staying ahead of the curve – literally – to beat a fast-moving pandemic will require hard work, investments and solidarity.

There is also a need to refine the current instruments used in assessing country capacity under the International Health Regulations (2005). A tool to measure the readiness of health systems and their resiliency may be needed to test how far health systems can be stretched. Health systems need to be resilient enough to absorb disruption and plan surge capacity to respond to health crises.

Global health security must remain high on the agenda. The threat of a second wave of COVID-19 or a new pandemic remains. The International Health Regulations (2005) remain the only legally binding framework within WHO for protection against, and response to, the international spread of diseases.

INVESTMENTS HELPED PREPARE KOREAN HEALTH SYSTEM

The Republic of Korea's response to COVID-19 reflected a public health system that had benefited from recent investments of more than US\$ 250 million. Following a joint external evaluation in 2017 and WHO recommendations after an outbreak of disease due to Middle East respiratory syndrome coronavirus (MERS-CoV) in 2015, the country improved its disease surveillance, laboratory systems, health worker training, and infection prevention and control.





DURING THE BIENNIUM,
**108 MILLION PEOPLE WERE
PROTECTED FROM YELLOW
FEVER IN AFRICA** THROUGH
VACCINATION CAMPAIGNS

PREVENTING EPIDEMICS AND PANDEMICS

WHO works on global strategies with partners from various fields to prevent and control high-threat infectious hazards and to scale them at the regional and country levels.

ELIMINATING YELLOW FEVER

In 2019, 59 million people were vaccinated in preventive mass campaigns. The **Eliminate Yellow fever Epidemics (EYE) Strategy**, launched in 2017, represents a significant milestone in the fight against re-emerging diseases. This unprecedented initiative plans to vaccinate 1 billion people in high-risk African countries by 2026 with the help of partners.

Recently, the strategy was updated in response to the disease's changing epidemiology, the resurgence of mosquitoes and the increased risk of urban outbreaks and international spread. Three high-risk countries have yet to introduce the vaccination into routine immunization – Ethiopia, South Sudan and Uganda. It is estimated that 125 million people in Africa have been protected through a combination of routine, preventive and reactive campaigns.

NIGERIA ACCELERATES EYE IMPLEMENTATION

By 2021, more than 85 million people will be protected against yellow fever in Nigeria, a priority country for the EYE Strategy. More than 46 million people have already been vaccinated during outbreak responses and preventive mass vaccination. Efforts will continue towards full implementation of the EYE 10-year plan.

MASSIVE DECLINE IN CHOLERA CASES

This decline was driven by mass vaccination campaigns, galvanized by the 2018 strategy **Ending Cholera: A Global Road Map to 2030**, which was developed by WHO and partners. At least 41 million doses of oral cholera vaccine were shipped to countries during the biennium. Since the oral cholera vaccine stockpile was created in 2013 with Gavi, the Vaccine Alliance, funding, almost 60 million doses have been shipped worldwide. WHO has airlifted tonnes of supplies.

In 2018, 34 countries reported about half a million cholera cases and nearly 3000 deaths to WHO. Most of the cases – an estimated 370 000 – were reported in **Yemen**. Over 3 million vulnerable people were targeted in three mass vaccination campaigns in **Somalia**, **Sudan** and **Yemen** in the biennium, which led to a significant decline in new cases and deaths in these hotspots.

South Sudan ended its longest cholera outbreak – going from 16 000 cases in 2017 to zero cases. This shows it is possible to stop persistent outbreaks in endemic settings. **Haiti** reported a full year without a cholera case in January 2020. In **Yemen**, oral cholera vaccine was used for the first time, but the destruction of water and sanitation infrastructure in that country has made cholera control difficult.

Bangladesh, Nigeria, Somalia, South Sudan, the United Republic of Tanzania and Zambia have also made significant progress in developing national action plans in line with the Ending Cholera strategy.

HAITI FREE FROM CHOLERA FOR ONE YEAR

Haiti has reported one year free of cholera after almost a decade of infections. The last reported case involved a 5-year-old boy in January 2019, who survived.

From the start of the outbreak in October 2010, 820 000 people were infected and nearly 10 000 killed. More than one third of the population lack basic drinking-water services, while two thirds have limited or no sanitation services. For elimination to be certified, the country must be cholera-free for a total of three years.

The WHO Region of the Americas supported the Ministry of Health in various areas, including epidemiology, surveillance and laboratory work. Rapid detection and testing were key. Under the Ministry's Labo Moto project, field nurses used motorcycles to rapidly transport samples from treatment centres to laboratories. This enabled the level of testing of suspected cases to increase from 21% in 2017 to 95% in 2019.

CLUSTER OF RESPIRATORY ILLNESSES IN LAO VILLAGES INVESTIGATED

In January 2019, a cluster of respiratory illness cases was reported in a remote area in Phongsaly province, **Lao People's Democratic Republic**. By mid-February, 417 cases and 16 deaths had been reported among minorities from nine villages, with limited access to health services and issues with water and sanitation.

Samples were sent to the National Centre for Laboratory and Epidemiology, Japan's National Institute of Infectious Diseases, and the United States Centers for Disease Control and Prevention. Reports of poultry deaths were also followed up. A rapid-risk assessment found the risk high at the provincial level, given the case fatality rate and uncertainty of the pathogen. The risk was reassessed after lab results confirmed that specimens were mostly seasonal influenza A(H1N1)pdm09.



SIGNIFICANT PROGRESS HAS BEEN MADE IN CHOLERA PREVENTION AND CONTROL GLOBALLY, WITH THE NUMBER OF **CASES DECREASING BY 60% IN 2018** AND FALLING IN MAJOR HOTSPOTS SUCH AS THE DEMOCRATIC REPUBLIC OF THE CONGO, SOMALIA AND YEMEN



ABOUT **500 MILLION**
PEOPLE WERE
VACCINATED
FOR SEASONAL
INFLUENZA IN 2019

MILLIONS VACCINATED FOR INFLUENZA

Through the **Pandemic Influenza Preparedness Framework**, more than 400 million doses of pandemic vaccine were secured – over four times the amount available in the 2009 pandemic. WHO raised US\$ 200 million to strengthen national preparedness capacities in 72 countries. Of those, 39 countries are being supported to develop influenza pandemic preparedness plans that are linked with their national action plans for health security.

A vaccination campaign was undertaken, with 3000 doses of seasonal influenza vaccine. Community awareness campaigns were conducted and multivitamins were provided to mothers, with vitamin A supplements for severe infant cases. The event tested system readiness, which is essential for pandemic preparedness.

In March 2019, WHO launched the **Global Influenza Strategy** 2019–2030, which provides an overarching framework to approach influenza preparedness holistically by strengthening capacities to prevent, control and prepare.

Eight new national influenza centres have been recognized by WHO, bringing the total number of centres to 147 in 124 countries. In 2019, more than 3 million specimens were collected by global system laboratories, informing influenza vaccine strain selection and supporting influenza risk management.

In 2018–2019, WHO supported the immunization of more than 50 million individuals during preventive or reactive vaccination in 13 African countries, confirming the elimination of meningococcal serogroup A epidemics and controlling seven major outbreaks due to other serogroups.

The **International Coordinating Group on Vaccine Provision** coordinates the provision of emergency vaccine supplies and antibiotics to countries during major outbreaks. It ensures the **availability** of therapeutics, ensuring stockpiles and negotiating fair prices; **access** for countries in need; and equitable **allocation**. During the biennium, WHO and partners deployed 34 million doses of emergency vaccines of yellow fever, cholera and meningitis, targeting 25 million people in 17 countries.



MENINGITIS HAS
BEEN EFFECTIVELY
REDUCED IN THE
“**MENINGITIS BELT**”
OF AFRICA, WITH NO
OUTBREAK IN THE
LAST THREE YEARS.
IMPLEMENTATION
OF A PLATFORM
FOR **INTEGRATED**
SURVEILLANCE IS
UNDER WAY

REAL-TIME LEARNING FOR RESPONDERS

WHO's new interactive web-based platform, OpenWHO, saw a massive increase in the uptake of its courses in the biennium, resulting in more front-line workers and decision-makers having access to life-saving knowledge. **OpenWHO** enables WHO and key partners to transfer knowledge on containing outbreaks and managing health emergencies to large numbers of front-line responders.

By the end of 2019, the OpenWHO.org platform had recorded 150 000 registrations from all countries for 70 courses. To increase accessibility, courses were offered in 21 languages.

Some courses were targeted to front-line workers during a real response, including during the outbreak of Ebola Virus Disease in the Democratic Republic of the Congo. Nearly 20 000 front-line personnel took the health and safety course **ePROTECT** for the response to the disease.



RESPONSE CAPACITY
WAS STRENGTHENED BY
TRAINING **1500 PERSONS**
IN 25 COUNTRIES
FACE-TO-FACE



IN 2019:

**ALMOST 100 000 PUBLIC
HEALTH THREAT SIGNALS
WERE DETECTED**

**500 EVENTS WERE
INVESTIGATED GLOBALLY**

**64 RAPID-RISK
ASSESSMENTS WERE
CONDUCTED IN 33
COUNTRIES**

RAPIDLY DETECTING EVENTS

The rapid detection and verification of potential health emergencies is critical to save lives. WHO has a 24-hour system of global event-based surveillance to detect all public health events and potential threats.

Various innovations have been developed by the WHO Health Emergencies Programme, including:

- **Epidemic intelligence from open sources** – strengthen early detection of all potential acute public health events or emergencies;
- **Health Resources Availability Monitoring System** – to assess and monitor access to health care;
- **Early Warning, Alert and Response System** – to quickly collect field data with an enhanced collection tool (used in emergencies in four countries);
- **Geospatial analysis** – to support decision-making through information in maps or infographics.



FIGHTING INFODEMICS

In dealing with the COVID-19 pandemic, WHO must at the same time face the challenge of an overabundance of information, some accurate and some not – that makes it hard for people to find trustworthy sources and reliable guidance when they need it. Due to the high demand for timely and trustworthy information on COVID-19, WHO has established the **Information Network for Epidemics (EPI WIN)**, which unites technical and social media teams that work closely to track and respond to misinformation, myths and rumours and provide specific information and evidence for action.

RESPONDING TO HEALTH EMERGENCIES

CONFRONTING THE MOST COMPLEX OF CHALLENGES

The world is dealing with health emergencies of an unprecedented scale and form. Every year, there are more than 200 outbreaks; many have specific challenges and some may be new diseases emerging in vulnerable areas.

WHO responded to grade 3 emergencies (the highest severity level) in the Democratic Republic of the Congo, Mozambique and Yemen, as well as large-scale emergencies of a protracted nature in Nigeria, Somalia, South Sudan and the Syrian Arab Republic. All higher-graded emergencies are managed through WHO's Incident Management System.

Significant progress was made in outbreak management. WHO adapted and optimized its operations, where necessary. The **Contingency Fund for Emergencies** allows WHO to respond rapidly – often in 24 hours or less – with funds that are not earmarked, allowing crucial flexibility. During 2019, a total of US\$ 83 million was disbursed from the Contingency Fund to fast-track support for WHO's emergency response activities. The **Research and Development Blueprint** mechanism prioritized research for a successful response, including by prequalifying drugs and vaccines.



EVERY YEAR, MORE THAN **200 MILLION** PEOPLE ARE AFFECTED BY EMERGENCIES, OF WHOM **130 MILLION NEED HUMANITARIAN ASSISTANCE**



IN 2019, 1328 **GEOSPATIAL INFORMATION** PRODUCTS WERE DELIVERED FOR **EBOLA VIRUS DISEASE, ZIKA VIRUS DISEASE, YELLOW FEVER, CHOLERA, MEASLES, MENINGITIS, PLAGUE**, THE HORN OF AFRICA FOOD INSECURITY CRISIS AND A NUMBER OF **HUMANITARIAN CRISES**



WHO RESPONDED TO **55 EMERGENCIES** IN MORE THAN **44 COUNTRIES** AND TERRITORIES IN **2019**



WHO RESPONDED IMMEDIATELY – **A DAY AFTER THE OUTBREAK WAS CONFIRMED**, THE WHO TEAM ARRIVED ON SITE. FIVE DAYS AFTER, **WHO'S DIRECTOR-GENERAL WAS THERE**



THE RESPONSE OF THE **MINISTRY OF HEALTH OF THE DEMOCRATIC REPUBLIC OF THE CONGO**, WHICH WHO SUPPORTED WITH ITS PARTNERS, WAS DESCRIBED AS **ONE OF THE FASTEST EVER RESPONSES TO EBOLA OUTBREAKS**

MOUNTING AN EFFECTIVE RESPONSE TO THE EBOLA OUTBREAK

In August 2018, WHO was confronted with what was described by an aid agency as “one of the most complex health emergencies the world has seen”, with the outbreak of Ebola virus disease in the eastern Democratic Republic of the Congo. WHO persisted through a dangerous security situation until finally, after 18 months, the outbreak was brought to a halt. During the same period, WHO responded to a humanitarian crisis involving displaced populations in the Kasai region of the country.

On 1 August 2018, an outbreak of Ebola virus disease was confirmed in Mangina, a small town in North Kivu province, eastern Democratic Republic of the Congo, long marked by violent conflict. It was marked by extraordinary, unparalleled challenges that would challenge any public health entity. How would WHO respond?

WHO responded immediately: a team arrived the very next day. Within the next 48 hours, travelling from Brazzaville, WHO's then Regional Emergency Director, Dr Ibrahima Socé Fall, had to cross the Congo river in a boat to Kinshasa and continue by plane to Goma, by helicopter to Beni and by road to Mangina. To arrive quickly at this remote location was no easy feat. Five days after the outbreak was confirmed, WHO's Director-General was there.

The response of the Ministry of Health of the Democratic Republic of the Congo, which WHO supported with its partners, was described as one of the fastest ever responses to Ebola outbreaks. Fresh from an outbreak in Équateur province, in the west of the country – which was successfully contained in under three months with 54 cases – the outbreak response team rapidly implemented prevention and control activities, with quickly deployed mobile laboratories, vaccination supplies and stockpiles of an effective experimental vaccine. There was optimism, and in September, signs of progress.

However, this health emergency was one of the most complex ever. Sited in the east, in North Kivu province, 1500 km away from the capital, it was in the middle of a volatile war zone that was disrupted by ethnic, social and political strife at the hands of armed militia groups. One million displaced people were on the move in the province and even more were in need of assistance, but little had come. Services and support were minimal and health facilities were fragmented and unregulated. It was the “perfect storm” for a crisis, even with the “right” response.

Ebola virus disease in the Democratic Republic of the Congo

1 August

grade 3 emergency declared;
Contingency Fund for Emergencies
US\$ 2 m approved; WHO response
teams from Equator arrive in North
Kivu; Labs with GeneXpert capacity
established in Beni and Mangina

4 August

Ebola treatment units established in
Beni and Mangina

8 August

vaccination starts

10 August

first patients receive investigational
therapeutics

21 August

all five investigational therapeutics
approved for compassionate use

7 November

vaccination of frontline workers begins
in Uganda

20 November

randomized-control trial approved for
treatment of Ebola virus disease

2018

24 March

outbreak reaches 1000 cases

3 June

outbreak passes 2000 cases

11 June

first case of Ebola virus disease
confirmed in Uganda

14 July

first case of Ebola virus disease
confirmed in Goma

2019

17 July

outbreak declared a Public Health
Emergency of International Concern
(PHEIC)

28 August

outbreak exceeds 3000 cases

19 December

United States Food and Drug
Administration approves first vaccine
for the prevention of Ebola virus
disease

17 February

zero new confirmed cases of Ebola
virus disease reported

2 March

end of outbreak countdown starts –
2nd negative test result for the last
confirmed case

10 April

A new case of Ebola virus disease is
confirmed in Beni

2020

BRINGING TOGETHER EXPERTS

Under the Ministry of Health's leadership, WHO supported the major pillars of the response in North Kivu, South Kivu and Ituri provinces, drawing on technical specialists from 70 partners specialized in infection prevention and control, risk communication and engagement, laboratories and logistics.

Key partners included:

- **Africa Centers for Disease Control and Prevention**
- **Alliance for International Medical Action**
- **European Civil Protection and Humanitarian Aid Operation**
- **Institut National pour la Recherche Biomedicale**
- **International Organization for Migration**
- **Médecins sans frontières**
- **Protection Civile/Democratic Republic of the Congo**
- **Public Health England**
- **Red Cross Movement**
- **United Kingdom Department for International Development**
- **United Nations Children's Fund**
- **United Nations entities, including the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo**
- **United States Agency for International Development**
- **United States Centers for Disease Control and Prevention**
- **World Bank**
- **World Food Programme.**



Other partners, especially networks helping to deploy experts and teams:

- Global Outbreak Alert and Response Network
- Emerging and Dangerous Pathogens Laboratory Network
- Emerging Disease Clinical Assessment and Response Network
- emergency medical team initiative
- regional partners and collaboration centres.

BACK TO BASICS: INFECTION PREVENTION AND CONTROL

One of WHO's first tasks was to close down a small hospital in Mangina that was a source of infection. It was reopened after proper decontamination.

Existing forms of care in local health facilities included traditional therapies, unsafe injection practices and very poor infection prevention and control. Soap was lacking and half of all health care facilities lacked running water. WHO had to build from scratch for a highly contagious disease.

Early on, many cases were seen in children. It turned out that during a malaria outbreak in Beni, many health facilities were reusing the same injection equipment several times for children with malaria, thus spreading the virus. Health workers were repeatedly trained to handle Ebola, but health facilities often amplified the outbreak still. WHO held a campaign to encourage oral medication and the safe use and handling of needles.

OVERCOMING OBSTACLES TO DISPATCH EBOLA SUPPLIES

Ensuring the daily delivery of about three tonnes of supplies for the Ebola response was not easy in an area which is difficult to access and with roving armed rebels. More than 400 motorcycles, a plane and two helicopters were utilized to facilitate operations, especially in hard-to-reach areas. "Flying" logisticians helped troubleshoot problems, including decontamination and drilling for water.

There was never any stock-out:

- a cold chain for the Ebola vaccine at -80 degrees Celsius was maintained
- more than 17 million gloves, 2 million masks, 900 000 gowns and 200 000 doses of the vaccine were delivered
- a WHO supply chain unit organized 745 international cargos to transport more than 1000 metric tonnes of medical goods from August 2018 to February 2020.

BUILDING BRIDGES FOR THE COMMUNITY

Unlike previous outbreaks of Ebola virus disease, the response team was armed with a powerful tool this time – an effective vaccine. However, a vaccine is only good when accepted and delivered. There were also pockets of community resistance to the other tools necessary to fight the disease: contact tracing, treatments and safe and dignified burials.

There was little awareness of Ebola virus disease, which was new in the area, while other threats, including violence, were more visible. There were suspicions that the disease was a scheme for the government to obtain aid money.

Community dialogues were essential to understand the concerns that led to reticence. Interventions were adapted in response to community concerns and needs. Forcing patients to comply with bio-care risked alienating them. Partnerships with communities helped to enable response activities. Community members were trained to sensitize families to safe burial practices and decontamination of affected areas – a process repeated every time that responders moved to a new area. Sometimes, it was necessary to first deal with other outbreaks, such as malaria and measles. To gain trust, WHO and partners sometimes supported communities in unexpected ways far beyond their traditional role. For example, a 12 km road and four bridges were built between communities near Mangina, cutting travel time by a quarter of an hour to one hour – a big win for locals seeking medical help.

In another big shift, WHO also deployed 20 social anthropologists. Over the course of the epidemic, an increasing number of staff employed by WHO were from the local community.

TENACITY AND BRAVERY OF HEALTH WORKERS

There is no doubt that the success of the response effort hinged on the tremendous tenacity and bravery of health workers, who stayed committed despite the threat of terrifying violence.

Health workers laid their lives on the line to combat one of the most dangerous diseases in one of the most dangerous areas of the world.

Going to work despite the risk of attack was the “hardest part of the job”.

WHO documented 420 attacks on health facilities during the outbreak,⁴ resulting in 11 deaths and 86 injuries among health workers and patients. People hid behind wardrobes and in riverbeds for hours to escape the violence. Kaswerma, who was attacked in the Biakato camp, remembers a machete blow to her head, a dash for safety and huddling in a room for several hours. Vaccination and burial teams were also pelted with stones when visiting some communities.

Attacks occasionally forced a temporary suspension of response efforts; infection would then spread when suspected cases were not investigated and safe and dignified burials not carried out.

Recognizing the grave biosecurity threat of Ebola virus disease, almost all the 900 staff on WHO's payroll and staff from many other partners steadfastly persisted – a contribution the world should not forget.

⁴ From 1 August 2018, the start of the outbreak, to 3 March 2020.



“BRAVE COLLEAGUES, ALREADY FIGHTING THE EBOLA OUTBREAK, FACE AN EVEN GRAVER THREAT: **BEING TARGETED BY MEN ARMED WITH MACHETES, GUNS AND EVIL INTENT.**”

- WHO Director-General
Tedros Adhanom
Ghebreyesus



THE ULTIMATE PRICE FOR KEEPING THE WORLD SAFE

Epidemiologist **Dr Richard Valery Mouzoko Kiboung** was always ready to go where people needed his help most. Passionate about public health, he worked hard to fight infectious diseases among vulnerable communities in his native Cameroon.

Deployed by WHO in the Ebola response in the Democratic Republic of the Congo, he had concerns about safety, like others, yet put himself on the front line to save lives. On 19 April 2019, he was killed in an attack on Butembo University Hospital. Colleagues described him as a “true professional, an excellent team leader”, who was selfless, compassionate and kind. His passing is an immense loss to Cameroon and the public health community. He leaves behind a wife and four children.

DR TEDROS LEADING THE FIGHT FROM THE GROUND

The hands-on leadership of WHO's Director-General Dr Tedros Adhanom Ghebreyesus was instrumental in the response effort. Dr Tedros's leadership set the tone of the response, rallying everyone from health workers on the ground to presidents in the fight to stop the disease. One of his first actions was to secure the highest level of political commitment for better security from countries surrounding the Democratic Republic of the Congo, which eventually proved crucial to stop the virus spreading. His visible presence in the field – he travelled to North Kivu several times, where he stayed and talked with responders and local communities – helped boost the morale of staff and mobilized local leaders to fight against Ebola. He appointed Dr Socé Fall, now Assistant Director-General for Emergency Response, to lead the operations at ground zero, directing him not to return to Geneva before finishing the job. Dr Socé Fall stayed in the field for 11 months until transmission was stopped.



BOLD SCIENTIFIC BREAKTHROUGHS: A GAME-CHANGER

The response to the outbreak of Ebola virus disease in eastern Democratic Republic of the Congo was different from previous outbreaks due to ground-breaking scientific advances.

In 2016, the **WHO Research and Development Blueprint** initiative was created to enable the fast-tracking of research in tests, vaccines and medicines in order to avert a large-scale crisis in an epidemic. This paved the way for progress in a vaccine and life-saving treatments.

The **rVSV-ZEBOV Ebola vaccine**, which was deployed a week after the outbreak began in August 2018, saved lives and slowed the spread of Ebola virus disease. WHO prequalified the vaccine in November 2019, a critical step to speed up licensing, access and roll-out. This was the first Ebola vaccine to be prequalified and the fastest vaccine prequalification process ever. The vaccine will continue to be used under a research protocol, for which more than 400 Congolese have been trained.

Two investigational treatment drugs substantially decrease mortality, especially if given early. A trial was conducted during the previous outbreak, proving that sound research can be conducted in an outbreak. The mortality of patients can be almost halved to 35% if patients seek treatment early.

WHO also conducted **social science research** to inform the strategies used in the response.

GeneXpert polymerase chain reaction technology was used in 11 laboratories to support many activities, including patient care, surveillance and research and development. Results were often available in 24 hours. National staff were trained in the diagnosis of Ebola virus disease. Laboratories were also equipped to diagnose other diseases.

A HERCULEAN TASK TO REACH THE END

On 3 March 2020, health workers at the Ebola treatment centre in Beni celebrated when a patient, Masiko, was discharged. To reach this point was a herculean task, after a peak of 120 cases a week spread over distances 1200 km apart. The outbreak involved :

- 166 000 million people screened for Ebola symptoms at borders or control points
- 3000 health facilities identified for infection prevention and control support
- 300 000 people vaccinated
- 11 laboratories testing about 3500 samples a week (more than 190 000 samples tested)
- 11 Ebola treatment centres providing care
- 26 000 safe and dignified burials
- more than 1000 metric tonnes of supplies delivered.

WHO and partners remain in active response mode until the end of the outbreak is declared. So when a new case in the Democratic Republic of the Congo was reported on 10 April, the country was ready to respond. "This only shows that we cannot let our guard down. We must be always ready to respond," says Dr Michael Ryan, Executive Director of WHO's Health Emergency Programme.



MEDICINES FOR
INJURIES AND PRIMARY
HEALTH CARE FOR
10 000 PEOPLE WERE
ALSO DISPATCHED

RESPONDING TO DISASTERS

Aside from outbreaks, the WHO Health Emergencies Programme also responds to disasters, which are expected to increase in frequency and severity due to climate change.

CARING FOR HEALTH AFTER A CYCLONE

In March 2019, Tropical Cyclone Idai struck, affecting 1.6 million people in three African countries and severely damaging 55 health centres. WHO responded quickly to prevent the second disaster of subsequent disease outbreak, deploying a team of experts to work with health ministries and 20 emergency medical teams providing life-saving care. Medicines for injuries and primary health care for 10 000 people were also dispatched.

WHO supported the Mozambique Ministry of Health in retaining direct coordination and reporting on all activities – reflecting the localization of coordination. WHO coordinated more than 48 partners within the health cluster and deployed experts from all levels of WHO and through the [Global Outbreak Alert and Response Network](#) to help set up a disease surveillance system. In response to the increasing number of cholera cases, WHO and partners immediately delivered more than 800 000 doses of oral cholera vaccine in a mass vaccination campaign, with 98.5% reported coverage, thus averting a potential disaster. Some 900 000 insecticide-treated bednets were also provided to prevent a spike in malaria cases.

PREVENTING HEALTH CRISES IN FRAGILE SETTINGS

About one quarter of the world's population – two billion people – live in fragile, conflict and vulnerable contexts, in which basic health services may be lacking. About 70% of all outbreak cases – such as cholera, measles and yellow fever – as well as 60% of preventable maternal deaths and roughly half of all child deaths occur in such settings.

The Organization's role as a last-resort provider of health services and its ability to deploy surge personnel has proven to be critical.

DOCUMENTING ATTACKS ON HEALTH CARE

In the **Syrian Arab Republic**, a total of 494 attacks on health facilities were confirmed between 2016 and 2019, of which 68% were recorded in the northwest of the country. Only half of the health facilities in the northwest of the country remain open. WHO advocates against these

attacks, collects evidence and promotes best practice to safeguard health care under the **Attacks on Health Care** initiative.

The initiative launched the **Surveillance System for Attacks on Health Care**, which documents

attacks in different countries. This database has been used in several forums as the evidence base to initiate dialogue on the need to protect health care and civilians from attacks, as well as for actions at political and technical levels.

PROVIDING BASIC HEALTH SERVICES IN YEMEN



IN YEMEN, WHO AND PARTNERS PROVIDED HEALTH ASSISTANCE TO **10 MILLION PEOPLE**

In Yemen, the world's worst humanitarian crisis, 20 million people are in need of health assistance. WHO is working to fill critical gaps in the provision of basic health care with the Ministry of Public Health and the Ministry of Population. WHO gives direct support to 49 hospitals and supports more than 3000 health facilities with its partners.

In response to the largest recorded cholera outbreak (almost 2.3 million cases at the end of 2019), WHO scaled up its operations and supported the establishment of 333 multidisciplinary rapid response teams. In 2019, WHO delivered 6261 cholera kits and 476 391 Ringer's lactate and IV sets, maintaining the provision of approximately 19 million litres of safe water to health care facilities and diarrhoea treatment centres. In addition, 3.1 million doses of oral cholera vaccination were administered in campaigns in high-risk districts.

WHO also initiated the United Nations medical air bridge for the transportation of patients needing medical attention unavailable in Yemen to agreed locations abroad.

Thanks to tremendous diplomatic efforts by the United Nations and some Member States, the first medical air bridge operation was launched in February 2020, when a group of Yemeni patients travelled from Sanaa to Amman, Jordan, for specialized care.

KEY FIGURES FOR 2018–2019: WHO HEALTH EMERGENCIES PROGRAMME



Approved Programme budget:
US\$ 554 million

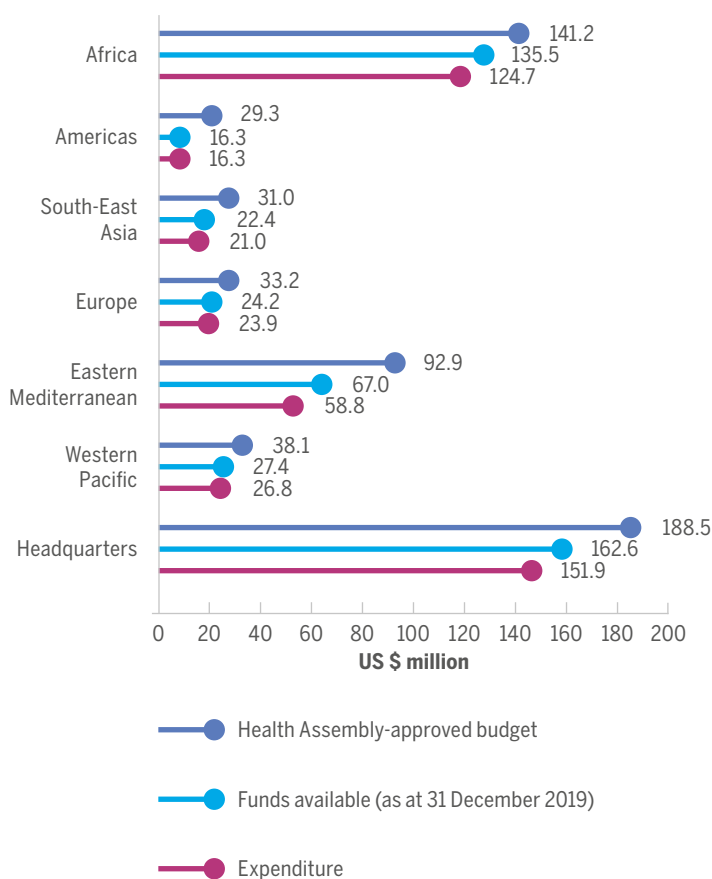


Funds available:
US\$ 455 million
(82% of Programme budget)

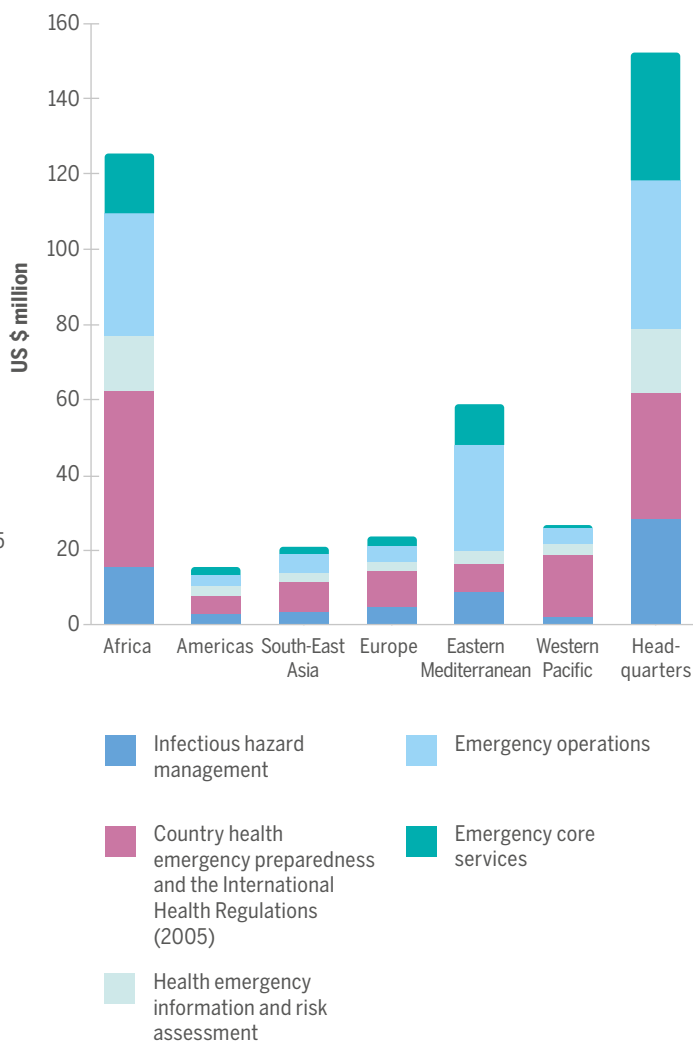


Expenditure:
US\$ 423 million
(76% of Programme budget,
93% of available resources)

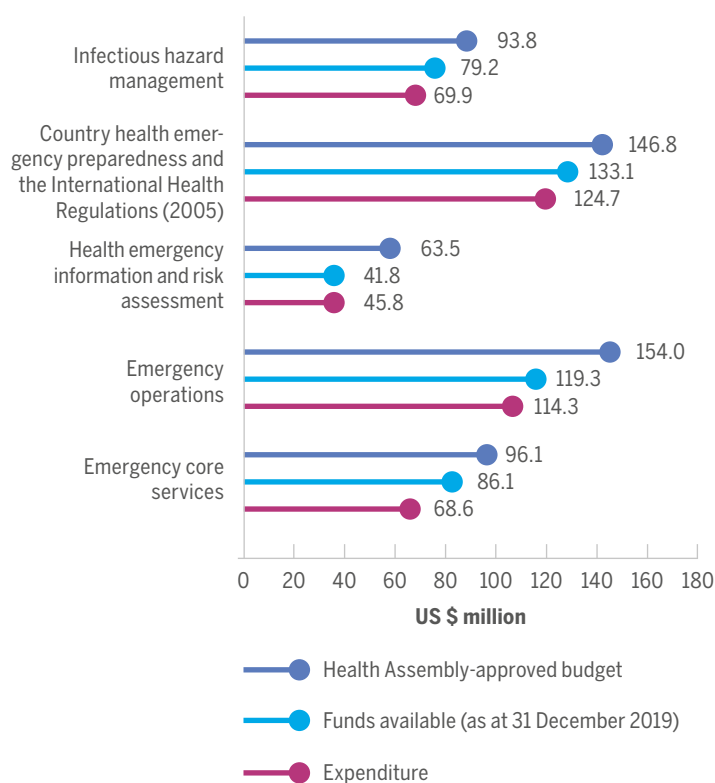
BASE BUDGET, FUNDS AVAILABLE AND EXPENDITURE, BY MAJOR OFFICE (IN US\$ MILLION)



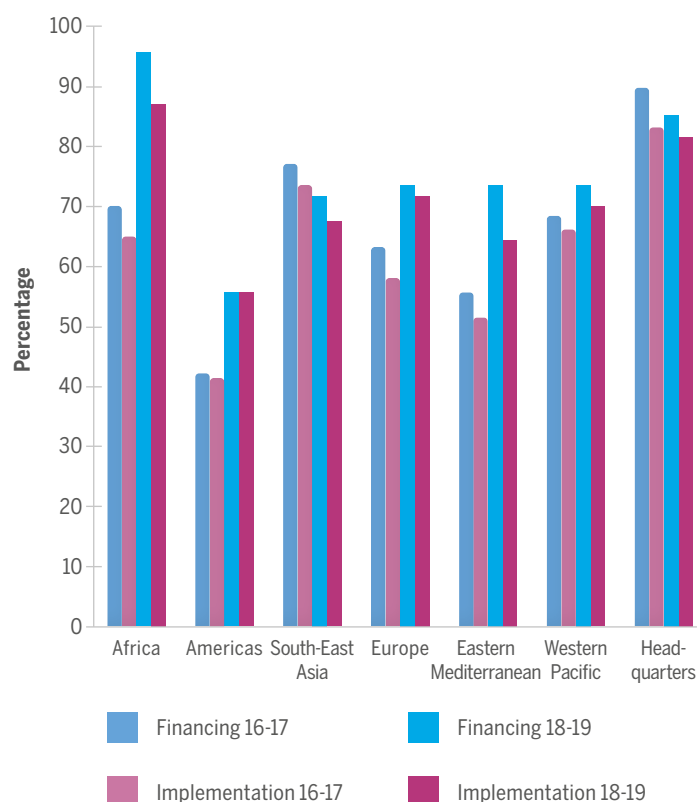
PROGRAMME BUDGET EXPENDITURE, BY MAJOR OFFICE AND PROGRAMME AREA (IN US\$ MILLION)



BASE BUDGET, FUNDS AVAILABLE AND EXPENDITURE, BY PROGRAMME AREA (IN US\$ MILLION)



LEVEL OF FINANCING AND IMPLEMENTATION OF PROGRAMME BUDGETS FOR 2016–2017 AND 2018–2019



In 2018–2019, the WHO Health Emergencies Programme was fully integrated into the WHO Programme budget for the first time. Its full biennial budget was US\$ 554 million, representing 16% of the Health Assembly-approved base budget for 2018–2019, and it was the third largest technical category after Communicable diseases and Health systems.

Following its creation in 2016, the Programme has required time and resources to establish appropriate staffing across the three levels and expand its operations. Although several challenges remain, good progress was achieved by the end of the biennium, which was put to test during the Ebola outbreak in the Democratic Republic of the Congo. At the end of the biennium, the Programme was in the process of responding to more than 60 active-graded emergencies.

By the end of the biennium, the WHO Health Emergencies Programme was financed to 82% of its approved budget, including allocations of corporate flexible funds comparable to that of the other two underfunded technical categories. That lack of a fully financed Programme budget remains one of the main obstacles to achieving solid preparedness and response capacities across all regions.

No major office was fully financed in 2018–2019; however, with the exception of headquarters and the South-East Asia Region, all regional offices increased the level of financing of their respective budgets compared to 2016–2017. There were substantial increases in the African and Eastern Mediterranean regions, which showed a good correlation between the level of emergency operations and the overall technical support required. In the African Region, the WHO Health Emergencies Programme had the second highest level of funding and implementation of all the technical categories.

The Country health emergency preparedness and the International Health Regulations (2005) programme area was the best financed (91%) and also saw a substantial increase in financing from 2016–2017; it is the largest programme area of this category in all regions except the Eastern Mediterranean Region. The Health emergency information and risk assessment programme area was the least financed programme (66%). Although its financing also improved compared to 2016–2017, the improvement was only slight and the proportion of funding from specified voluntary contributions was significantly lower than that of the other programme areas.

The implementation of the approved budget of the WHO Health Emergencies Programme was 76%, the same as that of other categories with a similar level of financing. The implementation of available resources was, however, high (93%). The best-funded major office (WHO Regional Office for Africa) and programme area (Country health emergency preparedness and the International Health Regulations (2005)) were also the highest implementers of the budget.

There was, therefore, a direct relationship between implementation as measured against the approved Programme budget and availability of funding: areas with high levels of funding had higher levels of budget implementation. The same was observed in the Noncommunicable diseases and the Promoting health through the life course categories. This could be taken to indicate the capacity to implement the planned budget to the extent that funding matched planning.

In summary, although both financing and implementation of the WHO Health Emergencies Programme budget increased in 2018–2019, there is room for further improvement. Although the Secretariat prioritized the Programme in the distribution of corporate flexible and thematic funds – at about 48% of 2018–2019 funding – those resources were insufficient to allow full and equitable financing of the budget across all areas and major offices. Additional voluntary resources are required to fully implement the planned Programme budget and ensure that 1 billion more people can be better protected from ongoing and future health emergencies.

KEY FIGURES FOR 2018–2019: OUTBREAK AND CRISIS RESPONSE AND SCALABLE OPERATIONS



Approved Programme budget:
US\$ 0 million

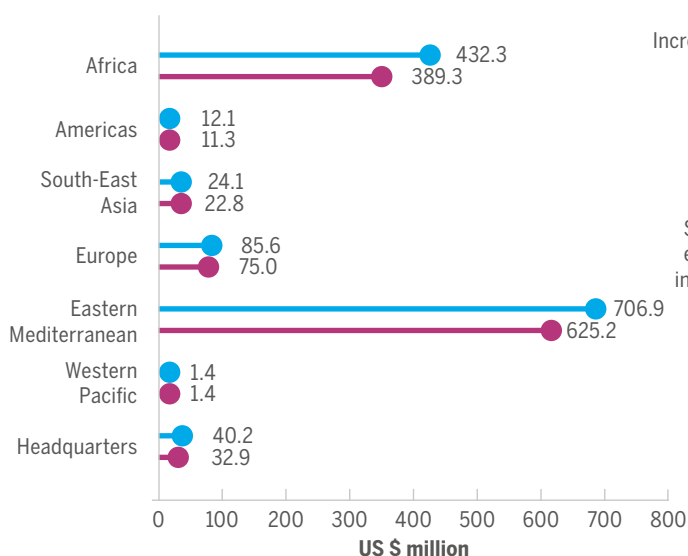


Funds available:
US\$ 1303 million

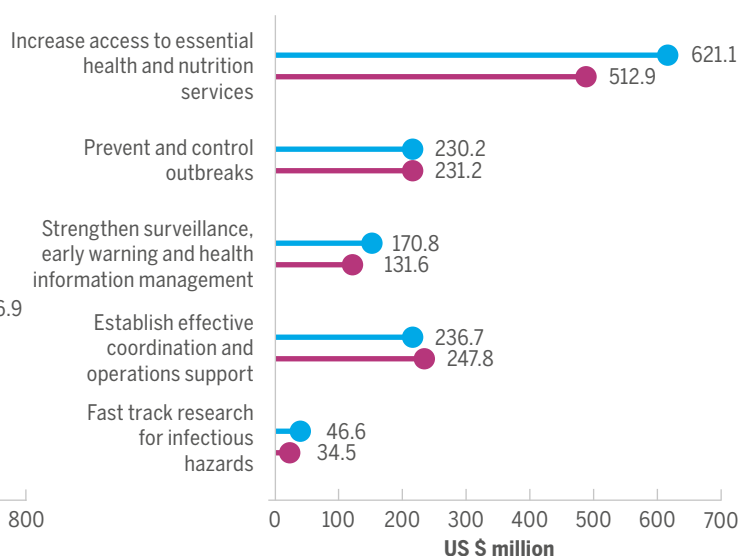


Expenditure:
US\$ 1158 million
(89% of available resources)

BASE BUDGET, FUNDS AVAILABLE AND EXPENDITURE, BY MAJOR OFFICE (IN US\$ MILLION)

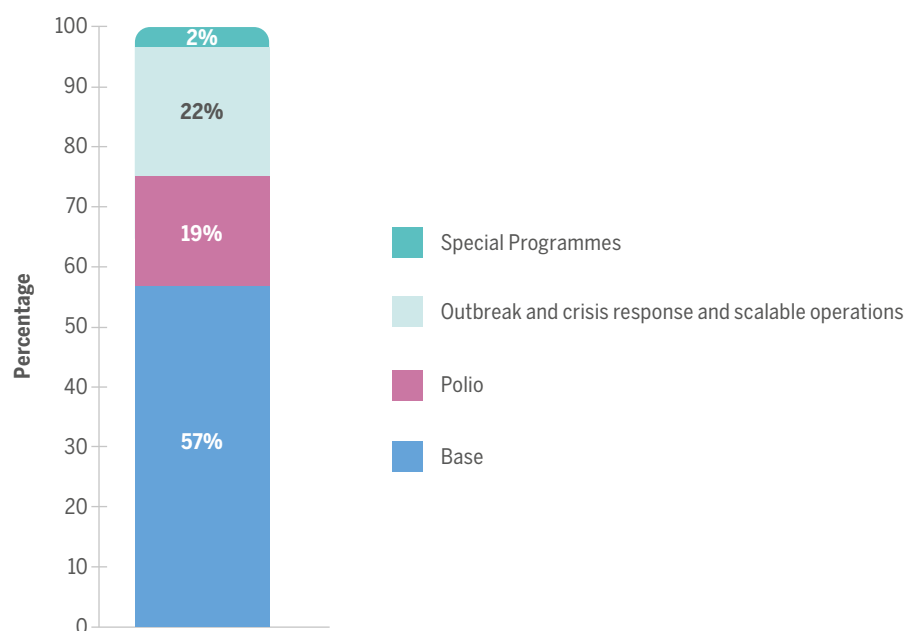


BASE BUDGET, FUNDS AVAILABLE AND EXPENDITURE, BY PROGRAMME AREA (IN US\$ MILLION)



● Funds available (as at 31 December 2019) ● Expenditure

SHARE OF EXPENDITURE BY SEGMENT IN 2018-2019



Due to the event-driven nature of the Outbreak and crisis response and scalable operations segment, it was not allocated a Health Assembly-approved budget for 2018–2019, as it is difficult to foresee and plan for an ascertained level of operations. The comparison of the level of financing or implementation of this segment to an approved budget is therefore not available. As stipulated in resolution WHA72.5, the Programme budget for 2020–2021 will include an estimated budget for the Outbreak and crisis response and scalable operations segment, allowing a full budget representation of the cost of WHO's operations, which is about 20% higher if this segment is included.

In 2018–2019, WHO implemented US\$ 1158 million in the Outbreak and crisis response and scalable operations, of which 88% was implemented in the African and Eastern Mediterranean Regions. The Eastern Mediterranean Region was the largest recipient and implementer of humanitarian funding (54% of the total), while the Outbreak and crisis response and scalable operations represented about 50% of total regional operations.

The Outbreak and crisis response and scalable operations are predominantly funded from voluntary contributions. In exceptional circumstances, the Secretariat provided emergency loan and allocation of flexible funds to allow for business continuity.

The Contingency Fund for Emergencies was set up by the World Health Assembly in 2015 as a rapid funding mechanism to establish immediate response and to maintain critical life-saving operations. In 2018–2019, the amount of US\$ 120 million was made available for immediate country-level response to disease outbreaks and humanitarian crises with health consequences. The single largest recipient of financing from the Contingency Fund was the response to the Ebola outbreak in the Democratic Republic of the Congo. To the extent possible, funds from the Contingency Fund are expected to be reimbursed when other sources of funds become available. Of the total amount of US\$ 120 million released in 2018–2019, the amount of US\$ 46 million was reimbursed by the end of the biennium.

The Contingency Fund has proven to be an invaluable source of funds for immediate response operations. However, despite success in deepening and broadening its resource base, the current replenishment model for the Contingency Fund, which is fully dependent on direct donor contributions from a few traditional donors, may not be fully sustainable. The Secretariat is considering alternative means and sources of funding for future biennia.

For further details on the Programme Budget funding, implementation for this category and achievements by programme areas including indicators, please refer to the WHO Programme Budget Portal (<http://open.who.int/2018-19/our-work/category/12/about/programme-outcomes> and <http://open.who.int/2018-19/home>).

HEALTH SYSTEMS

18 MILLION HEALTH WORKERS need to be recruited and trained globally to provide essential health services

COVERAGE OF CORE HEALTH SERVICES needs to at least double by 2030

National regulatory authorities ensured core regulatory functions for medicines and vaccines in **68 COUNTRIES**

Member States need to increase spending on **PRIMARY HEALTH CARE** by at least **1%** of their gross domestic product in order to reduce catastrophic health expenditure

National health workforce accounts implemented in **42 COUNTRIES**

Increase in service coverage index from a global average of **45/100** in 2000 to **66/100** in 2017

Strategies to improve patient safety in **91 COUNTRIES**

Progress on financial protection reported in **88 COUNTRIES**



Approved Programme budget:
US\$ 590 million



Funds available:
US\$ 617 million
(105% of Programme budget)



Expenditure:
US\$ 558 million
(95% of Programme budget,
90% of available resources)



“People and economies are also better protected from health security risks with a strong primary health care system... Primary health care is the first line of defence against outbreaks and health emergencies.”

DR TAKESHI KASAI
WHO Regional Director for the Western Pacific



UNIVERSAL HEALTH COVERAGE BASED ON PRIMARY HEALTH CARE IS A UNIFYING CONCEPT

The pandemic of coronavirus disease (COVID-19) has reminded the world of the importance of preparedness, strong health systems that are resilient to shocks and the need to ensure systems that can maintain essential health services without financial hardship, especially during times of crisis.

Universal health coverage based on primary health care is a unifying concept; a platform for integrated, people-centred delivery of health services; and one of the most powerful social equalizers among all policy options. It is the ultimate expression of fairness. People who cannot pay for health care are not left to suffer ill health or die as a result of a preventable or treatable condition. Only 10 years remain to reach the target under the Sustainable Development Goals of achieving universal health coverage – the target of 1 billion more people by 2023 will be a key milestone.

HELPING UKRAINE ACHIEVE UNIVERSAL HEALTH COVERAGE THROUGH SWEEPING HEALTH FINANCING REFORMS



DECISION TO FINANCE
THEM WITH TAX REVENUES
SO THAT THE **ENTIRE
POPULATION IS COVERED**,
INCLUDING THE ONE THIRD
OF THE LABOUR FORCE
THAT IS UNEMPLOYED
OR WORKING IN THE
INFORMAL SECTOR

Within the last two years, 29 million citizens – more than two thirds of the population – have enrolled with a physician. This choice of provider is critical to ensuring competition among public and private providers who are funded by the new single purchasing agency – the National Health Service of Ukraine. These patients are also guaranteed a list of primary health care services.

The transformation began with the passage of the 2017 Law on Financial Guarantees for Health Care, which aims to improve the population's access to primary health care and reduce the out-of-pocket expenses of those who seek medical care. WHO played a major role in shaping these reforms, including the decision to finance them with tax revenues so that the entire population is covered, including the one third of the labour force that is unemployed or working in the informal sector.

The share of the government budget for health increased by almost 50% between 2016 and 2019, from 9.8% to 14.6%. The low levels of public spending on health care, coupled with oversized hospital infrastructure prior to these reforms, had previously led to patients being burdened with significant out-of-pocket payments for most outpatient and inpatient services, as well as all medicines at outpatient level.

At the same time, an affordable medicines programme was launched to provide essential medicines for chronic conditions free of charge to more than 6.6 million Ukrainians, through pharmacies contracted by the National Health Service of Ukraine. WHO assessment and policy recommendations were instrumental in extending this programme into 2019. Between 2018 and 2020, the amount of public spending allocated to this programme more than doubled. Next steps include training for primary care providers and expansion of the purchasing system to cover hospital care.

KEY ACHIEVEMENTS

HIGH-LEVEL COMMITMENT TO UNIVERSAL HEALTH COVERAGE

The political declaration of the high-level meeting on universal health coverage of 2019 is the most comprehensive instrument ever adopted by the United Nations on the right of all people to access health services and a powerful statement of the world we want. Heads and representatives of **193 States and Governments** showed strong political vision and commitment to ensuring universal health coverage for the people they serve.

Building on the **Declaration of Astana** adopted at the Global Conference on Primary Health Care in 2018, the political declaration underscores the importance that world leaders have placed on achieving universal health coverage and related objectives under Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages). It describes the specific actions that governments and all stakeholders should take.

UNIVERSAL HEALTH COVERAGE: WHERE ARE WE?

The **2019 Global Monitoring Report** showed an increase in the service coverage index from a global average of 45/100 in 2000 to 66/100 in 2017.

All regions and income groups have recorded gains, although the pace of progress has slowed since 2010 and this progress masks gross inequities that are leaving the most vulnerable behind.

Although the decline in global poverty has driven increased health service use and coverage, the related increase in out-of-pocket health spending has resulted, conversely, in more people experiencing financial hardship that has pushed many into poverty. The incidence of catastrophic health expenditure has increased every year from 2000 to 2015.

The Report indicates that progress must accelerate significantly as coverage needs at least to double between 2019 and 2030. Countries need to recruit and train 18 million health workers globally – not only to achieve universal health coverage targets but also as an investment in human capital and sustainable development.

The Report notes that most countries underinvest in primary health care. There is a clear call for Governments to increase spending on primary health care by at least 1% of their gross domestic product. Investing an additional US\$ 200 billion per year on scaling up primary health care across low- and middle-income countries could save 60 million lives, increase average life expectancy by 3.7 years by 2030 and contribute significantly to socioeconomic development.



HEADS AND REPRESENTATIVES OF **193 STATES AND GOVERNMENTS** SHOWED STRONG POLITICAL VISION AND COMMITMENT TO ENSURING **UNIVERSAL HEALTH COVERAGE** FOR THE PEOPLE THEY SERVE



CALL FOR GOVERNMENTS TO INCREASE **SPENDING** ON PRIMARY HEALTH CARE BY **AT LEAST 1% OF THEIR GROSS DOMESTIC PRODUCT**

EGYPT'S NEW HEALTH INSURANCE LAW TO COVER ALL



ALL EGYPTIANS WILL BE COVERED ON A MANDATORY BASIS THROUGH FAMILY MEMBERSHIP

Egypt's universal health insurance law, adopted in 2018, has the potential to achieve significant progress towards universal health coverage. It is being implemented over a period of 15 years and is helping to ensure that all have access to the quality health services they need without suffering financial hardship.

WHO has been a key partner at all levels, providing close support

during the law's development and subsequent implementation and helping develop the policy document.

Under the law, all Egyptians will be covered on a mandatory basis through family membership.

Previously, only 58% of the population was covered. The State is expected to subsidize 30 to 35% of the population, including the poor and vulnerable, financed by payments from formal sector employees, tobacco taxes, road tolls and corporate taxes.

Importantly, a single payer system will be established, with enormous potential to redistribute funds from individuals with lower health needs and risks to those with higher health needs and risks.

The main challenge will be to ensure equitable access to health services during the long implementation process, when coverage arrangements will vary. WHO has helped develop options to improve the health financing system; supported a comprehensive assessment of the purchasing and governance arrangements; and also assisted in strengthening the health information system, especially for medical records. Subsequently, the Universal Health Insurance Agency approved the recommended mix of payment methods for different levels of care.

An important lesson from this experience is that continuous WHO engagement has been vital for the steady progress realized in Egypt.



NEW 1% CONSUMPTION TAX ON THE PURCHASE OF GOODS AND SERVICES

Gabon started on the road to universal health coverage in 2007 by establishing a national health insurance programme. Increased public funding has led to significant decreases in out-of-pocket payments and direct household payments. A fully subsidized fund for low-income groups, the Gabon Indigents Scheme, was financed until 2017 through a tax basket comprising a 10% tax on the annual turnover of mobile telephone companies and a 1.5% tax on individual international money transfers.

In 2017, the mobile telephone tax was abolished following pressure from the industry and replaced with

a new 1% consumption tax on the purchase of goods and services.

The comprehensive benefit package includes primary care consultations, inpatient care, drugs and medical evacuations, with 20% co-payments except for the poor. Over the last two years, WHO has continued to support Gabon on public financial management issues in health – a core element of an enabling environment for health financing reform and progress towards universal health coverage. WHO provided key recommendations to sustain reform assets and improve the design and implementation of budgets.

Regional progress highlights are as follows:

African Region

Greater capacity was established to conduct country-specific health accounts in 27 countries to inform a range of policy needs, such as the development of transition plans in the **Congo** and supporting advocacy for increased investment in health in **Burkina Faso**. Based on data from the Global Health Expenditure Database, the Africa Health Scorecard was produced in close collaboration with the African Union.

European Region

Estonia and **Lithuania** acted on policy recommendations and introduced new policies that improved financial protection for the poor and frequent users of health services. In **Estonia**, the number of people benefiting from direct payment of prescription costs rose steeply from 3000 in 2017 to 134 000 in 2018. The new system was implemented following a WHO analysis showing that financial hardship was being driven by out-of-pocket payments for outpatient medicines.

Region of the Americas

The report of the “High-Level Commission: Universal Health Coverage in the 21st Century: 40 years of Alma-Ata” provided a strategy to act on social determinants and create specific spaces to engage communities. A regional compact on primary health care for universal health coverage was launched.

South-East Asia Region

Technical assistance was provided to **Bangladesh**, **Sri Lanka** and **Timor-Leste** to design core service packages, including feasibility and costing studies. To inform their development of new, more integrated service delivery models, cross-programmatic efficiency analyses were conducted in **Bhutan** and **Sri Lanka**. These identified specific duplications and misalignments of functional responsibilities across different programmes, which helped advocacy for sustainable financing from domestic resources for these services and to inform health system-wide reforms.

Eastern Mediterranean and African Regions

A diagnostic analysis of the systematic approach to health financing was applied in fragile and conflict-affected situations such as **Afghanistan**. The humanitarian–development nexus provided an integrated planning and implementation framework.

Western Pacific Region

The action agenda on strengthening legal frameworks for health provides guidance on developing, implementing and evaluating health laws. A new law on universal health care was passed in the **Philippines**. Legislation was drafted on core health care and health promotion in **China**, on alcohol control in **Vanuatu** and on infectious disease control in **Viet Nam**.



160 COUNTRIES HAVE A COMPREHENSIVE NATIONAL HEALTH SECTOR POLICY/STRATEGY/PLAN WITH GOALS AND TARGETS UPDATED WITHIN THE LAST FIVE YEARS



INTEGRATED HEALTH SERVICES IN **90 COUNTRIES**



DISAGGREGATED HEALTH WORKFORCE REPORTS IN **161 COUNTRIES**

STRONGER AND BETTER PREPARED HEALTH SYSTEMS

Under the Joint Working Team for Universal Health Care, **South Sudan** is receiving intensified three-level support to build its health system to provide core health services and be prepared for emergencies. The country is acutely vulnerable to recurring public health events, such as the Ebola virus disease. Comprising health systems and health emergency experts, the Joint Working Team conducted three successive missions in 2019 and worked closely with the Ministry of Health and partners to identify areas in which critical interventions could be made to improve health system functioning. This included the development of a health sector recovery and rehabilitation plan – the first of its kind – with time-bound priorities across the six building blocks of health systems and to enhance preparedness and resilience to emergencies by ensuring continuity of service provision.

This work led to the development of a new intensified technical assistance programme to support ministries of health in the implementation of health sector recovery and rehabilitation plans, involving health system and emergency and preparedness experts from the three levels of the Organization. The programme focuses on health systems strengthening for primary health care and essential public health functions, with particular emphasis on vulnerable/outreach groups (women, girls); emergency preparedness and risk reduction; the governance function of ministries of health; and coordination with development partners. In addition, the programme aims to provide an essential package of health services in 10 targeted counties; increasing the outpatient department utilization rate; improving the performance of health management information systems (HMIS) and district health information software (DHIS2); improving immunization coverage; and increasing skilled birth attendance in 25 counties.

BETTER HEALTH WORKFORCE DATA

Initiated in 2016, implementation of National Health Workforce Accounts allows countries to compile data across sectors and regularly report it to the platform for National Health Workforce Accounts through a designated focal point. This systematic process, including national data validation, has built ownership of the data at national level. Currently, 193 countries have data within the past 5 years, compared with less than 100 countries before implementation of National Health Workforce Accounts. **Normative guidance documents**, complemented by workshops conducted across all regions, have enabled successful implementation.

The report ***Delivered by Women, Led by Men: A Gender and Equity Analysis of the Global Health and Social Workforce*** highlighted barriers to gender equity in four key areas: occupational segregation by gender; decent work; gender pay gap; and leadership. This led to political commitments to address those barriers at the highest level in different global forums, such as the Commission on the Status of Women and the United Nations General Assembly.

BOOSTING UNIVERSAL HEALTH COVERAGE IN COUNTRIES

Ministry of Health leads with a roadmap of activities needed to make their health system resilient, effective and sustainable.

93 health policy advisers operate on the ground and 23 in regional offices – with support of 7 donors coordinated in WHO by the Joint Working Team for universal health coverage.

Currently > **1.2 bn**
beneficiaries in **115**
countries across
all 6 WHO regions



DOMINICA

Increased focus on **community health centres** means Dominica is better placed to achieve universal health coverage – after hurricane Maria.

NIGERIA

Government of Nigeria sets up annual forum where updates, **knowledge and best practices are shared** on health workforce planning.

TUNISIA

New Tunisian health **policy driven by aspirations and needs of 4000 citizens** – though a 2-year participatory consultative process

ESTONIA

In Estonia, population covered by seamless and more protective **payment system for prescribed medicines** increased from 0.2% to 10% between 2017 and 2018.

SAMOA

Non-communicable disease interventions implemented – women's committees achieve **92% screening of 7 pilot villages** in Samoa and find 45% need referral to clinic for further care

TIMOR-LESTE

Essential package of services developed in Timor-Leste, based on a **family medicine** approach combined with updated **health workforce accounts** contributed to the national human resources for health strategic plan 2020–2024



ACTION ROAD MAPS WERE DEVELOPED AND ARE BEING IMPLEMENTED WITH **WHO SUPPORT**

QUALITY OF CARE IN THE UNITED REPUBLIC OF TANZANIA AND NAMIBIA

Over the past two years, seven countries in Africa have requested WHO collaboration on developing and implementing a national quality policy and strategy to improve the performance of their health care systems. In August 2019, the Secretariat organized a three-level workshop to build the capacity of national quality directorates in this regard. Action road maps were developed and are being implemented with WHO support. The United Republic of Tanzania is part of the Network for Improving Quality of Care for Maternal, Newborn and Child Health, which aims to halve maternal and newborn deaths and stillbirths

in health facilities by 2022 and improve patients' experience of the care received at health facilities. Supportive governance policy and structures have been established, quality improvement manuals have been developed and coaches have been trained to support health facilities.

In Namibia, WHO supported the development and implementation of a framework to measure the impact of quality interventions that is aligned with the national health management information system and includes activities at the subnational and facility levels to improve data on quality.



THE PROJECT HAS CONTRIBUTED TO **INTERNATIONAL LEARNING** IN HOW IMPROVEMENTS IN MATERNAL, NEWBORN AND CHILD HEALTH, USING AN INTEGRATED, PEOPLE-CENTRED HEALTH SERVICES APPROACH, MIGHT BE IMPLEMENTED IN OTHER CONTEXTS AND SETTINGS

USING PEOPLE-CENTRED APPROACHES IN MALI

In Mali, as part of efforts to implement the Framework on integrated, people-centred health services, WHO and partners supported a project to promote and assess people-centred approaches to health services in maternal, newborn and child health care. Ten community health centres in the districts of Diéma and Yélimané in the Kayes region participated in the project, starting in 2016. The main goal was to promote people-centred approaches in clinical consultations by health providers during pregnancy and delivery at peripheral health centres, based on the quality improvement approach of setting measurable objectives, conducting small-scale testing of changes in care delivery processes and measuring results with predefined indicators.

The project also sought to examine whether health providers were responsive to the needs and preferences of patients and whether patients were supported in the management of their own care. The main achievements included increased dignity and privacy of pregnant mothers during childbirth; reduced gaps in care delivery; improved provider-patient relationships; reduced waiting times; and improved management of referrals according to patients' needs. The project has contributed to international learning in how improvements in maternal, newborn and child health, using an integrated, people-centred health services approach, might be implemented in other contexts and settings.

THE NIGER BUILDS ITS HEALTH WORKFORCE TO REACH THE UNDERSERVED



AN ADDITIONAL **11 500** **HEALTH PROFESSIONALS** JOBS NATIONWIDE

Based on the recommendations of the United Nations High-level Commission on Health Employment and Economic Growth, as adopted by the Health Assembly in resolution WHA70.6 (2017), the Niger engaged with a range of sectors and ministries to translate the Commission's recommendations to the national context. The resulting national action plan for investment in health and social sector employment and growth in economic health 2018–2021 was informed by WHO's technical assistance on health labour market analysis, which

showed that employment in the health sector represents less than 4% of the active labour force and is inequitably distributed: only 35% of health workers practice in rural areas, where 60% of the population is located. The national action plan calls for the creation by 2021 of an additional 11 500 health professionals jobs nationwide and prioritized expanded coverage of health services to underserved areas. Related data is validated through the National Health Workforce Accounts to strengthen its availability, comprehensiveness and quality.



PREQUALIFICATION OF PRIORITY DRUGS IN BANGLADESH

In Bangladesh, given that 67% of out-of-pocket health expenditure was on medicines in 2015 and that purchasing assistance from international funds is decreasing, there is a need for affordable and safe priority medicines. The country produces about 98% of the needed medicines locally, but none of the manufacturers prequalified finished pharmaceutical products. A Coalition of Interested Partners was established in 2016 to coordinate efforts with WHO to support local capacity-building to manufacture and regulate medicines. WHO's country office played a key role in advocacy and technical assistance to generate interest and improve capacity in both the local manufacturers of medicines and the country's national regulatory authority.

The WHO inspection team conducted the initial inspection of the manufacturing site of Beximco Pharmaceuticals, the first manufacturer to apply for prequalification in 2017. Two years later, in January 2019, WHO prequalified the first product, lamivudine, an antiretroviral drug for HIV/AIDS. A number of other applications from local manufacturers are currently under assessment.



WHO PREQUALIFIED
THE FIRST PRODUCT IN
BANGLADESH, **LAMIVUDINE**,
AN ANTIRETROVIRAL DRUG
FOR **HIV/AIDS**



PREQUALIFICATION HELPS PROVIDE QUALITY-ASSURED PRODUCTS TO MILLIONS

The prequalification programme covers medicines, vaccines, diagnostics, vector control products, cold chain equipment, immunization devices, male-circumcision devices and two pilots for selected cancer medicines and for human insulin. During the 2018–2019 biennium, **326 products were prequalified**, providing guidance on the quality, safety and efficacy or performance of health products.

Key accomplishments include:

- prequalification of the **first similar biotherapeutic for breast cancer**;
- prequalification listing of **Ervebo**, a vaccine to prevent Ebola virus disease, less than 36 hours after EU approval;
- launch of pilot prequalification of **human insulin** to increase treatment for diabetes in low- and middle-income countries;
- vector control: in less than 18 months of operation, **71 products** have been converted from WHO Pesticide Evaluation Scheme (WHOPES) listings and six products have been prequalified, while new tools are being developed to manage the rapidly developing resistance of mosquitoes to pyrethroids;
- prequalification of **two polio vaccines**, boosting efforts to eradicate the disease;
- first **in vitro diagnostic** for HIV prequalified through the alternative performance evaluation mechanism.

HISTORICAL STEP IN PREQUALIFYING EBOLA VACCINE

WHO prequalified the first Ebola vaccine – a historical step towards the accelerated licensing, access and roll-out in countries most at risk of Ebola outbreaks. This is the fastest vaccine prequalification process conducted by WHO, which was delivered less than 36 hours after **European Union** approval. The prequalified vaccine meets WHO standards for immunogenicity, safety and efficacy. Ninety days after WHO prequalification, **Burundi**, the **Democratic Republic of the Congo**, **Ghana** and **Zambia** licensed an Ebola vaccine.



**326 PRODUCTS
WERE PRE-QUALIFIED**

RESEARCH AIMING TO IMPROVE HEALTH PROGRAMMES EXPANDED IN NEPAL



TECHNICAL SUPPORT WAS PROVIDED BY **ALL LEVELS OF WHO**

As in many other countries, there is a critical gap in research in Nepal to help implement public health programmes and interventions by looking at barriers and at what works and what does not. The Country-Led Implementation

Research Initiative was created by WHO headquarters to address this gap, starting with Nepal. As efforts to achieve universal health coverage often fail at the implementation stage, implementation research could be a game changer.

Technical support was provided by WHO at all levels. A series of workshops trained policymakers, researchers and programme managers. One year later, Nepal's capacity to conduct high-quality implementation research had significantly improved. Seven

studies were selected, including one study that aims to increase enrolment in Nepal's Social Health Insurance Scheme, which was launched in 2016 to reduce the financial burden of medical costs. The findings of the studies will be applied in 2020.

This experience shows that how strong technical support, mentoring and a relatively small amount of seed money from WHO (US\$ 6500 to US\$ 9000 per study) can help develop a new, sustainable national research capacity in a short period.

BETTER INFORMED DECISION-MAKING IN LAO PEOPLE'S DEMOCRATIC REPUBLIC



NATIONAL CAPACITY WAS BUILT THROUGH **DHIS2** ACADEMIES AND TRAINING AT ALL LEVELS OF THE HEALTH SYSTEM

In 2018, WHO identified the need to develop an integrated approach to using the District Health Information Software 2 (DHIS2) platform implemented in the Lao People's Democratic Republic in 2013. A complete information system needed to be developed

for tuberculosis, HIV and disease surveillance within the DHIS2 platform.

WHO ensured political commitment at the highest level, while a ministerial decree endorsing DHIS2 as the national platform triggered buy-in from 12 key public health programmes and focused coordination with development partners to secure funding.

National capacity was built through DHIS2 academies and training at all levels of the health system, including locally. A systematic and rigorous process was carefully developed to give the Ministry of

Health complete ownership and enable the aggregation of routinely collected countrywide data across public health facilities.

Now that the 12 key public health programmes are using the same platform, the information collected will inform the analysis of health services, the forecasting of future needs and the evaluation of health worker performance. This will improve the quality of care and deliver cost savings by providing a basis for evidence-based decision-making.

LEARNING INTERNATIONAL NONPROPRIETARY NAMES AND IMPROVING THE QUALITY OF CARE

In 2019, WHO launched the School of INN (SoINN) to mainstream international nonproprietary names and contribute to better treatment outcomes and patient safety globally. The SoINN is a virtual school and collaborative platform that links innovation, normative work, research and education. It provides functionality for ad hoc sharing of courses or information with user groups, based on different predefined user profiles.

The goals of the SoINN are to advocate for the correct and effective use of international nonproprietary names; develop and raise interest in the science of medicines nomenclature; and cultivate the future success of the harmonization of nomenclature programmes around the world. After only a few months, it has received more than 2500 visitors and several universities have set up pilot sites.

Learning international nonproprietary names will help prevent medication errors and increase use of these names in clinical practice. This will facilitate interchangeability and support substitution policies to help buyers of medicines select the appropriate medicine and the most affordable treatment among therapeutic equivalents.

PRESSING FOR VALUE-FOR-MONEY IN ESSENTIAL MEDICINES

More than 150 countries use WHO's Essential Medicines List to guide decisions about which medicines represent the best value-for-money, based on evidence and health impact. In 2019, the Expert Committee recommended additions, including:

- five cancer therapies, which are regarded as the best in terms of survival rates to treat melanoma, lung, blood and prostate cancers;
- three new antibiotics for the treatment of multidrug-resistant infections;
- new oral anticoagulants to prevent stroke, which are particularly advantageous for low-income countries as they do not require the regular monitoring such as that required by warfarin;
- biologics and their respective biosimilars for chronic inflammatory conditions such as rheumatoid arthritis and inflammatory bowel diseases;
- heat-stable carbetocin for the prevention of postpartum haemorrhage, which has similar effects to oxytocin but does not require refrigeration.

The Committee also updated the AWaRE classification categories to strengthen advice on which antibiotics to use for the most common and serious infections in order to achieve better treatment outcomes and reduce the risk of antimicrobial resistance.



AFTER ONLY A FEW MONTHS, IT HAS RECEIVED MORE THAN **2500 VISITORS AND SEVERAL UNIVERSITIES**



MORE THAN **150 COUNTRIES** USE WHO'S ESSENTIAL MEDICINES LIST TO GUIDE DECISIONS



THE AIM OF THE SCIENCE DIVISION IS **TO INCREASE COUNTRIES' USE OF WHO GUIDANCE AND RECOMMENDATIONS**, IMPROVE THEIR RESEARCH CAPACITIES AND STRENGTHEN GLOBAL AND COUNTRY-LEVEL GOVERNANCE FOR DIGITAL HEALTH



Three WHO-hosted research entities are also linked to the Science Division in order to ensure optimal collaboration among these programmes as well as the most effective use of their resources in capacity-building for research, especially in low-income countries:

- UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases
- Alliance for Health Policy and Systems Research
- UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction

WHO STAYING AHEAD OF THE CURVE

In March 2019, the Director-General established the Science Division to ensure that WHO can fully exploit the power of science and innovation to deliver impact at country level and stay ahead of the curve.

Science Division's three departments

1. **Research for Health.** Mobilizes outcome-focused, country-led research agendas; ensures coordination of high-quality, cross-organizational research; and drives more effective translation of research evidence into health impact in countries.
2. **Quality Assurance of Norms and Standards.** Ensures that WHO norms and standards are produced to a consistently high quality, in a timely way, driven by what Member States need to have designed and delivered.
3. **Digital Health and Innovation.** Enables the digitalization and innovation of WHO and supports Regional Offices to harness the power of digital health and innovation.

A theory of change has been developed to strengthen collaboration among the three research entities.

Progress

- The decision was made to re-establish the Advisory Committee on Health Research to provide WHO with high-level science policy advice.
- A compendium of target product profiles has been launched to articulate unmet product needs
- Interim ethics guidance on gene editing has been developed.
- New standards for public consultation and the constitution of expert groups for the development of norms and standards have been established to ensure that all WHO norms and standards are developed based on state-of-the-art methodologies.
- WHO has joined cOAlition S, a global partnership for open access to research publications.

DIGITAL HEALTH

WHO's draft global strategy on digital health offers a framework for action to facilitate international collaboration in regulating, benchmarking and certifying artificial intelligence and digital health medical devices in order to achieve health for all. A call for international health data regulations that consolidate health data as a global public health good is included, as well as equitable data-sharing principles for research and artificial intelligence that protect patients' rights.

NEXT GENERATION OF INTERNATIONAL STANDARDS

The eleventh revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-11) was adopted by the Health Assembly in resolution WHA72.15 (2019). ICD-11 contains codes for new types of cancers and allergies, as well as updates on such matters as road traffic incidents and the alignment of codes with the Global Antimicrobial Resistance Surveillance System and the patient safety system of reporting. The revision is the result of the transparent public processing of 11 000 requests and ongoing maintenance. It is now fully digital and multilingual and can be accessed easily using the search feature or the the application programming interface. This ensures interoperability between systems and also empowers the use of real-time public health and big data.

While traditional use-cases have been preserved, ICD-11 also responds to the clinical uses requested by Member States, including individual patient records; support for decision-making in primary care; quality assessment of individual cases and health system outcomes; and reimbursement and health system financing. About 70% of the systems that manage health expenditure and resource allocation use ICD as their base and it is an essential tool for greater effectiveness and efficiency in countries.

The WHO Secretariat has produced a set of tools to help Member States in the implementation of ICD-11 by simplifying access to, and use of, the classification by end-users. To date, 102 countries from all six WHO regions have been trained in the hands-on use and implementation of this global standard for diagnostic health information; 29 of those countries are actively preparing for implementation and 10 of them are piloting national roll-out in anticipation of ICD-11 coming into effect on 1 January 2022.

CHALLENGES AND LESSONS LEARNED

Countries should increase spending on primary health care by at least 1% of their gross domestic product in order to close coverage gaps and meet the health targets agreed in 2015. Countries, with the support of WHO, should also intensify efforts to expand services countrywide in order to double health coverage between now and 2030.

Investing an additional US\$ 200 billion per year on scaling up primary health care across low- and middle-income countries could save 60 million lives, increase average life expectancy by 3.7 years by 2030 and contribute significantly to socio-economic development. That would represent an increase of about 3% over the US\$ 7.5 trillion already spent on health by the world each year.

For the poorest countries, including many affected by conflict, WHO should continue to provide assistance that is carefully targeted to provide lasting improvement to health systems and services through systematic strengthening of primary health care countrywide. The WHO Secretariat will continue to provide support to all its Member States to achieve these important goals.



**THE WHO SECRETARIAT
WILL CONTINUE TO
PROVIDE SUPPORT TO
ALL ITS MEMBER STATES
TO ACHIEVE THESE
IMPORTANT GOALS**

KEY FIGURES FOR 2018–2019: HEALTH SYSTEMS



Approved Programme budget:
US\$ 590 million

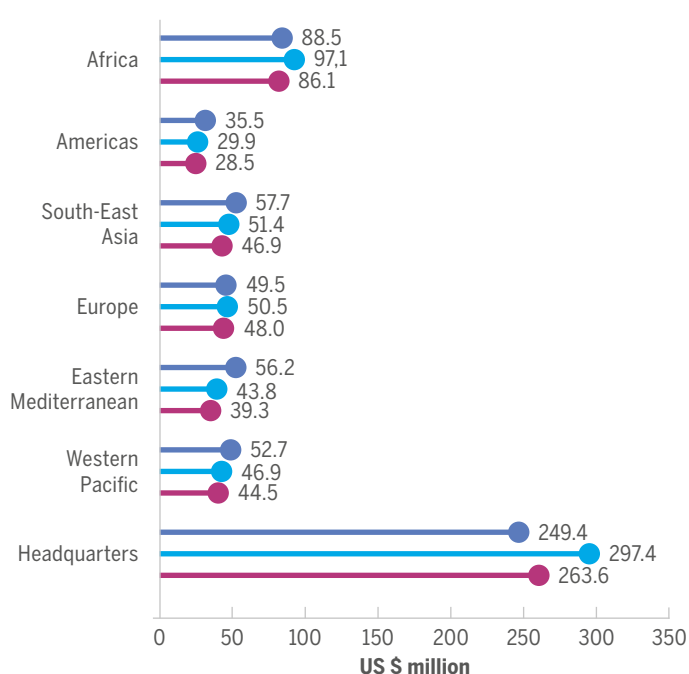


Funds available:
US\$ 617 million
(105% of Programme budget)

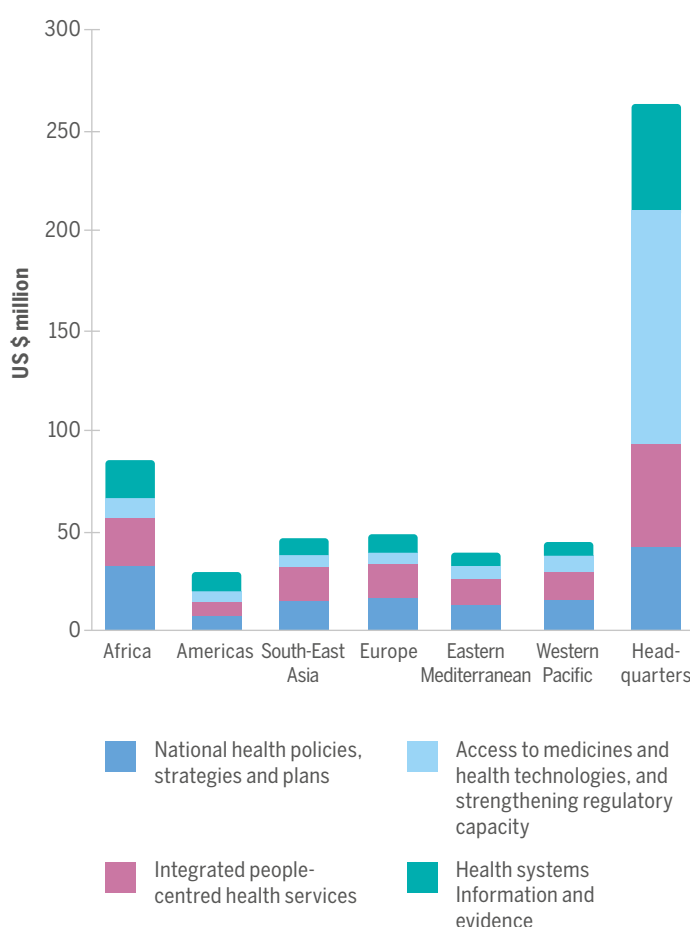


Expenditure:
US\$ 558 million
(95% of Programme budget,
90% of available resources)

BASE BUDGET, FUNDS AVAILABLE AND EXPENDITURE, BY MAJOR OFFICE (IN US\$ MILLION)



PROGRAMME BUDGET EXPENDITURE BY MAJOR OFFICE AND PROGRAMME AREA (IN US\$ MILLION)



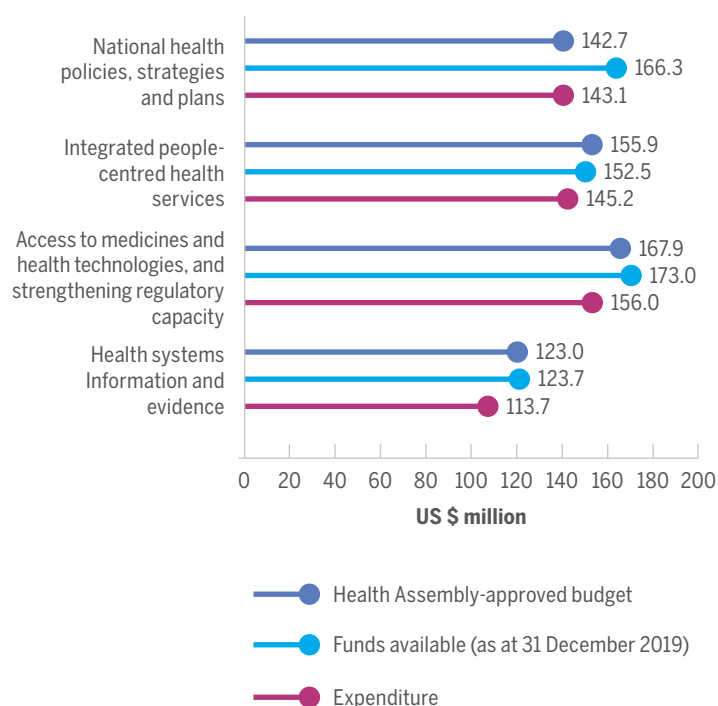
● Health Assembly-approved budget
● Funds available (as at 31 December 2019)
● Expenditure

■ 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

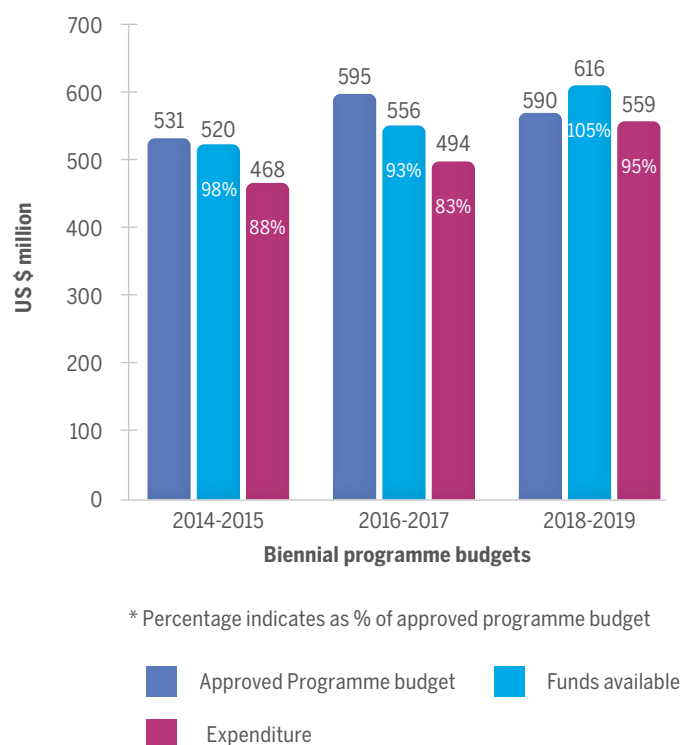
In 2018–2019, the Health systems category was 105% funded and implemented 95% of its approved budget. The high level of financing was partially attributable to the Universal Health Coverage Partnership, mainly in the National health policies, strategies and plans programme area. Overall, the levels of funding and expenditure reflect a strong and expanding global commitment to strengthening health systems and services.

In all major offices, expenditure levels increased at a similar rate to those of funding levels, with the budget fully implemented at headquarters and almost fully in both the African and European regions. Lower implementation levels in the Eastern Mediterranean Region are because some critical work in the programme area of health systems was delivered as part of emergencies work and polio eradication efforts.

BASE BUDGET, FUNDS AVAILABLE AND EXPENDITURE, BY PROGRAMME AREA (IN US\$ MILLION)



COMPARISON OF 3 BIENNIAL BASE PROGRAMME BUDGETS UNDER THE TWELFTH GENERAL PROGRAMME OF WORK (IN US\$ MILLION)



Funding and expenditure levels in the regions were concentrated in the National health policies, strategies and plans programme area and the Integrated people-centred health services programme area. However, at headquarters, the expenditure levels in the Access to medicines and other health technologies and strengthening regulatory capacity programme area and the Health systems information and evidence programme area – at 44% and 20%, respectively – reflect the important work on norms, standards and other global public health goods that was carried out there. Much of this normative work provided a solid foundation for the work conducted by all seven major offices; 71% of expenditure in the National health policies, strategies and plans programme area and 64% of expenditure in the Integrated people-centred health services programme area was delivered at regional office and country office levels. The benefits of this approach have been fully recognized in the integrated planning for 2020–2021, with the strong “triple billions” focus on a systems approach, investment in countries underpinned by important global and regional leadership, and technical expertise and public health goods provided at headquarters and regional office levels.

Considering the overall trend across the period of the Twelfth General Programme of Work (2014–2019), the financing and implementation of the Health systems category have shown a positive trend: in absolute terms, both financing and implementation improved by close to 20% from 2014–2015 to 2018–2019.

Overall, two important lessons have emerged from the achievements in the Health systems category in terms of funding and expenditure levels. First, all programme areas were similarly funded. Second, investments in the Health systems category were high across all major offices in 2018–2019, with matching budget implementation.

For further details on the Programme Budget funding, implementation for this category and achievements by programme areas including indicators, please refer to the WHO Programme Budget Portal (<http://open.who.int/2018-19/our-work/category/04/about/programme-outcomes> and <http://open.who.int/2018-19/home>).

POLIO ERADICATION AND POLIO TRANSITION

TYPE 1 wild poliovirus cases increased in **AFGHANISTAN** and **PAKISTAN**

339 CASES of circulating vaccine-derived **POLIOVIRUS DETECTED**

FAILURE TO ERADICATE POLIO from its last remaining strongholds could result in as many as **200 000 NEW CASES EVERY YEAR**

175 CASES of **WILD POLIOVIRUS** detected

ZERO REPORTED CASES of wild poliovirus in Africa in the last three years

18 MILLION cases of wild **POLIOVIRUS** averted

100 000 acute flaccid paralysis ("suspected polio") **CASES DETECTED** and investigated

1.5 MILLION children's lives saved from polio

2.2 BILLION vaccine doses delivered

450 MILLION children vaccinated against poliovirus in **2019**



Approved Programme budget:
US\$ 903 million



Funds available:
US\$ 1088 million
(120% of Programme budget)



Expenditure:
US\$ 1018 million
(113% of Programme budget,
94% of available resources)



"In many countries, the polio programme is supporting Governments and communities as the first responder and the lead responder.... Over more than three decades, the polio programme has built a remarkable public health machine in each of the more vulnerable countries in our Region."

DR AHMED AL-MANDHARI
WHO Regional Director for the Eastern Mediterranean



THE REGIONS, WITH HIGH-LEVEL SUPPORT FROM HEADQUARTERS, **HAVE TAKEN THE LEAD IN PLANNING TO SUSTAIN WIDESPREAD POLIO STAFF AND ASSETS THROUGH DETAILED**, COUNTRY-SPECIFIC TRANSITION PLANS, AS THE INITIATIVE'S RESOURCES ARE INCREASINGLY CONCENTRATED ON ENDEMIC AND OUTBREAK COUNTRIES



As long as a single child remains infected, children in all countries are at risk of contracting polio. Failure to eradicate polio from its last remaining strongholds could result in as many as 200 000 new cases every year, within 10 years, all over the world.

Cases of wild poliovirus have decreased 99% since 1988, from an estimated 350 000 cases to just 175 reported cases in 2019. However, that number nonetheless represents a setback from 2018, when there were only 33 cases. The challenge for 2020 is to reinforce the programme to resume progress towards total eradication of wild poliovirus in Afghanistan and Pakistan and to stop the spread of vaccine-derived poliovirus, especially in sub-Saharan Africa.

The year 2019 was a challenging year for the Global Polio Eradication Initiative. Wild poliovirus cases increased over the previous year in Afghanistan and Pakistan, the two countries that are still affected, while an unexpected number of circulating vaccine-derived poliovirus type 2 (cVDPV2) outbreaks occurred, largely in Africa but also in parts of the Middle East and South-East Asia. New strategies to stop cVDPV2 outbreaks and wild poliovirus transmission in order to secure a permanently polio-free world were developed and are being implemented. The Global Polio Eradication Initiative partnership was also strengthened by the addition of Gavi, the Vaccine Alliance, as a core partner.

There have been some encouraging developments. Africa has not reported a single case of wild poliovirus for more than three years, meaning the African Region is now eligible for certification in 2020. In addition, type 3 wild poliovirus has officially been certified as globally eradicated, with the last case detected in 2012. The international development community showed its continued commitment to eradication at the Last Mile Forum held in Abu Dhabi, at which a total of US\$ 2.6 billion was pledged towards the effort through 2023. While ensuring the timely receipt of pledges, the Global Polio Eradication Initiative is actively soliciting additional support for outbreaks and the replenishment of vaccine stockpiles, which has increased the programme's overall resource requirements. The regions, with high-level support from headquarters, have taken the lead in planning to sustain widespread polio staff and assets through detailed, country-specific transition plans, as the Initiative's resources are increasingly concentrated on endemic and outbreak countries.

As Global Polio Eradication Initiative is increasingly concentrated, polio-free countries and prospective donors are being asked to find ways to take over the responsibility for sustaining the core functions and capacities that have historically been supported by the polio programme as early as 2021.



ZERO REPORTED CASES OF WILD POLIOVIRUS IN AFRICA IN THE LAST THREE YEARS



The Global Polio Eradication Initiative, particularly with Gavi, the Vaccine Alliance as a new core partner, is working in increasingly close collaboration with broader health partners to actively the address root causes of outbreaks, such as by strengthening surveillance and routine immunization, including the wider use of inactivated polio vaccine. A core element of the new Polio Endgame Strategy is integrating with broader Expanded Programme on Immunization objectives and coordinating activities and services with the WHO Emergencies programme.



**LONG-TERM
FINANCIAL
SUSTAINABILITY**
IS A KEY
COMPONENT OF THE
TRANSITION PLANS

PLANNING POLIO TRANSITION IN WHO'S SOUTH-EAST ASIA REGION

WHO's South-East Asia Region has helped pioneer polio transition work, ensuring that polio eradication investments contribute to future health goals, by systematically transitioning knowledge, lessons learned and assets acquired. The infrastructure built by WHO over the past two decades – comprising the human workforce, surveillance and laboratory infrastructures and other equipment and systems – has been re-purposed to contribute to broader health objectives, such as measles and rubella elimination, strengthening surveillance for vaccine-preventable diseases and strengthening health systems to help increase immunization coverage and equity, responding to disease outbreaks and other health emergencies.

National polio transition plans were developed in five countries of the Region with substantial polio-funded assets – **Bangladesh, India, Indonesia, Myanmar and Nepal** – tailored to national context, applying three principles:

1. Clear articulation and re-alignment of programmatic needs with national priorities in consultation with national governments.
2. Identification of mechanisms to transfer capacities to the national government.
3. Engaging national governments to own the transition process and its outcomes and to increase domestic funding, as well as identifying potential donors to fill funding gaps.

Long-term financial sustainability is a key component of the transition plans. Implementation of the plans is being monitored through the Regional Polio Transition Steering Committee.



KEY ACHIEVEMENTS

In 2019, type 3 wild poliovirus was officially certified as globally eradicated, following the certified global eradication of type 2 wild poliovirus in 2015. Of the wild serotypes, only type 1 wild poliovirus (WPV1) continues to circulate, in parts of **Afghanistan** and **Pakistan**.

Also in 2019, Nigeria marked three years since detection of the last wild poliovirus case in the country and indeed on the continent, making Africa eligible for wild poliovirus-free certification as early as 2020. It would be the fifth WHO region to be officially certified free of wild poliovirus.

The **Global Polio Eradication Initiative** launched the **Polio Endgame Strategy 2019–2023**, laying out the building blocks and a roadmap to achieving a world permanently free of all polioviruses. The Strategy was officially launched on the margins of the World Health Assembly in 2019, engaging partners and stakeholders to join in this effort.

US\$ 2.6 billion was pledged to the global eradication programme during the **Last Mile Forum held in Abu Dhabi**. Gavi, the Vaccine Alliance, officially joined the Global Polio Eradication Initiative as a core partner in 2020. It remains a key challenge, however, to fill the existing funding gap and ensure that pledges are fully and rapidly operationalized.

WHO continues to place a priority on sustaining the essential public health functions supported by the Global Polio Eradication Initiative and mitigating the risks posed by the drawdown of funding from the Initiative for polio eradication in countries. Accordingly, polio transition activities are managed under the direct oversight of the Deputy Director-General and the Regional Directors.

Significant momentum has been gained during the biennium in increasing the awareness of governments in countries supported by Global Polio Eradication Initiative of the urgency of addressing polio transition issues and integrating the functions supported by the Initiative into national health programmes. In some countries, polio transition plans are being operationalized and alternative sources of funding are being identified to replace resources from the Initiative, including domestic financing. There have also been increasing efforts to integrate polio activities with the broader immunization and comprehensive surveillance functions and outbreak and emergency response.

In addition, the risks and opportunities associated with polio transition and the need for sustainable transition strategies have been embedded into the immunization vision and strategy for the next decade on the theme “Immunization Agenda 2030”, which will be operationalized through regional and country plans.



POLIO TRANSITION
**PLANS ARE BEING
OPERATIONALIZED** AND
ALTERNATIVE SOURCES
OF FUNDING ARE BEING
IDENTIFIED TO REPLACE
RESOURCES FROM THE
INITIATIVE



US\$ 2.6 BILLION
WAS PLEDGED
TO THE GLOBAL
**ERADICATION
EFFORT** FOR FOUR
YEARS

FIGHTING VACCINE-DERIVED POLIOVIRUS IN INDONESIA



THE INDONESIAN MINISTRY OF HEALTH ACTED IMMEDIATELY, AND WITH WHO AND PARTNERS, WORKED ON THE NECESSARY INTERVENTIONS, LABORATORY CONFIRMATIONS AND SURVEILLANCE MEASURES

In early 2019, Indonesia declared a polio outbreak after new cases of vaccine-derived poliovirus type 1 (VDPV1) were confirmed in Papua province. One involved a case of acute flaccid paralysis (AFP) in an unvaccinated child of 31 months. Community stool specimen sampling also identified two other healthy children with a virus of the same genetic origin.

The Indonesian Ministry of Health acted immediately, and with WHO and partners, worked on the necessary interventions, laboratory confirmations and surveillance measures. Also, two rounds of oral polio vaccine immunization campaigns were conducted in Papua and West Papua provinces.

These provinces have severe geographic access challenges.

WHO played an important role by delivering high-quality data analysis to inform decision-making to reach those left behind. WHO trained all district surveillance officers; conducted hospital record reviews; developed guidelines; procured stool collections kits and supported the transportation of surveillance samples by air to Jakarta. A field office in Papua Province was set up. The vaccination campaign was ultimately successful, with more than 1.2 million children immunized, and the outbreak was controlled.

SPOTLIGHT ON GENDER



THE POLIO ENDGAME STRATEGY 2019–2023 IDENTIFIES GENDER AS AN ENABLING FUNCTION FOR ACHIEVING THE ERADICATION OF POLIO

The Polio Endgame Strategy 2019–2023 identifies gender as an enabling function for achieving the eradication of polio. Gender equality and equity are core values for the Global Polio Eradication Initiative and the programme recognizes that gender-responsive approaches further strengthen polio eradication interventions. In May 2019, the Global Polio Eradication Initiative

Gender Equality Strategy 2019–2023 was approved.

The polio programme regularly collects sex-disaggregated data and uses gender-sensitive indicators to ensure equal access to vaccinations, surveillance and the engagement of women, and it swiftly address any gender-related discrepancies.

To enhance gender equality in its workforce, the Global Polio Eradication Initiative is committed to increasing the number of female frontline workers, while ensuring their security. In the last few years, there has been marked progress in increasing the number of women in the polio health workforce.

In Pakistan, for example, women currently make up more than 63% of frontline health workers (compared

to 60.5% in 2018) and account for 78% of vaccinators in the country's highest-risk areas.

In Afghanistan, where insecurity and strict gender roles often restrict women's work and movement outside the home, women now make up 28% of social mobilizers and 40% of frontline health workers in urban areas¹ – a 9% increase since 2018. In Nigeria, despite not seeing a wild poliovirus in three years, over 87.5% of frontline health workers are women.

¹ While 40% of frontline workers in urban areas are female, women comprise only 13% of all frontline workers in Afghanistan. The low number of women frontline workers can primarily be attributed to an increasingly volatile security situation on the ground that hinders women's overall participation in the health workforce.

CHALLENGES

In **Afghanistan** and **Pakistan**, cases of WPV1 increased in comparison to 2018, as too many children remain unvaccinated or undervaccinated in key areas.

In **Pakistan**, there was a dramatic increase in WPV1 cases and positive environmental samples in 2019. This is an alarming development as it follows an earlier 18-month period that saw **Pakistan** achieve the lowest number of WPV1 cases in 10 years, including a number of months in which it did not report a single case. Challenges include gaining access to all populations (complicated by the refusal to vaccinate, insecurity and partial bans on immunization in **Afghanistan**); the quality of immunization campaigns in reservoir areas; population movement; and the safety of frontline workers. Rising vaccine hesitancy, often related to misinformation spread over traditional or social media, has further complicated efforts to reach every child with polio vaccine.

Afghanistan and **Pakistan** implemented comprehensive programme reviews in 2019 to overhaul operations and aim to turn the tide against the virus. Measures taken include making transformative changes to improve management, applying a laser focus on transmission reservoirs, implementing measures to increase community engagement and working to overcome access barriers. To support these efforts, a new support hub focused on endemic countries has been established in **Jordan** in order to provide them with more efficient, responsive and coordinated support.

Also in 2019, the world saw an unexpectedly large number of circulating vaccine-derived poliovirus type 2 (cVDPV2) outbreaks, mostly in Africa but also in parts of the Eastern Mediterranean and South-East Asia regions.

To address the evolving cVDPV2 emergency, in 2019 the Global Polio Eradication Initiative developed a new strategy to more effectively address such outbreaks, including through the accelerated development, approval and roll-out of a novel oral polio vaccine type 2 (nOPV2), which could be available as early as mid-2020.

The added costs of responding to cVDPV2 outbreaks and replenishing depleted vaccine supplies has strained the Global Polio Eradication Initiative's finances, which may require scaling back in some areas and concentrating resources on endemic, outbreak-affected and most at-risk countries. Challenges posed by the decline in resources from the Initiative will need to be mitigated by the accelerated implementation of transition strategies – such as integrating with complementary health programmes, including essential immunization and health emergencies, in alignment with primary health care, in order to strengthen the health system and attain universal health coverage.



THE DETECTION OF THESE STRAINS UNDERSCORES THE **IMPORTANCE OF MAINTAINING HIGH LEVELS OF ROUTINE POLIO VACCINATION COVERAGE** AT ALL LEVELS TO MINIMIZE THE RISK AND CONSEQUENCES OF ANY POLIOVIRUS CIRCULATION

ON ALERT FOR A RAPID RESPONSE



Operating out of a small prefabricated container, the rapid response team at WHO's Regional Office for Africa coordinates the polio outbreak response, supporting 12 countries in combating the vaccine-derived strain of the virus.

Dr Ndotoubé Modjirom, based in the Regional Office in Brazzaville, coordinates a team of 20 experts in operations and vaccination management, epidemiology, logistics and communications, drawn from the Global Polio Eradication Initiative core partners. The team is mobilized whenever a new polio outbreak (of the vaccine-derived strain) is confirmed in the African region.

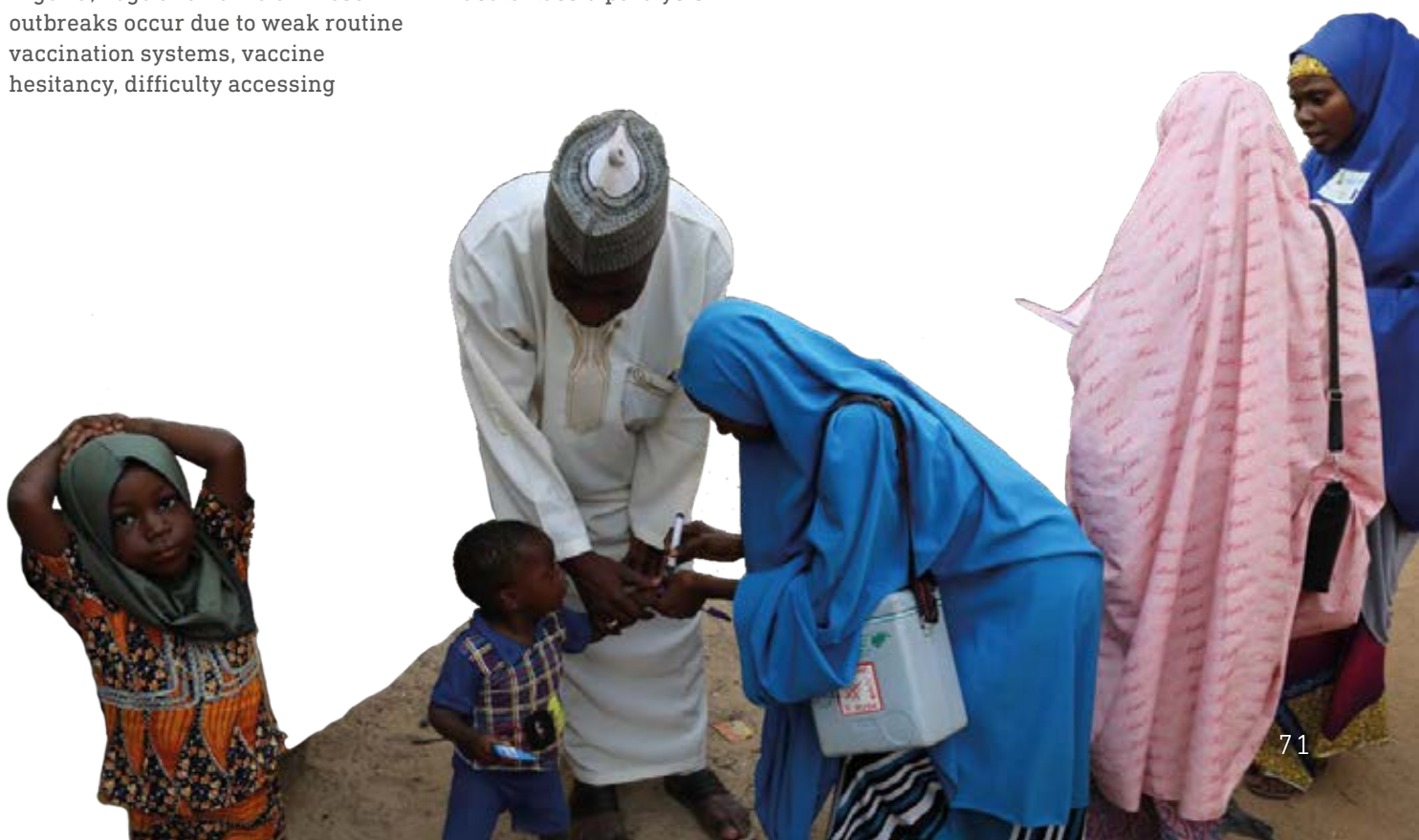
The countries experiencing outbreaks of vaccine-derived poliovirus in Africa are Angola, Benin, Cameroon, the Central African Republic, Chad, Côte d'Ivoire, the Democratic Republic of the Congo, Ethiopia, Ghana, Nigeria, Togo and Zambia. These outbreaks occur due to weak routine vaccination systems, vaccine hesitancy, difficulty accessing

some locations and low-quality vaccination campaigns. "Every minute that passes after the lab confirmation means that the poliovirus is circulating and risks infecting more children", says Dr Modirom.

Within the first 72 hours of its activation, the rapid response team deploys team A to prepare a risk assessment and outbreak response plan, working closely with local health authorities and WHO and UNICEF. The emergency response vaccination campaign, called “round zero”, is activated within 14 days. Team B takes over after eight weeks and assumes outbreak response activities.

Three rounds of high-quality vaccination campaigns are implemented in response to every outbreak. Countries must also intensify disease surveillance activities to detect new cases of acute flaccid paralysis.

**"EVERY MINUTE THAT
PASSES AFTER THE LAB
CONFIRMATION MEANS
THAT THE POLIOVIRUS
IS CIRCULATING AND
RISKS INFECTING MORE
CHILDREN", DR MODJIROM**



**21 COUNTRIES REPORTING**
CVDPV2 IN 2018–2019

Bringing an end to WPV1 transmission and stopping cVDPV outbreaks is the most urgent priority for Global Polio Eradication Initiative in 2020, while mobilizing the necessary financial resources to do so. For polio transition, shifting functions and funding from the Initiative to other financial streams, including raising domestic resources, will be the main priority.

Challenges in polio eradication, both in stopping wild poliovirus transmission and responding to cVDPV outbreaks, are posing additional constraints on the Global Polio Eradication Initiative's resources, which may necessitate an acceleration of transition strategies and their implementation.

The emergence of the above challenges poses additional hurdles to scaling up polio transition activities as resources will have to be focused on addressed eradication efforts. WHO aims to mitigate these risks by integrating polio transition into other technical and planning processes, including primary health care and universal health coverage; heightened advocacy to enhance country ownership and accelerate allocation of domestic resources; better global planning of human resources to evaluate critical needs and gaps; and more proactive resource mobilization.



KEY FIGURES FOR POLIO ERADICATION AND TRANSITION



Approved Programme budget:
US\$ 903 million

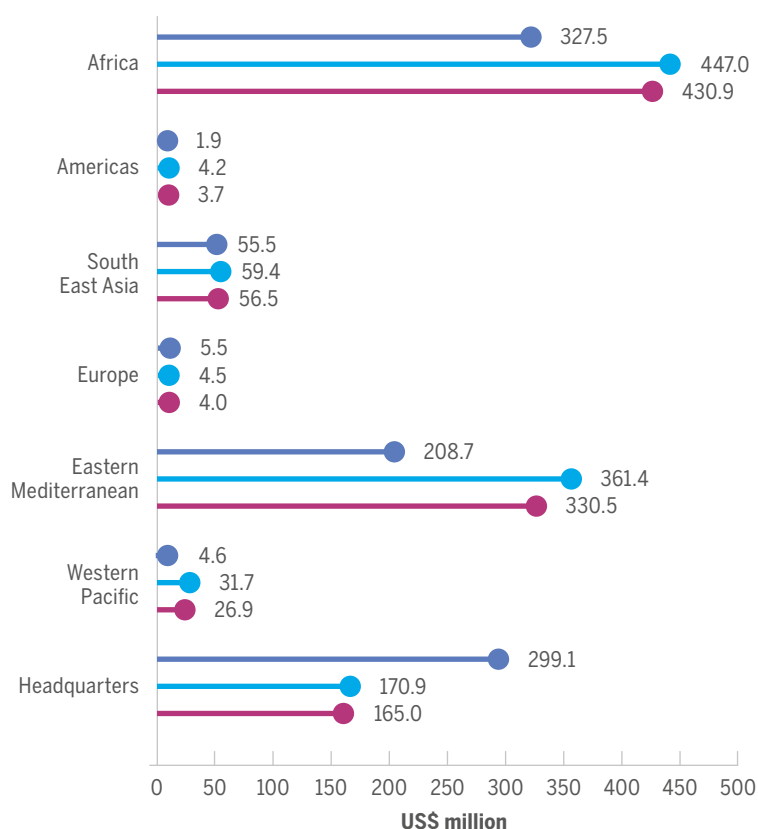


Funds available:
US\$ 1088 million
(120% of Programme budget)

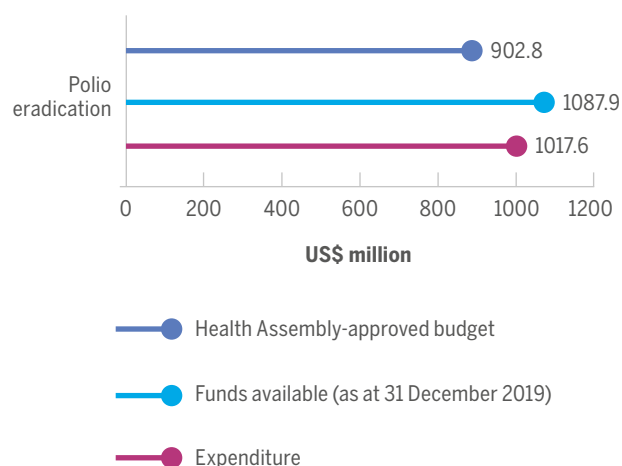


Expenditure:
US\$ 1018 million
(113% of Programme budget,
94% of available resources)

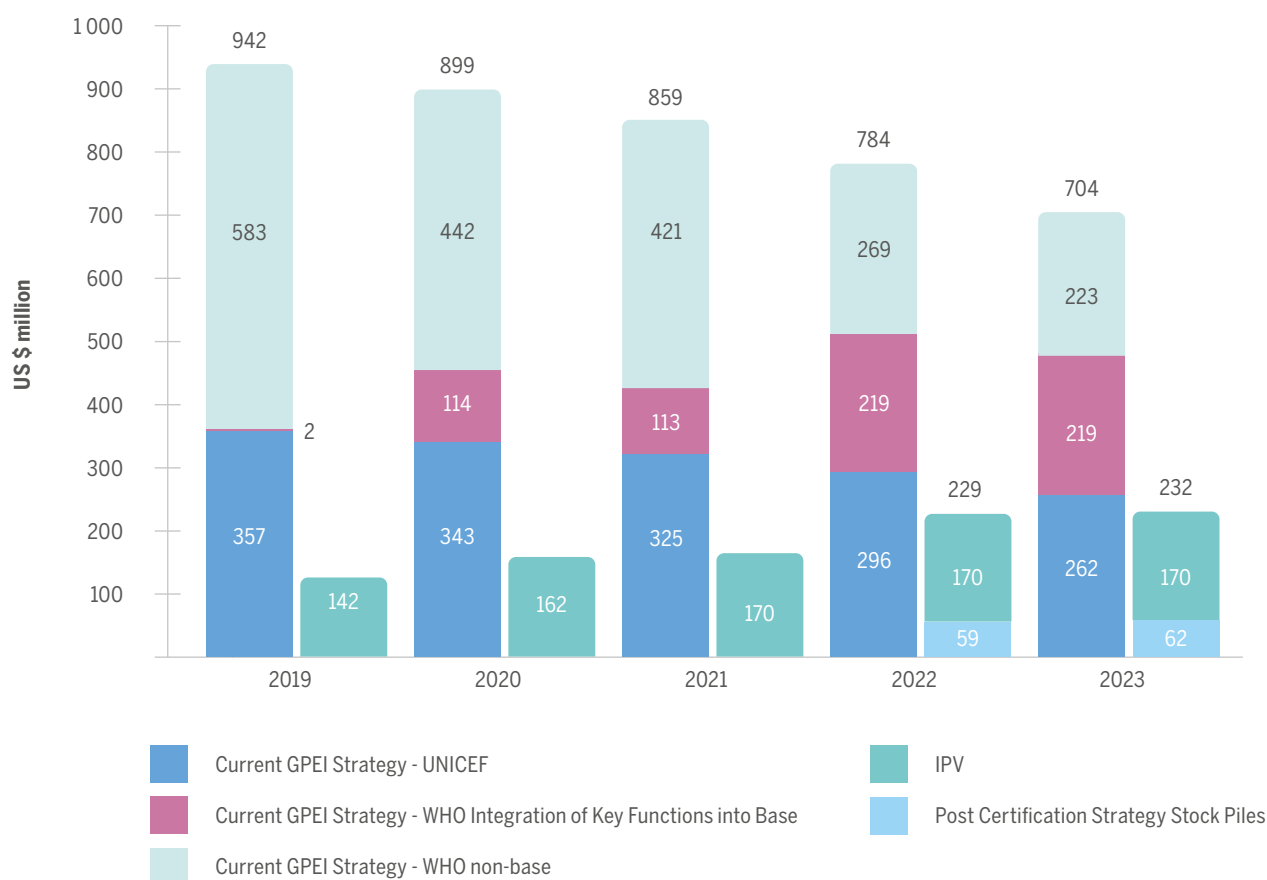
BASE BUDGET, FUNDS AVAILABLE AND EXPENDITURE, BY MAJOR OFFICE (IN US\$ MILLION)



BASE BUDGET, FUNDS AVAILABLE AND EXPENDITURE FOR POLIO ERADICATION SEGMENT, BY PROGRAMME AREA (IN US\$ MILLION)



GPEI POLIO ENDGAME STRATEGY 2019–2023 APPROVED BUDGET (IN US\$ MILLION)



WHO's approved Programme budget 2018–2019 for polio eradication (US\$ 903 million) was based on the Global Polio Eradication Initiative (GPEI) Polio Eradication and Endgame Strategic Plan 2013–2018, which aimed to achieve a lasting polio-free world by the end of 2018. However, the circulation of the wild poliovirus was not interrupted as planned, and it became necessary to adapt a new strategy beyond 2018 to achieve eradication. The new GPEI Polio Endgame Strategy 2019–2023 was adopted, which had implications for the approved programme budget 2018–2019 of US\$ 903 million.

The resulting allocated budget for the polio eradication programme for 2018–2019 was about US\$ 1.2 billion. It accommodated the resources needed for large-scale immunization campaigns in endemic and vulnerable countries (mainly in the African and Eastern Mediterranean regions) and urgent responses to several outbreaks of vaccine-derived poliovirus in subSaharan Africa.

All major offices showed an average implementation rate of available funds of about 92%. The increasing requirement to support front-line countries and regions where poliovirus transmission is occurring explains the relatively low level of approved programme budget financing at headquarters and the substantial increases in the **African and Eastern Mediterranean** regions instead. Increases in the budget for 2018–2019 and the financing of unplanned activities and expenses for vaccines and outbreaks have disproportionately depleted the programme's flexible funding. This will likely result in a significant gap for polio eradication activities in 2020–2021, which in turn could advance the timing of transitioning core and essential functions in countries that relied on polio funding into the base WHO budget and base WHO funding.

For further details on the Programme Budget funding, implementation for this category and achievements by programme areas including indicators, please refer to the WHO Programme Budget Portal (<http://open.who.int/2018-19/our-work/category/10/about/programme-outcomes> and <http://open.who.int/2018-19/home>).

COMMUNICABLE DISEASES

Declines in hepatitis B incidence although **1.4 MILLION PEOPLE** die from hepatitis B and C each year

1 MILLION CANCERS per year related to viral hepatitis, HIV and sexually transmitted infections

Almost **20 MILLION CHILDREN** were unvaccinated or undervaccinated

DRUG RESISTANT TUBERCULOSIS, MALARIA AND HIV threaten achievement of disease elimination targets

More than **1.1 BILLION PEOPLE RECEIVED A CUMULATIVE TOTAL OF 1.7 BILLION DOSES MEDICINES** for neglected tropical diseases (2019 estimate)

Major **OUTBREAK OF DENGUE** in over 50 countries in 2019

13.6 MILLION LIVES SAVED as a result of antiretroviral therapy for HIV

38% FALL IN GLOBAL TUBERCULOSIS DEATHS from 2000 to 2018

A total of **38 COUNTRIES** and territories have been certified malaria-free by WHO

ALMOST 9 OUT OF 10 CHILDREN WERE COVERED by vaccination programmes in 2018



Approved Programme budget:
US\$ 805 million



Funds available:
US\$ 897 million
(111% of Programme budget)



Expenditure:
US\$ 800 million
(99% of Programme budget,
89% of available resources)



"In the decade ahead, we must sustain and accelerate progress on the unfinished agenda in communicable diseases, leveraging the full power of innovation to advance towards a healthier, safer and more equitable world."

DR POONAM KHETRAPAL SINGH
WHO Regional Director for South-East Asia



THE FIGHT AGAINST
COMMUNICABLE DISEASES
IS **A GLOBAL HEALTH AND
DEVELOPMENT SUCCESS
STORY AND SAVES
MILLIONS OF LIVES EVERY
YEAR**

The fight against communicable diseases is a global health and development success story and saves millions of lives every year. Yet the substantial and promising progress made in the last two decades is still not enough to end epidemics by 2030. Every year, 4 million people die from the epidemics of HIV, tuberculosis, malaria and neglected tropical diseases, as well as viral hepatitis. There are still nearly 20 million children in the world today who are missing out on life-saving vaccines, such as those for measles, diphtheria and tetanus. In addition, there is a persistent threat from many vector-borne diseases, including mosquito-borne diseases such as malaria and dengue.

One key challenge is the pace of change. This biennium saw a strong global political commitment to the End TB strategy and momentum to eliminate hepatitis C epidemics, highlighting the role of WHO as an advocate and global health leader.

In high-burden countries where the pace of progress has stalled, WHO has launched special initiatives to expand access and scale up the response with partners and countries, such as the high burden to high impact approach to accelerate progress to achieve reductions in malaria, the **"FIND. TREAT. ALL. #ENDTB"** initiative and the measles, rubella and polio campaigns.

For the many countries in all regions making good progress on the road to meeting their Sustainable Development Goals targets (HIV) or to reaching elimination (neglected tropical diseases, malaria), WHO continued to provide, as one team, expertise and support at the country level.



KEY ACHIEVEMENTS

Significant progress was achieved in this area, with an increasing array of available and accessible prevention, testing, treatment and care interventions and tools as a result of innovation, greater collaborative efforts and effective use of funding.

Some of these improvements are low-cost options delivered at the primary care level and represent a significant shift from the relatively narrow range of options that were available a decade or so ago. Successes include more low-cost HIV testing and treatment services; more people than ever receiving quality tuberculosis care; the expansion of hepatitis C curative treatment to low-income and middle-income countries; medicines for neglected tropical diseases reaching 1.1 billion people; and the launch of the first malaria vaccine in a pilot implementation programme in three African countries.

SAVING LIVES FROM HIV STARTS WITH TESTING

The field of HIV testing has dramatically changed since the early days of the epidemic. Today, simple, rapid and low-cost diagnostic tests are available for use at clinics, communities or at home. New WHO recommendations on HIV testing services have been developed to help countries reach the 8.1 million people living with HIV who have yet to be diagnosed and are therefore unable to obtain life-saving treatment.

Globally, of the estimated 37.9 million people living with HIV in 2018, more than 8 million people were unaware of their HIV infection. HIV testing for children and adolescents lags behind that for adults. 77 countries have adopted self-testing policies and many others are developing them.

**37.9
MILLION**

**PEOPLE LIVING WITH
HIV IN 2018**

↓ 16%

**NEW HIV INFECTIONS
FELL BY 16% BETWEEN
2010 AND 2018**

↓ 33%

**HIV-RELATED DEATHS
FELL BY 33% BETWEEN
2010 AND 2018**

UNITED REPUBLIC OF TANZANIA AMENDS LAW TO IMPROVE ACCESS TO HIV TESTING



THE UNITED REPUBLIC OF **TANZANIA** MADE HIV SELF-TESTING LEGAL, THUS ENABLING **ACCESS TO LIFE-SAVING HIV TREATMENT** SOONER

In November 2019, the United Republic of Tanzania made HIV self-testing legal, thus enabling access to life-saving HIV treatment sooner.

Parliament amended the HIV law to allow HIV self-testing at 18 years of age and consent for HIV testing at 15 years of age (previously 18 years of age). Adolescents were known to face legal and policy barriers such as parental or guardian consent when accessing HIV testing and counselling services.

WHO supported the Ministry of Health through a review of a policy document for parliamentary meeting processes.



MORE COUNTRIES ADOPTING TREAT ALL POLICY

The uptake of WHO's HIV **Treat All policy** continued to extend to most of the world. As of July 2019, 93% of low- and middle-income countries (compared with 40% at the end of 2016) and 100% of fast-track countries had adopted the policy, while another 2% of all low- and middle-income countries planned to adopt the Treat All recommendations.

Implementation is well under way and 115 low- and middle-income countries (84%) have put the policy fully into practice. In 2019, WHO released updated guidance on HIV treatment, including on the use of dolutegravir, while also promoting a woman-centred approach in which women have greater choice in respect of HIV treatment and access to contraception.

SUPPORTING PAKISTAN DURING AN HIV OUTBREAK AMONG CHILDREN

When an HIV outbreak among children was detected in in Ratodero-Larkana, Sindh Province, in Pakistan, a coordinated response was provided at all three levels of the Organization. More than 90% of diagnosed cases are now receiving treatment at a newly established ART centre. WHO focused on ensuring a continuous supply of blood tests and antiretrovirals, adapting treatment regimens, training health care providers and reinforcing infection control.

SUCCESSES IN ELIMINATING MOTHER-TO-CHILD TRANSMISSION OF HIV AND SYPHILIS

Three Asian nations achieved the elimination of mother-to-child transmission of HIV and congenital syphilis during the biennium – Malaysia, Maldives and Sri Lanka. WHO assisted with the validation and verification process.

Sri Lanka was validated in November 2019. Both HIV and syphilis are low-incidence epidemics today, at 0.02% and 0.005%, respectively, thanks to strong health programmes and political commitment. Coverage of antenatal services at 99% ensures that pregnant women living with HIV receive the appropriate level of care to avoid mother-to-child transmission.

WHO also played a role in mobilizing and using donor funding and worked with the Government of **Sri Lanka** to set higher standards for HIV prevention and care services, using evidence-based strategies.

Achieving the elimination of mother-to-child transmission in Maldives in 2019 was facilitated by improved access to HIV testing and treatment, as well as high-quality disease surveillance, which enabled sporadic cases of HIV and syphilis to be quickly detected, tested and treated. WHO provided support for an electronic database and training to health care workers.

Malaysia's success in the elimination of mother-to-child transmission in 2018 was attributed to early testing, early diagnosis and early treatment. The country started a national programme to prevent mother-to-child prevention of HIV 20 years ago, in 1998. Antenatal testing and treatment for HIV and syphilis are provided free of charge and women have access to health services, including for births with skilled attendants.

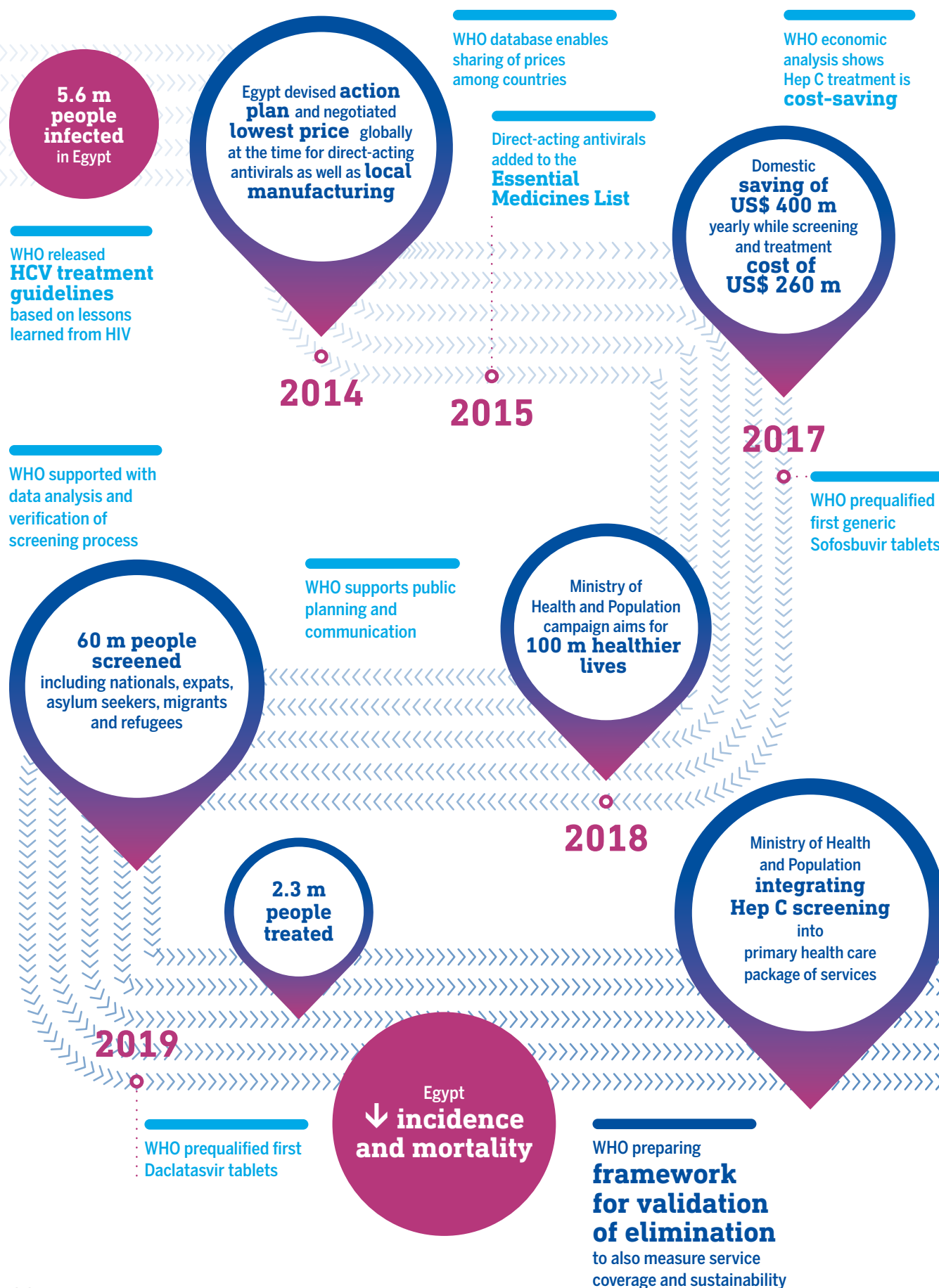
“TREAT ALL”

93% OF LOW-INCOME AND MIDDLE-INCOME COUNTRIES HAD ADOPTED A **TREAT ALL POLICY BY 2019**



THERE IS A SUBSTANTIAL GAP IN MEETING THE 30 MILLION TARGET OF PROVIDING CONTACTS AND **PEOPLE LIVING WITH HIV WITH TUBERCULOSIS PREVENTIVE TREATMENT**

GETTING HEPATITIS C UNDER CONTROL IN EGYPT



Egypt's ambitious drive for hepatitis elimination aligns with **WHO's Global health sector strategy on viral hepatitis 2016–2021**. WHO is working closely with Egypt's Ministry of Health and Population on the current campaign and supported testing and treatment scale-up. It also supported the monitoring of implementation, supervision and training and the review of indicators and criteria for elimination.

The WHO Director-General visited Egypt in August 2019 to learn from the Egyptian experience and to congratulate the President on the country's significant achievement towards hepatitis C elimination. They discussed the possibility of the initiative treating 1 million in the African Region with hepatitis C. WHO has undertaken to transfer the lessons learned from Egypt's successful experience to its global activities.

MAKING HEPATITIS B AND C MEDICINES AFFORDABLE IN CHINA

Hepatitis B and C medicines are now available, accessible and covered under the national health insurance in China, which has a substantial hepatitis disease burden that has led to one of the highest incidences of liver cancer globally.

In 2019, negotiations for price reductions of direct acting antiviral medicines for hepatitis C cure resulted in an 85% drop from the retail price of US\$ 10 000 for a three-month course, enabling its inclusion under universal health insurance. WHO worked with the Government and stakeholders to develop an investment case and economic analyses to provide evidence for action. WHO also focused on communications, harmonization of partners and sharing of price information from other countries. The high prices of hepatitis B medicines (tenofovir), at almost US\$ 3000 per person-year (2015), had previously precluded inclusion under universal health insurance and hindered access. With WHO's support, the national insurance agency centrally negotiated for pooled procurement of generic drugs, reducing the price to US\$ 10 per person per year, with inclusion under universal health insurance.

TUBERCULOSIS INCIDENCE DECLINING IN MYANMAR



A COUNTRY ON THE WHO LIST OF 30 HIGH BURDEN TUBERCULOSIS COUNTRIES

Over the past decade, tuberculosis prevalence in Myanmar has declined, including a 50% reduction among adults aged 15 or older, which suggests that Myanmar is on track to achieve the Sustainable Development Goals target 3.3 (By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and

combat hepatitis, waterborne diseases and other communicable diseases). This data is based on two national tuberculosis prevalence surveys (2009–2010 and 2017–2018) conducted under WHO's guidance.

Myanmar is among the 30 high-burden tuberculosis countries in the South-East Asia Region, with prevalence at three times the global average.

Factors that helped reduce prevalence were rapid expansion of basic tuberculosis services; provision of treatment, with support and community tuberculosis care, to rural and remote communities, particularly those with ethnic minorities; and active case

detection with mobile X-ray teams. The WHO Secretariat has provided support to the country in establishing tuberculosis situational analysis through its normative work, regular monitoring, surveillance support, review of programme activities and provision of recommendations to improve the tuberculosis programme.

However, the decline in prevalence was not observed in urban Yangon. New challenges are emerging in the city, such as urban areas becoming more densely populated with increasing migration to the city, tuberculosis among the elderly, and co-morbidities.

IMPACT ON TUBERCULOSIS IN CHILDREN AS A RESULT OF INTEGRATING SERVICE DELIVERY IN ETHIOPIA



THE NUMBER OF TUBERCULOSIS CASES IDENTIFIED INCREASED BY ALMOST 600% IN THE COUNTRY

Tuberculosis is a major health burden in Ethiopia. Children make up 11% of all tuberculosis cases. Ethiopia achieved a major success in tackling the disease in children by using an approach

that integrates the treatment of tuberculosis with reproductive, maternal, newborn and child health.

The number of tuberculosis cases identified increased by almost 600% in the country. Cases are now being referred for diagnosis three times faster. With more cases being identified, tuberculosis treatment coverage increased.

This was a result of a project that started in Oromia Regional Health Bureau which was then scaled up countrywide after a successful pilot. The project, which

integrated tuberculosis services into reproductive, maternal, newborn and child health units was supported by WHO. Three levels of the Organization worked together to revised reproductive, maternal, newborn and child health registers, documenting best practices, training health workers on sputum collection for tuberculosis diagnosis, and other measures to improve skills and motivation to find tuberculosis cases.

MORE PEOPLE RECEIVE TUBERCULOSIS CARE THAN EVER BEFORE

In 2018, about 7 million people received quality care for tuberculosis. The number of people receiving such care increased by 600 000 over the previous year due to better diagnosis and treatment. The first-ever **United Nations General Assembly high-level meeting on the fight against tuberculosis**, held in September 2018, brought together Heads of State, ministers and other leaders, which generated increased political commitment to end the tuberculosis epidemic. The world is thus on track to reach the target of treating 40 million people with tuberculosis between 2018 and 2022.

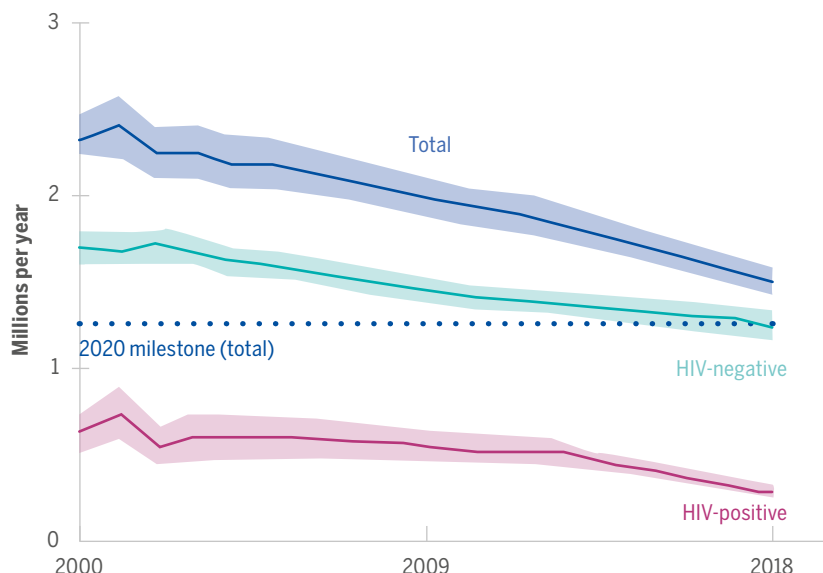
Seven high tuberculosis-burden countries (**Kenya, Lesotho, Myanmar, Russian Federation, South Africa, United Republic of Tanzania and Zimbabwe**) and one region (Europe) are on track to meet the incidence and deaths milestones by 2020.

Huge challenges still lie ahead. Tuberculosis remains the leading infectious killer worldwide, causing 1.5 million deaths in 2018, including among 251 000 people with HIV. Drug-resistant tuberculosis remains a public health crisis. Only one in three of the more than half a million people who needed treatment for multidrug-resistant tuberculosis had access to it.

The WHO Director-General launched the flagship initiative “**FIND. TREAT. ALL. #ENDTB**” jointly with the Stop TB Partnership and the Global Fund in 2019 in order to scale up the response in countries towards universal access to tuberculosis prevention and care.

WHO released the Multisectoral Accountability Framework to Accelerate Progress to End Tuberculosis by 2030 at the Seventy-second World Health Assembly. In 2019, WHO, in cooperation with countries and national partners, initiated the campaign “**RACE TO END TB**” in **Bangladesh, Cambodia and the Philippines** in order to urge action at all levels to implement the commitments of the political declaration. In 2018–2019, a global strategy for tuberculosis research and innovation was developed by WHO, in collaboration with Member States and external partners.

GLOBAL TRENDS IN THE ESTIMATED NUMBER OF TUBERCULOSIS DEATHS



Shaded areas represent lower and upper bounds.
Source: Global TB report 2019



58 MILLION LIVES WERE SAVED THROUGH EFFECTIVE TUBERCULOSIS DIAGNOSIS AND TREATMENT FROM 2000 TO 2018

3 MILLION

3 MILLION PEOPLE WERE UNDIAGNOSED WITH TUBERCULOSIS OR UNREPORTED



TUBERCULOSIS DEATHS DECREASED FROM **1.6 MILLION IN 2017 TO 1.5 MILLION IN 2018**, WITH DEATHS DECLINING BY 42% BETWEEN 2000 AND 2018. HOWEVER, THE WORLD IS NOT ON TRACK TO REACH THE TARGET OF 35% REDUCTION BY 2020



ONLY 40% OF MALARIA-
ENDEMIC COUNTRIES WERE
ON TRACK TO REDUCE
MALARIA INCIDENCE **BY 40%**
OR MORE BY 2020



RATE OF DECLINE OF
MALARIA INCIDENCE
HAS SLOWED

MORE COUNTRIES ELIMINATING MALARIA AND PREVENTING RE-ESTABLISHMENT

Although progress in many high-burden countries has stalled, a growing number of countries with a low burden of malaria are moving quickly towards elimination.

- Number of malaria-endemic countries reporting fewer than 10 000 cases: increased from 40 in 2000 to 49 in 2018.
- Number of malaria-endemic countries with fewer than 100 indigenous cases: increased from 17 in 2000 to 27 in 2018.
- Number of countries with fewer than 10 indigenous cases increased from 19 in 2017 to 24 in 2018.
- Four countries were certified as malaria-free in the last biennium: Algeria, Argentina Paraguay and Uzbekistan.
- Globally, a total of 38 countries and territories have been certified malaria-free by WHO.
- “High burden to high impact” approach to combat malaria launched for the 11 most affected countries.

In 2018, an estimated 228 million cases of malaria occurred, mostly in the African Region and India, compared with 251 million cases in 2010. Over the last decade, the rate of progress towards global elimination has slowed dramatically and the milestone of 40% reduction in morbidity by 2020 as compared with 2015 will not be met.

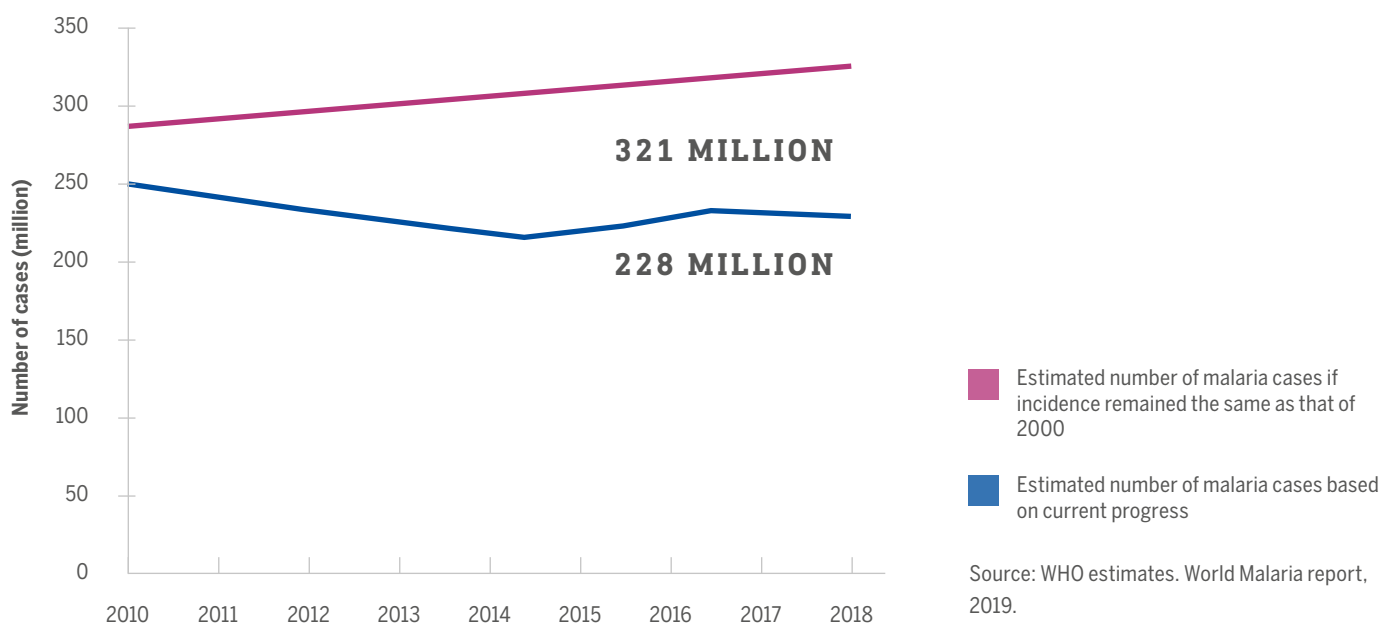


ESTIMATED DEATHS
DUE TO MALARIA
GLOBALLY **DECLINED**
FROM 585 000 TO
405 000 BETWEEN
2010 AND 2018

Furthermore, without accelerated progress, particularly in the high-burden countries, the milestones of 75% reduction in morbidity by 2025 and 90% reduction in morbidity by 2030 will not be achieved.

In 2018, the Director-General announced a redoubling of efforts to combat malaria and the new “high burden to high impact” approach was launched in Mozambique. Driven by the 11 most affected countries, it relies on four key elements: political will, strategic information, better guidance and strategies, and a coordinated national response.

COMPARISON OF CURRENT ESTIMATED MALARIA CASES WITH EXPECTED CASES HAD MALARIA INCIDENCE REMAINED AT 2000 LEVELS GLOBALLY



COMBATING THE THREAT OF MULTIDRUG-RESISTANT MALARIA IN THE GREATER MEKONG SUBREGION



THE EMERGENCE AND SPREAD OF **MULTI-DRUG RESISTANT MALARIA IS A HUGE CHALLENGE**

Malaria elimination is within reach in the Greater Mekong Subregion, which includes Cambodia, China, the Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam. Between 2012 and 2018, the number of falciparum malaria cases in the six countries of the subregion fell by 74% and the number of deaths by 95%. Several countries attained significant national milestones: Cambodia reported zero malaria-related deaths for the first time, China reported its third consecutive year of zero indigenous cases and Thailand saw a 38% drop in cases between 2017 and 2018.

The emergence and spread of multidrug-resistant malaria

remains a huge challenge. To address this, WHO worked with countries and partners to raise political commitment on the basis of the WHO strategy for malaria elimination in the Greater Mekong Subregion 2015–2030. WHO provides closer support through its subregional hub in Phnom Penh.

The ministerial call for action to eliminate malaria in the Greater Mekong Subregion before 2030 was signed by the health ministers in the affected countries in 2018 to strengthen surveillance, improve collaboration across borders, increase access to interventions and implement targeted action in vulnerable communities.

SCALING UP NEW TREATMENT REGIMENS FOR ELIMINATION OF LYMPHATIC FILARIASIS ACROSS FOUR WHO REGIONS

More than 10 million people from at-risk communities in 11 countries were treated with the new WHO-recommended regimen of ivermectin, diethylcarbamazine and albendazole (IDA) to eliminate lymphatic filariasis. This was achieved just two years after the release of the relevant guideline. WHO provided technical and operational support for revising national policies and for planning, implementing and monitoring the coverage of IDA in each of the 11 countries.

- Samoa was the first country to adopt the regimen nationally. Four other countries in the Western Pacific Region (as

well as others elsewhere) have implemented IDA with WHO support.

- Preliminary results indicate that a single round of IDA in East New Britain Province, Papua New Guinea, has reduced infection levels below elimination thresholds.
- Guyana's mass drug administration reached all endemic areas, guided by endemicity mapping that determined where mass drug administration was required.
- Kenya and Sao Tome and Principe were the first

countries to implement IDA in the African Region through good leadership and partnership in tackling neglected tropical diseases.

- Remarkable progress in lymphatic filariasis elimination in Timor-Leste, making it most likely to be the next country in the South-East Asia Region to achieve elimination targets.

Continued support from WHO will be required to ensure that these countries and 44 other countries stay on track to achieve elimination targets.

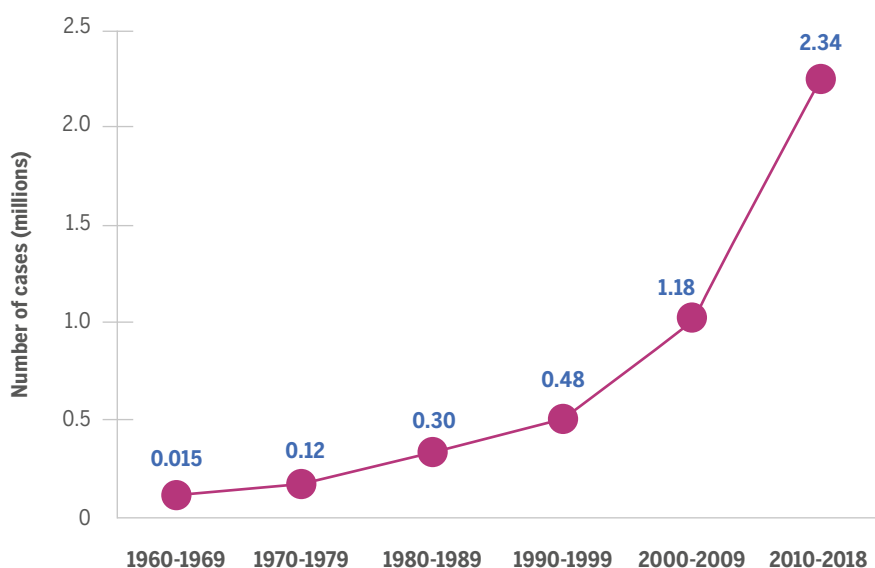
REACHING ALL THOSE IN NEED OF TREATMENT FOR NEGLECTED TROPICAL DISEASES

In 2018 and 2019, for the second and third consecutive years, more than 1 billion people received treatment for at least one neglected tropical disease. In 2019, more than 1.1 billion people received a cumulative total of 1.7 billion doses of medicines for neglected tropical diseases. This involved working with governments and partners, using WHO norms and practices and relying on large-scale donation of medicines under WHO management. With WHO's support, mass treatment was delivered through integrated packages of medicines, usually at yearly intervals, for lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminthiasis, trachoma and foodborne trematodiasis. Individual case management was provided for diseases requiring complex diagnostic and treatment protocols for target diseases such as Buruli ulcer, Chagas disease, dengue, chikungunya, dracunculiasis, leprosy, leishmaniasis and sleeping sickness.

SHAPING GLOBAL HEALTH POLICY FOR NEGLECTED DISEASES

The **Health Product Profile Directory** was launched in May 2019 by WHO's **Special Programme for Research and Training in Tropical Diseases**. Created to improve the efficiency of efforts to develop new products for neglected tropical diseases and inform discussions of research and development priorities. The Directory is a searchable database describing key characteristics of product profiles for medicines, vaccines, diagnostics and other products, mostly for HIV, tuberculosis and malaria, as well as Ebola, Zika and Lassa Fever.

AVERAGE ANNUAL NUMBER OF DENGUE FEVER CASES REPORTED TO WHO BY MEMBER STATES, 1960–2018



THE INCIDENCE OF **CUTANEOUS LEISHMANIASIS**, WHICH CAUSES DISFIGUREMENT AND STIGMA IS INCREASING IN SOME AREAS



IN 2019, **DENGUE OUTBREAKS** WERE REPORTED IN MORE THAN **50 COUNTRIES** AND WHO SUPPORTED COUNTRIES TO ENSURE THE **EFFECTIVE DEPLOYMENT AND UTILIZATION OF TRAINED STAFF** IN AFFECTED COUNTRIES AND PROVIDED FIELD SUPPORT



UPTAKE OF NEW AND **UNDERUSED** **VACCINES IS** **INCREASING**

IMMUNIZATION CONTINUES TO SAVE MILLIONS OF LIVES

Immunization is a global health and development success story that saves millions of lives every year. We now have vaccines to prevent more than 20 life-threatening diseases, helping people of all ages live longer, healthier lives. In 2018, 116 million children completed vaccination with a basic set of vaccines, up from 90 million children in 2000, while 2019 marked the year when all 194 Member States delivered at least one dose of inactivated polio vaccine in their national schedules, representing the fastest global trajectory for new vaccine introduction in history.

Nevertheless, despite the progress made, in 2018, WHO and UNICEF estimated that there were still nearly 20 million children in the world who were not covered by life-saving vaccinations, such as those against measles, diphtheria and tetanus.

Countries with large populations such as India or Nigeria have made immunization coverage improvements by identifying gaps at subnational levels and implementing tailored strategies in these areas. However, in other countries, progress has stalled or even reversed. For example, while many countries have successfully sustained maternal and neonatal tetanus elimination, the global targets for measles, rubella and maternal and neonatal tetanus elimination are unlikely to be achieved by the end of 2020. Over the last two years, the world has seen multiple outbreaks of measles, diphtheria, pertussis and other vaccine-preventable diseases.

Expanding access to immunization is still one of the best public health investments. The new vision and strategy for the next decade needs to be focused more strongly on strengthening immunization programmes as a part of primary health care to maintain the momentum and sustain the gains in vaccines and immunization. WHO is leading the co-creation of a new global vision and strategy to address these challenges over the next decade together with partners.

WORLD'S FIRST MALARIA VACCINE

The world's first malaria vaccine, RTS,S/AS01, was launched in 2019 by the Governments of Ghana, Kenya and Malawi in a landmark pilot programme coordinated by WHO and supported by a range of partners. An estimated 265 000 African children died from the disease in 2018. New tools are needed – as well as more effectively-targeted use of existing tools – to get malaria control back on track to meet global milestones.

RTS,S/AS01 is the first and only vaccine that significantly reduces malaria in young African children. It has the potential to save tens of thousands of children's lives as an additional prevention tool and is being given in routine immunization programmes in selected areas in the three pilot countries. Some 200 000 children received the first dose in 2019. Data and information from the pilot will inform WHO policy recommendations on broader use.



MALARIA REMAINS ONE
OF **THE WORLD'S LEADING**
KILLERS, CLAIMING THE
LIFE OF ONE CHILD EVERY
TWO MINUTES.



MEASLES, RUBELLA AND POLIO CAMPAIGN IN PAPUA NEW GUINEA



MEASLES CAUSED MORE THAN **140 000 DEATHS** WORLDWIDE IN 2018 DESPITE THE AVAILABILITY OF A VACCINE

More than 1 million children under five years old were vaccinated in Papua New Guinea in the nationwide vaccination campaign against three dangerous diseases: measles, rubella and polio. The campaign was launched in June 2019 by the National Department of Health, with support from WHO, UNICEF and other partners. Children from 6 months to 5 years of age were immunized with measles-rubella vaccine, while children 0 to 5 years of age were given oral polio vaccine, regardless of their previous vaccination status. The integrated measles-rubella and polio

campaign was implemented after the initial polio vaccine campaigns were completed in response to the polio outbreak in June. The measles outbreak was reported in 2014–2015, with more than 70 000 suspected cases, more than 2000 confirmed cases and 362 reported deaths. Additional cases were reported in 2017 and 2018. This integrated campaign demonstrates the country's commitment to improve the health and well-being of its children by protecting them against vaccine-preventable diseases.

DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA DECLARED MEASLES-FREE

The Democratic People's Republic of Korea was declared measles-free in 2018, after having no local transmission since 2007. The country has consistently reported near universal coverage of all

childhood vaccinations, including measles. In 2017, WHO and UNICEF provided support for a vaccine coverage evaluation survey that confirmed the high reported rates. Support was also provided

to enhance the country's measles and rubella surveillance system. WHO provided technical support to strengthen national testing capacity after the criteria for testing was broadened.

PAKISTAN TYPHOID CONJUGATE VACCINE INTRODUCTION

From November 2016 to December 2019, more than 11 000 cases of extensively drug-resistant typhoid were reported in an outbreak in Sindh Province of Pakistan. Additional cases of extensively drug-resistant typhoid have been reported in other parts of Pakistan. As part of its efforts to control typhoid fever, including

of extensively drug-resistant typhoid, Pakistan became the first Gavi-funded country to introduce typhoid conjugate vaccine into its routine immunization schedule. The introduction of typhoid conjugate vaccine has taken a phased approach, starting with a catch-up campaign in Sindh Province in November 2019 that targeted

10.1 million children, followed by province-wide routine vaccination. The phased introduction of the vaccine will continue in order to cover most parts of the country by 2021, supported by strong collaboration among WHO, Gavi, the Vaccine Alliance, UNICEF and other partners.

EBOLA VACCINE PREQUALIFIED

Another milestone was the prequalification of the Ebola vaccine by WHO for the first time, in a critical step to speed up its licensing, access and roll-out in countries most at risk of Ebola outbreaks.

FASTEST TRAJECTORY FOR POLIO VACCINE

In 2019, the milestone of full global introduction of at least one dose of inactivated polio vaccine in all 194 Member States was achieved.

Recognizing that once symptoms of rabies present the disease is nearly always fatal, Gavi, the Vaccine Alliance has agreed to include human post-exposure prophylaxis for rabies in their list of vaccines for Gavi-eligible countries from 2021. This is a critically important intervention that will save lives. The Tripartite organizations (WHO, FAO and World Organisation for Animal Health) are working to generate the support required to ensure that governments are able to conduct mass dog vaccinations to enable the disease to be eliminated.

HIGH DEMAND FOR VACCINE TO PREVENT CERVICAL CANCER

Vaccination against human papillomavirus (HPV) is recognized as the most cost-effective public health measure to significantly reduce the risk of cervical cancer, the fourth most common cancer in women. Currently, four HPV vaccines have been licensed; they are very effective and have an excellent safety profile. By end-2019, more than 100 countries had introduced the HPV vaccine, including lower-income countries, with funding from Gavi, the Vaccine Alliance, and partner support.

The strong increase in demand for an HPV vaccine led to a global HPV vaccine shortage. In October 2019, the Strategic Advisory Group of Experts on immunization and WHO issued new guidance that recommended prioritizing the vaccination of girls between 9 and 14 years of age.

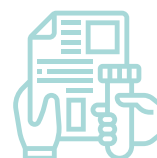
INTEGRATING GENDER INTO HEALTH RESEARCH

WHO's Special Programme for Research and Training in Tropical Diseases has long supported researchers through training and postgraduate programmes to develop the leadership skills of scientists in low- and middle-income countries. In recent years, the Programme has also focused on building the capacity of scientists to investigate the gender dimensions of health.

The Programme has developed tools to strengthen such research capacities, including an intersectional gender research toolkit and an innovative global classroom approach (using means that include online learning, web conferencing and social media). The University of Ghana, School of Public Health, with the support of the Programme, has developed and pilot-tested an online course for developing skills in gender-based analysis for vector-borne diseases and climate change research, which has been integrated within existing gender and health courses.



BY END-2019, MORE THAN **100 COUNTRIES** HAD INTRODUCED THE **HPV VACCINE**, INCLUDING LOWER-INCOME COUNTRIES



CAPACITY OF SCIENTISTS IS BEING STRENGTHENED TO INVESTIGATE THE GENDER DIMENSIONS OF HEALTH

COMBATING ANTIMICROBIAL RESISTANCE

Inappropriate use of antimicrobials (antibiotics, antivirals, antiprotozoal and antifungals) is rendering them ineffective due to selection for resistance. As the same antibiotics used on humans may be used for animals or plants, resistant bacteria can spread between animals and humans and to the environment.

Strong intersectoral collaboration is thus critical to coordinate human, animal, plant and environmental policies in order to prevent antimicrobial resistance and tackle it as a threat to the achievement of universal health coverage and the Sustainable Development Goals.

In May 2018, the tripartite “One Health” organizations – WHO, the Food and Agriculture Organization of the United Nations (FAO) and the World Organisation for Animal Health (OIE) – agreed to step up joint action in this area through a memorandum of understanding. A key initial focus was to revamp action at country level for the implementation of the Global Action Plan on Antimicrobial Resistance, including by protecting antibiotics that are critically important for human health.



TRIPARTITE “ONE HEALTH” COLLABORATION IN FULL GEAR

The tripartite “One Health” collaboration of WHO/FAO/OIE resulted in:

- a multisectoral monitoring and evaluation framework that guides countries in establishing systems to develop, monitor and report progress made in data-tracking in respect of their antimicrobial resistance national action plans;
- a tripartite antimicrobial resistance country self-assessment survey to monitor implementation of national action plans, with 159 countries (representing 91% of global population) responding in 2019;
- support for the successful completion of the mandate of the United Nations Inter-agency Coordination Group (IACG) on Antimicrobial Resistance and submitting a comprehensive report to the United Nations Secretary-General in 2019;
- establishment of a tripartite joint secretariat on antimicrobial resistance, based in WHO and with full-time liaison officers in FAO and OIE, to coordinate joint activities and facilitate the implementation of the IACG mandate;
- establishment of a funding vehicle, the Antimicrobial Resistance Multi-Partner Trust Fund, to catalyse and expedite action at the national level; an initial 12 countries have been identified to expand the impact and results at country level.
- WHO strengthening its normative function in antimicrobial resistance;
- publication of a global monitoring and evaluation framework for the Global Action Plan on Antimicrobial Resistance (for use at national and global levels), with a recommended list of indicators;
- development of a country guidance document to help countries to establish monitoring of relevant antimicrobial resistance data;
- development of methodologies for a global programme on surveillance of antimicrobial consumption and a point prevalence survey of antibiotic use in hospitals and publication of the first WHO report on the surveillance of antimicrobial consumption;
- development and publication by WHO of a framework for health workers' education and training on antimicrobial resistance;
- development of the AWaRe (Access, Watch, Reserve) classification of antibiotics in the Model List of Essential Medicines to help guide optimal use.

IT IS ALL ABOUT COUNTRIES: WHO HELPING COUNTRIES TO RESPOND

National action plans on antimicrobial resistance have been developed in 135 countries and an additional 50 countries are finalizing their plans. WHO is developing a costing tool to help prepare budgets for multisectoral plans and a guidance document to help countries establish a monitoring framework for their national action plans. A practical toolkit for antimicrobial stewardship programmes in health care facilities in low- and middle-income countries was finalized and the Antimicrobial Stewardship Global Online Network established.



THE ROLE OF IPC IN **REDUCING THE NEED FOR ANTIMICROBIALS** APPLIES TO BOTH HUMAN AND ANIMAL WORLD



WITH FEW NEW
ANTIMICROBIALS
DEVELOPED IN RECENT
DECADES, **INVESTMENT IN
RESEARCH IS CRITICAL**

WHO HELPING TO OPTIMIZE THE USE OF ANTIMICROBIALS

Antimicrobial stewardship helps increase the longevity of existing antimicrobials through promotion of appropriate use, thereby improving quality of care and patient outcomes and slowing down the emergence and spread of antimicrobial resistance. WHO supported 10 countries in 2019 in initiating national and health care facility antimicrobial stewardship programmes by providing regional and national technical support and organizing health care facility training workshops. WHO also contributed to the process of revision of the relevant Codex Alimentarius standards to reduce antimicrobial resistance in the food chain.



IN 2019, IT ESTABLISHED
NEW SURVEILLANCE SITES
AND REPORTED DATA
FROM **1136 INFECTIONS**,
INCLUDING FROM BLOOD
SAMPLES AND FOR SEVERAL
PATHOGENS

SUDAN RAMPS UP EFFORTS AGAINST ANTIMICROBIAL RESISTANCE

In July 2018, Sudan successfully launched its multisectoral national action plan on antimicrobial resistance, which was endorsed by its Ministry of Health and Ministry of Animal Resources, with support from WHO, in collaboration with FAO, OIE and the United Nations Environment Programme. Surveillance systems for antimicrobial resistance were set up as a priority to implement the plan. Sudan also enrolled in the Global Antimicrobial Resistance and Use Surveillance System (GLASS) in 2018 and worked on data collection

under guidance from WHO. It reported antibiotic susceptibility testing profiles for 32 urinary tract infections due to *Escherichia coli*. In 2019, it established new surveillance sites and reported data from 1136 infections, including from blood samples and for several pathogens.

WHO has also supported Sudan successfully in completing a point prevalence survey on antimicrobial use and this platform will be used to further assess hospital and laboratory capacity.

BACK TO BASICS: INFECTION PREVENTION AND CONTROL

Infection prevention and control (IPC) is one of the first measures to safeguard the dissemination of pathogens in the community and health care setting. Yet progress in the implementation and adoption of IPC standards has been limited. The role of IPC in reducing the need for antimicrobials applies to both human and animal world. Progress has included:

- development of health care facility core components and minimally required core components;
- development of practical tools and support to 48 countries to strengthen IPC capacity;
- implementation of recommendations in guidelines to prevent carbapenem-resistant gram-negative bacteria in health care facilities;¹
- two WHO surveys on the global situation of IPC programmes at the national and facility levels, conducted in 88 countries in 2018 and in 5925 facilities in 141 countries in 2019;
- strengthening of basic water, sanitation and hygiene (WASH) services in health care facilities and wastewater treatment and key linkages with antimicrobial resistance highlighted in WHO's WASH strategy 2018–2025.

GLASS data monitors the scale of current threats and trends. Recent progress in this area includes:

- 89 countries enrolled in GLASS, with 66 countries providing antimicrobial resistance data collected from more than 9000 surveillance sites;
- recent approval of a new Sustainable Development Goals indicator on antimicrobial resistance to monitor progress in countries as part of the monitoring framework of the Goals, based on data being collected through GLASS;
- GLASS-EAR (GLASS Emerging AMR Reporting) launched to support detection, early warning and risk assessment capacities;
- pilot development of a global integrated surveillance protocol for antimicrobial resistance in humans, the food chain and the environment, subsequently implemented in nine countries and under way in four countries.

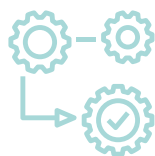


GLASS DATA MONITORS
THE SCALE OF CURRENT
THREATS AND TRENDS

INVESTING IN RESEARCH AND DEVELOPMENT OF NEW ANTIMICROBIALS

With few new antimicrobials developed in recent decades, investment in research is critical. WHO is now working with the Global Antibiotic Research and Development Partnership on sepsis in newborns (in a study in 11 countries) and a new treatment for drug-resistant gonorrhoea (now in phase III clinical trials). In addition, the pre-clinical and clinical antibacterial and anti-tuberculosis pipeline is being monitored on an annual basis against the global priority list of resistant bacteria posing the greatest public health threat and for which research and development efforts for new treatments are needed. WHO is also working to catalyse innovative financing for research and development, in close collaboration with partners such as the European Investment Bank.

¹Carbapenem-resistant Enterobacteriaceae, *Acinetobacter baumannii* and *Pseudomonas aeruginosa*.



INVESTMENTS IN SERVICE DELIVERY, PRIMARY AND COMMUNITY HEALTH CARE AND HEALTH SYSTEMS **HAVE BEEN SHOWN TO BE EFFECTIVE IN IMPROVING HEALTH OUTCOMES**

CHALLENGES AND LESSONS LEARNED

A key challenge is sustaining national political commitment and resources to ensure that disease targets and universal health coverage are achieved. Investments in service delivery, primary and community health care and health systems have shown themselves to be effective in improving outcomes.

Despite a drop in new HIV infections, insufficient progress was made to reach the 2020 elimination targets and remain on course for reaching those for 2030. Uptake of effective prevention interventions was too slow while major gaps remain in testing and treatment coverage.

The low coverage of birth-dose hepatitis B vaccination, notably in the African Region, is hampering elimination efforts, while hepatitis C continues to spread rapidly in some communities. Treatment coverage for hepatitis B and C is low and access to testing limited.

Two critical WHO targets for malaria – reducing malaria case incidence and death rates by at least 40% by 2020 – will be missed. Major gaps in access to core interventions for preventing, detecting and treating malaria persist, particularly in the highest burden countries.

In 2019, dengue outbreaks were reported in more than 50 countries and the expanding distribution of *Aedes* and *Culex* mosquitoes poses a threat in Europe. Leishmaniasis and leprosy are emerging in conflict zones and refugee settlements. Many neglected tropical diseases are emerging in complex emergency situations where there is a lack of both safe, quality medicines and funding.

Access to diagnosis and quality-assured and affordable treatment for drug-resistant tuberculosis remains limited, particularly for the most marginalized populations. More work needs to be done to help countries to strengthen capacity to detect and treat drug-resistant tuberculosis. Drug resistance is also a challenge for efforts against HIV and malaria. Research and innovation will be critical in the fight against drug resistance.

Work to prevent antimicrobial resistance is challenged by a lack of systems and capacity to generate high-quality data for the surveillance of drug use and resistance. Regulatory frameworks to ensure access to safe antimicrobials and prevent substandard and falsified medical products need strengthening. This is particularly important in countries where there is a very large, unregulated private sector. There is also a need for Member States to increase political commitment, resources and capacity to implement integrated antimicrobial stewardship programmes at the national level and in health care facilities. More investments are needed to develop new antibiotics, vaccines and diagnostic tools as well as for implementing infection prevention and control measures in health care facilities, including strengthening water, sanitation and hygiene (WASH).

KEY FIGURES FOR 2018–2019: COMMUNICABLE DISEASES



Approved Programme budget:
US\$ 805 million



Funds available:
US\$ 897 million
(111% of Programme budget)



Expenditure:
US\$ 800 million
(99% of Programme budget,
89% of available resources)

UNICEF/UNDP/WORLD BANK/WHO SPECIAL PROGRAMME FOR RESEARCH AND TRAINING IN TROPICAL DISEASES



Approved Programme budget:
US\$ 50 million

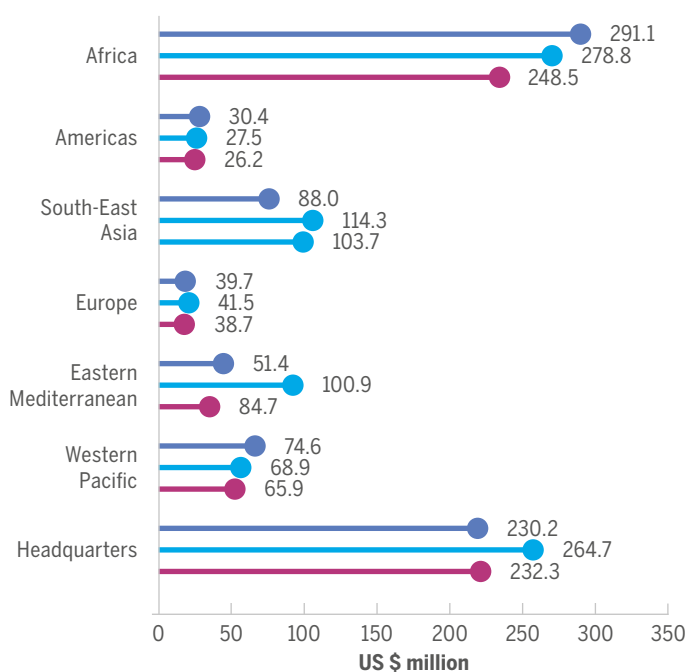


Funds available:
US\$ 43.7 million
(87% of Programme budget)

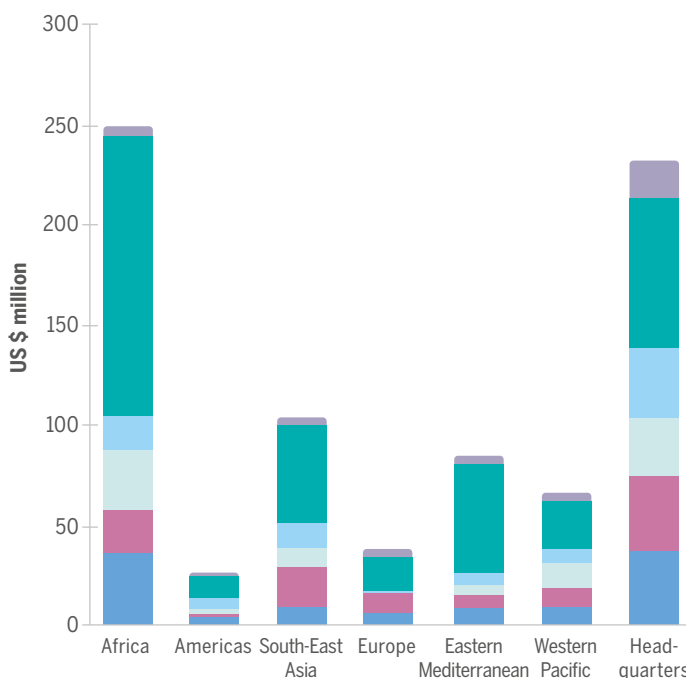


Expenditure:
US\$ 37 million
(74% of Programme budget,
85% of available resources)

BUDGET, FUNDS AVAILABLE AND EXPENDITURE, BY MAJOR OFFICE (IN US\$ MILLION)



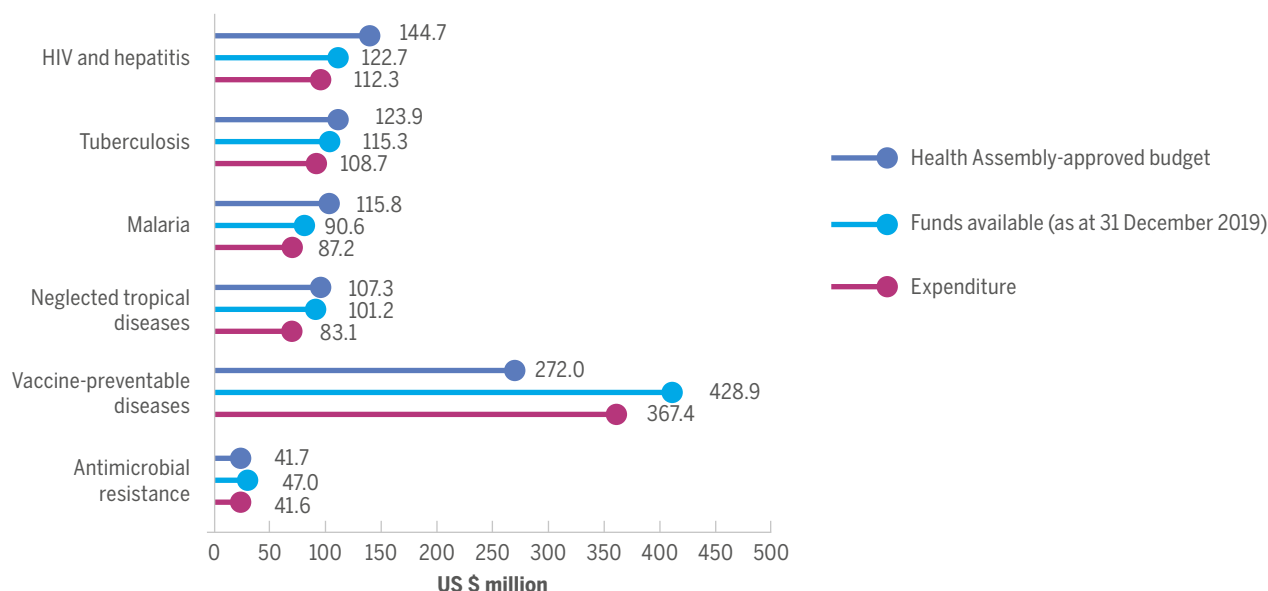
PROGRAMME BUDGET EXPENDITURE, BY MAJOR OFFICE AND PROGRAMME AREA (IN US\$ MILLION)



- Health Assembly-approved budget
- Funds available (as at 31 December 2019)
- Expenditure

- HIV and hepatitis
- Tuberculosis
- Malaria
- Neglected tropical diseases
- Vaccine-preventable diseases
- Antimicrobial resistance

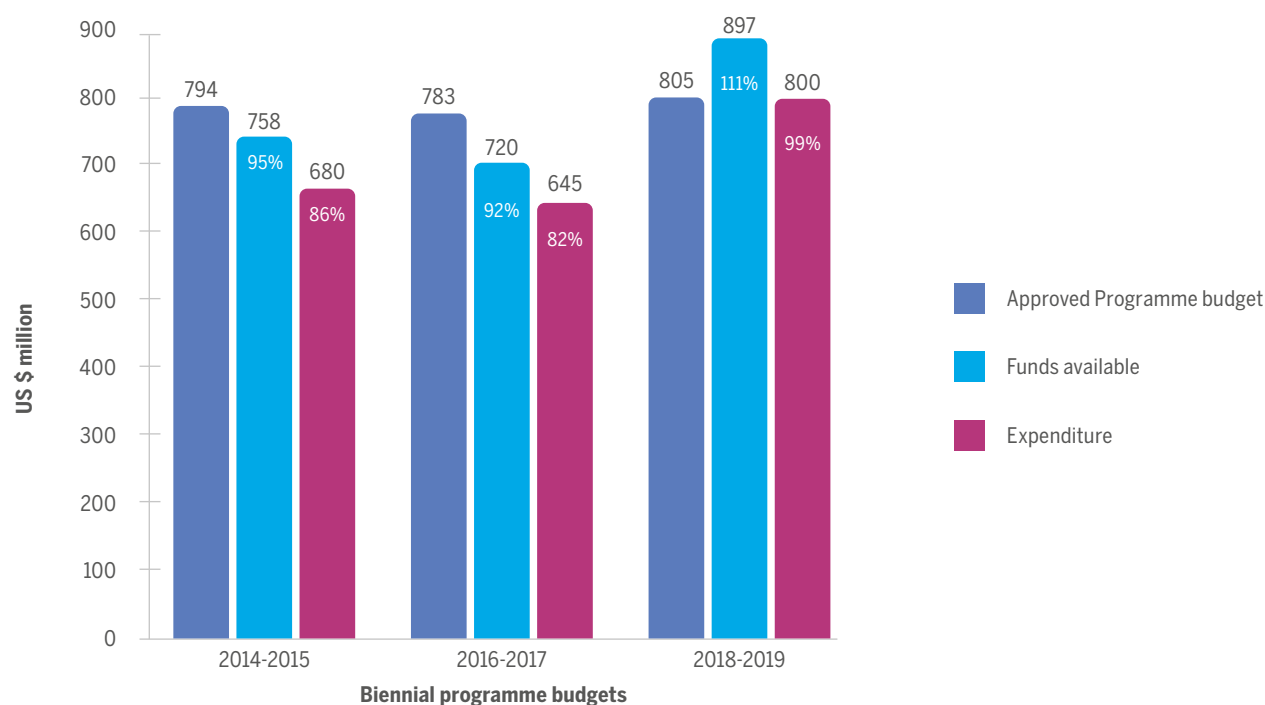
BASE BUDGET, FUNDS AVAILABLE AND EXPENDITURE, BY PROGRAMME AREA (IN US\$ MILLION)



At the end of the biennium 2018–2019, the Communicable diseases category had 111% of available funding compared to its approved budget. This substantial funding increase over the approved programme budget was mainly due to the reprogramming of financing from Gavi, the Vaccine Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria, some of which was previously accounted outside the base budget. Those funds were used to finance countries in protracted emergencies, for which WHO acted as a funding agent. In view of factors such as the transparency of WHO's management and its reporting on those funds on the Programme budget web portal, it was decided to integrate them into the base budget in 2018–2019. This resulted in a level of funding that was 58% over the planned budget of the Vaccine-preventable diseases programme area, mostly in the Eastern Mediterranean and South-East Asian regional offices. However, it is important to note that the biennial expenditures of the Communicable diseases category remain within the budget approved by the Health Assembly and the spending limit defined by the appropriation resolution WHA70.5 (2017).

The Communicable diseases category relies heavily on highly earmarked specified voluntary funding, which restricts the capacity to shift funding across programme areas and major offices. For instance, while efforts to combat tuberculosis and find solutions to tackle neglected tropical diseases are resourced almost to their approved budget level, efforts to combat HIV and hepatitis as well as malaria have comparatively lower levels of available funding.

COMPARISON OF 3 BIENNIAL BASE PROGRAMME BUDGETS UNDER THE TWELFTH GENERAL PROGRAMME OF WORK



* Percentage indicates as % of approved programme budget

Nonetheless, the overall improved financing of all major offices and programme areas and better alignment among them compared to 2016–2017 have enabled 99% implementation of the approved Programme budget for the Communicable diseases category. The Vaccine-preventable diseases programme area has the largest budget across all major offices in the Communicable diseases category; it is well resourced in all offices (at or over 100%) and well implemented (over 100%). The adequacy of the budget level for this programme area across all major offices should be addressed in the future, taking into account the inclusion into the base budget of income that was previously accounted outside the Programme budget.

The Antimicrobial resistance programme area was incepted into Programme budget 2018–2019 as a dedicated programme area, in keeping with resolution WHA70.5. Although there was uncertainty about how well and how fast WHO could resource this new programme area, it ended the biennium with a 13% funding excess and 100% implementation compared to the approved budget. This clearly demonstrates the importance of political leadership in a highly cross-cutting area.

In the perspective of the Twelfth General Programme of Work, the 2018–2019 biennium had the highest approved budget in the Communicable diseases category because of the inclusion of the Antimicrobial resistance programme area. There were also more funds available in 2018–2019 due to the integration of non-base funds and the approved budget was fully implemented. WHO will continue to address challenges involving the lower-funded areas in the Communicable diseases category across all major offices and organizational levels and to improve the quality of tightly earmarked funds, which impede the full alignment of programmatic results and resources.

For further details on the Programme Budget funding, implementation for this category and achievements by programme areas including indicators, please refer to the WHO Programme Budget Portal (<http://open.who.int/2018-19/our-work/category/01/about/programme-outcomes> and <http://open.who.int/2018-19/home>).

NONCOMMUNICABLE DISEASES

The global prevalence (age-standardized) of **DIABETES** has nearly doubled since 1980, rising from 5% to 9% in the adult population in 2018; 1 in 2 people with diabetes were undiagnosed

The prevalence of **INSUFFICIENTLY PHYSICALLY ACTIVE ADULTS** increased from 23% in 2010 to 28% in 2016

The prevalence of **OVERWEIGHT AND OBESITY IN ADULTS** increased from 36% in 2010 to 39% in 2016

DOMESTIC GOVERNMENT EXPENDITURE ON noncommunicable diseases as a percentage of overall domestic government expenditure on health remains unchanged between 2015 and 2017, with lower income groups spending proportionally less than high-income countries

The prevalence of **TOBACCO USE AMONG ADULTS** above 15 years of age fell from 27% in 2010 to 24% in 2018

Between 2012 and 2018, **CANCER CASES AND DEATHS** increased by 28% and 16%, respectively, reaching 18 million new diagnoses and 10 million deaths in 2018

There was no progress in reducing the total **ALCOHOL PER CAPITA CONSUMPTION** (among adults 15 years of age and older)

The current rate of decline in the risk of dying from any of the four main noncommunicable diseases between the ages of 30 and 70 is insufficient to meet **TARGET 3.4 OF THE SUSTAINABLE DEVELOPMENT GOALS**

The **RISK OF DYING FROM THE FOUR MAIN NONCOMMUNICABLE DISEASES** (cardiovascular disease, cancer, diabetes and chronic lung disease) between 30 and 70 years of age continued to decline, falling from 22% in 2000 to 18% in 2016

The number of **STUNTED CHILDREN** under 5 years of age fell from 166 million in 2012 to 149 million in 2018



Approved Programme budget:
US\$ 351 million



Funds available:
US\$ 293 million
(83% of Programme budget)



Expenditure:
US\$ 268 million
(76% of the approved budget;
92% of available resources)



"We must recognise that the greatest threats to public health often arise from decisions in other sectors, such as economic, educational, and welfare policies.... To tackle these challenges, we will need to complement a biomedical approach with other disciplines and skillsets."

DR HANS KLUGE
WHO Regional Director for Europe



AIR POLLUTION IS RESPONSIBLE FOR 7 MILLION PREMATURE DEATHS; 9 OUT OF 10 PEOPLE BREATHE AIR CONTAINING **HIGH LEVELS OF POLLUTANTS**.

AIR POLLUTION (AMBIENT AND HOUSEHOLD) IS THE SECOND LEADING CAUSE OF NONCOMMUNICABLE DISEASES

Noncommunicable diseases – **heart attacks, strokes, cancers, diabetes** and **chronic lung diseases** – cause almost 70% of all deaths worldwide. The majority of these deaths occur prematurely and in low- and lower middle-income countries, where primary health care and referral systems between primary and other levels of care are unable to meet the demand for early diagnosis, screening and appropriate treatment of noncommunicable diseases. Five major risk factors drive noncommunicable diseases: tobacco use, unhealthy diets, insufficient physical activity, air pollution and harmful use of alcohol.

A comprehensive response to noncommunicable diseases should include mental health, disability, violence, injuries, substance use, food safety and zoonoses. The presence of these conditions also influence the response to noncommunicable diseases. Together, these noncommunicable conditions are among the largest, most underfunded public health challenges facing sustainable development in the 21st century.

Many premature deaths can be avoided through simple, cost-effective, high-impact interventions, but these are not being implemented and scaled up sufficiently in the majority of countries to reach the targets of the Sustainable Development Goals.

BHUTAN'S NEW APPROACH TO FIGHT NONCOMMUNICABLE DISEASES



Bhutan was an early adopter, in 2015, of the WHO Package of Essential Noncommunicable Disease Interventions (PEN). Noncommunicable diseases accounted for nearly 70% of deaths in 2016. A 2014 STEPS survey showed that one quarter of the population was overweight, more than one third had raised blood pressure and more than three quarters did not engage in vigorous physical activity.

In 2019, WHO collaborated with Bhutan to introduce the innovative, cost-effective PEN HEARTS package. A training model was designed to screen noncommunicable disease patients, which was rolled out to trainers who then trained health workers in two districts, Tsirang and Punakh. People-centred services have been initiated, together with improved information management, which has had a positive impact on the community. The model of care will be evaluated after one year. The Government is committed to scaling up the approach across the nation.

KEY ACHIEVEMENTS

Today, the majority of countries are seeking ways to implement WHO's “**best buys**” and other recommended interventions to address the complex and interconnected challenges of noncommunicable diseases, mental health, disability, violence, injuries, substance abuse, food safety and zoonoses. During the period 2018–2019, WHO finalized its work to develop integrated responses to these issues through 10 multisectoral **signature solutions** (technical packages) tailored to countries, using current scientific knowledge and available evidence. Each solution is built on a theory of change with interventions geared towards key targets of the Sustainable Development Goals based on the “best buys”.

Progress in the implementation of WHO's cost-effective **signature solutions** (technical packages) includes:

- **12 countries** have implemented at least one intervention included in REPLACE (to eliminate trans fats from the food supply);
- **20 countries** have implemented HEARTS (to ↓ hypertension);
- **25 countries** have implemented PEN (to ↑ diagnosis and treatment of noncommunicable diseases in primary health care and universal health care);
- **136 countries** have implemented one or more interventions included in MPOWER (to ↓ tobacco use);
- **100 countries** have implemented at least one intervention included in ACTIVE (to ↑ physical activity).

In response to government requests, more than 100 countries were provided with technical assistance from WHO to refine and implement these signature solutions, with differentiated approaches for each.

NEW MULTISTAKEHOLDER GLOBAL INITIATIVES

To enhance multistakeholder partnerships that strengthen collaboration with Governments, as well as with civil society and the private sector, the WHO Director-General launched a number of special global initiatives in 2018 and 2019. These initiatives scale up a mix of policy advisory, technical assistance, financing and programme implementation modalities, in close collaboration with stakeholders, such as:

- the Special Initiative for Mental Health
- the Global Hearts Initiative
- the Global Initiative to Eliminate Cervical Cancer
- the Global Initiative for Childhood Cancer
- the Global Initiative to Eliminate Industrially-produced Trans-fat from the Global Food Supply. majority of countries to reach the targets of the Sustainable Development Goals.

IMPLEMENTATION OF THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL IN ALL COUNTRIES

The Global Strategy to Accelerate Tobacco Control 2019–2025 was adopted by the Conference of the Parties to the Convention at its eighth session. It will fuel momentum and enable stronger engagement by the various stakeholders to implement the Convention.



ROAD TRAFFIC INJURIES ARE THE TENTH LEADING CAUSE OF DEATH GLOBALLY, RESPONSIBLE FOR ABOUT **1.3 MILLION DEATHS EACH YEAR**. THEY ARE THE LEADING CAUSE OF DEATH FOR 15-TO-34 YEAR-OLDS IN LOW- AND MIDDLE-INCOME COUNTRIES

PROVIDING EVIDENCE-BASED FISCAL MEASURES

Fiscal measures reduce demand, which in turn lowers health care costs while increasing revenue for the government. WHO has tracked scientific knowledge and available evidence and reviewed international experience regarding fiscal measures and shared its latest findings at the Health Assembly in May 2019. In particular:

- 73 countries now have a tax on sugar-sweetened beverages
- 94 countries increased their tobacco excise taxes on tobacco products between 2016–2018
- 114 countries established or increased an excise tax on alcohol since 2010.

Political momentum increased during the biennium following the third **High-level meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases**, held in September 2018, at which world leaders (including two dozen Heads of State or Government and 55 ministers) committed to implement a series of WHO-recommended policies.

A commitment to progressively cover 1 billion additional people with essential health services and medicines for the early detection, screening and appropriate treatment of noncommunicable diseases and mental health conditions by 2023, as an essential component of universal health coverage, was made at the **high-level meeting of the United Nations General Assembly on universal health coverage**, held in September 2019.

To leverage their leadership and policy expertise, WHO convened 28 presidents, ministers and global health advocates in the **WHO Independent High-level Commission on Noncommunicable Diseases** to propose innovative solutions that accelerate action on noncommunicable diseases and have a multiplier effect across the Sustainable Development Goals.

For the first time, WHO was able to place fully dedicated staff on tobacco control, hypertension management, childhood cancer treatment and road safety in its country offices.

GLOBAL PUBLIC HEALTH GOODS RELEASED

- The **Global Action Plan on Physical Activity and Health 2018–2030** provides evidence-based policy actions for multisectoral action, outlining how countries can reduce physical inactivity in adults and adolescents by 15% by 2030.
- The **Guidelines on physical activity, sedentary behaviour and sleep for children under 5 years of age** set out the benefits of physical activity and recommendations on its contribution to children's growth, physical, motor and cognitive development and healthy start to life.
- The **Guidelines on risk reduction of cognitive decline and dementia** set out how people can reduce their risk of dementia by getting regular exercise, not smoking, avoiding the harmful use of alcohol, controlling their weight, eating a healthy diet and maintaining healthy blood pressure, cholesterol and blood sugar levels.
- The **Guidance to increase support for breastfeeding in health facilities** provides advice on maternity and newborn services.
- The **Global business case for investment in the prevention and treatment** of noncommunicable diseases shows that low- and lower-middle-income countries can gain US\$ 350 billion by 2030 by scaling up investments in preventing and treating noncommunicable diseases, which cost an additional US\$ 1.27 per person annually. Such actions would save more than 8 million lives over the same period.

- The **WHO Classification of Diabetes Melitus 2019** was issued.
- **Policy briefs** on what government ministries beyond health need to know about noncommunicable diseases were developed under the auspices of the WHO-led United Nations Inter-Agency Task Force on the Prevention and Control of Noncommunicable Diseases.
- The **Model policy** for agencies of the United Nations Development System on preventing tobacco industry interference was developed under the auspices of the WHO-led United Nations Inter-Agency Task Force on the Prevention and Control of Noncommunicable Diseases.
- A total of **12 cancer medicines** were added to the **2019 WHO Essential Medicines List** for five cancer therapies and a comprehensive set of cancer tests was added to the **2019 WHO Essential Diagnostics List**.

KEY NEW FINDINGS

- Findings show that **baby foods are high in sugar** and inappropriately marketed for babies.
- New data show that people at risk of **trachoma** have fallen from 1.5 billion in 2002 to 142 million in 2019, a reduction of 91%.
- New data show that three quarters of people living with **epilepsy** in low-income countries do not get the treatment they need, increasing their risk of dying prematurely and condemning many to a life of stigma.

COMMON APPROACH TO FOOD SAFETY REGULATIONS IN SOUTH ASIA

The Codex Trust Fund has been established by FAO and WHO to support Member States in building strong, stable and sustainable national capacity to engage in the Codex Alimentarius. The Fund will support a project on developing a common approach to food safety regulations and facilitating cross-border trade, which is led by **India** and also involves **Bhutan** and **Nepal**. This project will further strengthen national Codex activities in participating countries through intercountry collaboration and common positions on the Codex standard-setting process. **Myanmar** has worked with **Cambodia** and the **Lao People's Democratic Republic** to develop a similar project based on this model.



THE WHO **BE HEALTHY, BE MOBILE TOOL** TO SUPPORT RISK FACTOR PREVENTION AT THE POPULATION LEVEL **INCLUDED NEW BEHAVIOUR CHANGE MODULES**



THE **HEARWHO SMARTPHONE APPLICATION** FOR HEARING TESTING WAS MADE AVAILABLE FOR FREE DOWNLOAD. TO DATE, IT **HAS BEEN DOWNLOADED 130 000 TIMES**

FROM SMOKESCREEN TO SMOKE-FREE: 15 YEARS OF THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

There was a time when even children were unprotected against the harms of tobacco. Tobacco firms targeted young people in their advertising and sponsored sports events. In some countries, minors could buy cigarettes. Icons such as film stars smoked on the silver screen, providing free advertising for the industry. The deadly effects of tobacco and second-hand smoke were not clear to the public.

Today, the climate around tobacco and the tobacco control environment have been entirely transformed. Extraordinary progress has been made in tobacco control in the past 15 years, since the **WHO Framework Convention on Tobacco Control (WHO FCTC)** entered into force in February 2005. Smoking bans are now in effect in most public places, including indoor workplaces, restaurants and bars, while the price of cigarettes has dramatically increased and in many countries graphic health warnings appear prominently on cigarette packs and tobacco sales to children are prohibited.

Evidence from countries of all income levels shows that price increases on cigarettes are highly effective in reducing demand. Higher prices encourage people to give up tobacco use and prevent them from starting it, while also discouraging those who have given up from relapsing and reducing consumption among continuing users. On average, a 10% price increase on a pack of cigarettes would be expected to reduce demand for cigarettes by about 4% in high-income countries and by about 5% in low- and middle-income countries, where lower incomes tend to make people more sensitive to price changes. Children and adolescents are also more sensitive to price increases than adults, allowing price interventions to have a significant impact on this age group.

AN UNCONVENTIONAL CONVENTION

From the start, the WHO FCTC was unique and historic. It was the first international treaty negotiated under the auspices of WHO and currently has 181 Parties (WHO Member States and the European Union). It also represented a new approach and legal landmark in public health.

The Convention was first conceptualized in the 1990s. WHO recognized that something had to be done to combat the rise of tobacco-related diseases. After three years of negotiation, it was adopted by the Health Assembly in resolution WHA56.1 of 21 May 2003 and entered into force in 2005. Today, it is one of the most widely and rapidly ratified treaties in the history of the United Nations.

Parties to the WHO FCTC also developed and adopted a second international treaty, based on Article 15 (Illicit trade in tobacco products) of the Convention. The Protocol to Eliminate Illicit Trade in Tobacco Products entered into force in September 2018 and currently has 58 Parties.

The WHO works closely with the secretariat of the WHO FCTC and the Protocol to Eliminate Illicit Trade in Tobacco Products to provide support to Member States on tobacco control.

STRENGTHENING TOBACCO CONTROL IN BRAZIL IMPROVES HEALTH OUTCOMES

WHO's Framework Convention on Tobacco Control adopted unanimously by World Health Assembly

The Convention enters into force and Brazil is one of 40 signatory countries. Today, there are 181 Parties.

6 tobacco control measures focus government action with launch of **MPOWER**

2003

21.8%
of population
smoking

W

"There are no safe levels for the consumption of these substances" covers 100% of the back of packs (2001)

2004

O

Cessation treatment covered by health system expanded to primary health care

2005

2006

Monitor tobacco use and prevention policies
Protect people from tobacco smoke
Offer help to quit tobacco use
Warn about the dangers of tobacco
Enforce bans on tobacco advertising, promotion and sponsorship
Raise taxes on tobacco

2014

P

Law strengthened to a complete ban on smoking in public places, workplaces and public transport

E

Law strengthened to a complete ban on tobacco advertising, promotion and sponsorship

2015

M

Recent, regular and representative surveillance of tobacco use among adults and young people

M P O W E R

Study finds 5.2% ↓ in infant mortality & 3.4% ↓ in neonatal mortality over 5 y since complete smoking ban in Brazil

2018

13.4%
of population
smoking

R

83% of retail price of most sold brand is tax - the highest rate in the region

2019



36 countries introduced one or more **MPOWER** measures at the highest level in that period

Half the world's population now benefit from prominent and graphic pack warnings that feature all the **MPOWER** recommendations, making this measure the most far-reaching by population

One third of the world's population have access to smoking cessation services provided at best practice level (**23 countries** have comprehensive cessation programmes)



62 countries have comprehensive legislation on smoke-free environments, while **70 countries** have minimal to moderate laws that ban smoking in some but not all public spaces and workplaces



Tobacco prevalence has declined in most countries, although the number of smokers is still high – **1.1 billion** – most of whom live in low- and middle-income countries



Tobacco kills more than 8 million people every year, including 1.2 million non-smokers who have been exposed to second-hand smoke. An additional **65 000 people die every year** from illnesses attributable to second-hand smoke



FIVE BILLION PEOPLE – ABOUT TWO THIRDS OF THE GLOBAL POPULATION – ARE NOW COVERED BY AT LEAST ONE MEASURE UNDER **MPOWER**

In 2007, WHO launched the “**MPOWER**” initiative to promote government action on six tobacco control measures in line with the WHO FCTC. The MPOWER measures have saved millions of people from early death and averted billions of dollars in spending and their uptake is increasing.

Despite the gains of the past 15 years, much remains to be done: only two countries, Brazil and Turkey, have put all MPOWER measures in place. Furthermore, the gains that have been made remain at risk – they face constant challenges by the tobacco industry, which continues to spend tens of billions of dollars every year on advertising, promotion and sponsorship of tobacco products.

“Declines in tobacco use amongst males mark a turning point in the fight against tobacco,” said Dr Tedros Adhanom Ghebreyesus, WHO Director-General. “For many years we had witnessed a steady rise in the number of males using deadly tobacco products. But now, for the first time, we are seeing a decline in male use, driven by governments being tougher on the tobacco industry. WHO will continue working closely with countries to maintain this downward trend.”

Between 2000 and 2018, the number of tobacco users worldwide fell by approximately 60 million people, from 1.397 billion to 1.337 billion, according to the WHO global report on trends in prevalence of tobacco use 2000–2025, third edition. The report shows that the number of male tobacco users has stopped increasing and is projected to decline below 2018 levels by more than 1 million by 2020 (to 1.091 billion) and by 5 million by 2025 (to 1.087 billion).

The report also projects that the number of tobacco users, male and female, will decline below 2018 levels by 10 million by 2020 and by a further 27 million by 2025 (to 1.299 billion). Some 60% of countries have been experiencing a decline in tobacco use since 2010. “Reductions in global tobacco use demonstrate that when governments introduce and strengthen their comprehensive evidence-based actions, they can protect the well-being of their citizens and communities,” said Dr Rüdiger Krech, Director of Health Promotion at WHO.

17 MILLION REDUCTION IN STUNTING IN SIX YEARS

Stunting is the result of poor nutrition. It has a devastating impact on children who are starting their lives at a disadvantage against growing to their full potential. More than half of the world's stunted children live in Asia and one third in Africa.

The number of stunted people decreased from 166 million in 2012 to 149 million in 2018. These dramatic improvements highlight the positive effect of policy reform that integrated nutrition into social protection strategies.



THE NUMBER OF STUNTED PEOPLE **DECREASED FROM 166 MILLION IN 2012 TO 149 MILLION IN 2018**

INCREASING SURVIVAL RATE FOR CHILDREN WITH CANCER

With support from WHO, 15 national governments have stepped up services for childhood cancer as part of national cancer control programmes with the aim of reaching at least a 60% survival rate for children with cancer by 2030.

The **WHO Global Initiative for Childhood Cancer**, launched in September 2018, aims to double child cancer survival rates and alleviate the suffering of all children by 2030. Cancer is a leading cause of death for children.

Children with cancer in low- and middle-income countries are about four times more likely to die of the disease than children in high-income countries.

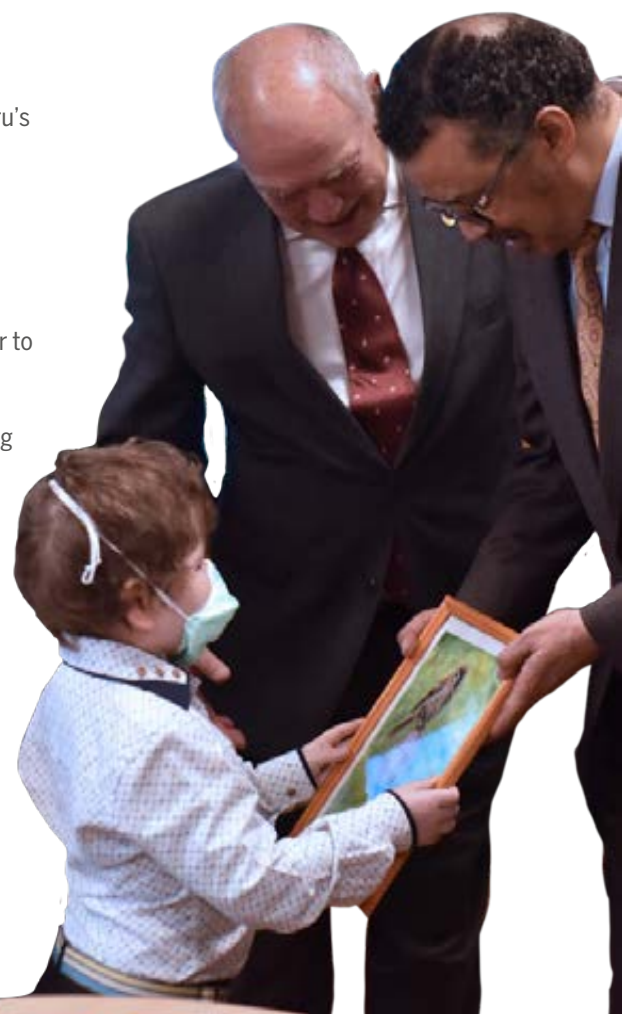
PROGRESS IN PERU ON CHILDHOOD CANCER

Peru, which has also made a strong commitment to universal health coverage, is offering essential services at the primary care level, reaching children in rural areas. With political leadership and strong commitments from partners across sectors, Peru's example shows what can be done for children with cancer.

Every year in Peru, nearly 1800 children and adolescents are diagnosed with cancer. Due to delays in diagnosis, which makes treatment more difficult, more than 50% of them die.

In 2019, Peru requested support from the WHO Global Initiative for Childhood Cancer to improve survival rates for children with cancer to at least 70%.

WHO helped to focus the national paediatric cancer plan on four main goals, including improving early diagnosis of childhood cancer; decreasing treatment abandonment; implementing a national paediatric cancer registry; and improving the quality of services in paediatric oncology units. Six cancers – including leukaemia and brain tumours – have been selected as tracers to monitor progress.



LEBANON IMPROVES THE QUALITY OF MENTAL HEALTH SERVICES



THURUYYA ZREIK WAS ADMITTED THREE TIMES TO A PSYCHIATRIC HOSPITAL IN LEBANON FOR **BIPOLAR DISORDER TREATMENT**. THE SUPPORT SHE RECEIVED DURING HER THIRD STAY IN HOSPITAL, WHICH BEGAN IMPLEMENTING QUALITYRIGHTS, WAS IN STARK CONTRAST TO HER PREVIOUS VISITS. SHE IS NOW A FIELD MANAGER OF THE COUNTRY'S **QUALITYRIGHTS PROGRAMME**

In Lebanon, 250 persons with mental health conditions per year are accessing better mental health services.

In February 2019, the Al-Fanar Psychiatric Hospital in Lebanon was closed down following allegations of human rights violations involving inadequate standards of living, lack of hygiene and suboptimal treatment such as coercion and neglect.

WHO and the country's national mental health programme helped to advocate for the rights of the beneficiaries and the use of the WHO QualityRights Toolkit to assess and improve the quality and human rights aspects of mental

health services. A team of national assessors were trained to use the Toolkit.

As part of a strategy for comprehensive mental health system reform, there is now a team of more than 30 assessors of mental health services, comprising mental health professionals, social workers, lawyers and service users. All these improvements are being channelled through the WHO QualityRights Programme.

RUSSIAN LIFE EXPECTANCY RISES WITH ALCOHOL INTERVENTIONS



IN 2019, A WHO REPORT FOUND THAT PER CAPITA **CONSUMPTION OF ALCOHOL HAD FALLEN BY 43%** OVER THE PAST 15 YEARS

In 2005, the Russian Federation was lagging behind on many health indicators. Life expectancy averaged just 66 years – 14 years less than France and eight years less than Poland.

In the same year, a joint WHO/World Bank report on premature mortality and noncommunicable diseases in the Russian Federation identified harmful use of alcohol as a major risk factor. The impact on the labour supply included lower expected early retirement age or job loss and an earlier reliance on pensions. With WHO support, the Russian Federation implemented a series of “best buys” policies in the subsequent years to: increase excise taxes on alcoholic beverages; establish minimum prices for vodka and other alcoholic beverages; introduce a real-time tracking system on the production and sale of alcohol; restrict the availability of retailed alcohol; eliminate the use of alcohol in selected public places; and restrict the marketing

of alcoholic beverages that target young people.

In 2019, a WHO report found that per capita consumption of alcohol had fallen by 43% over the past 15 years. This trend mirrored a drop in all-cause mortality for the same period, with the sharpest decline in alcohol-related deaths.

The Government's implementation of WHO's “best buys” and other interventions outlined in the **WHO Global Strategy to Reduce the Harmful Use of Alcohol** also helped to reduce consumption of homemade, smuggled or illegally produced alcohol. This shows WHO's evidence-based interventions help to save lives.

TOOLKIT FOR QUALITY AND RIGHTS IN MENTAL HEALTH

WHO's QualityRights Toolkit provides countries with the information and tools to assess and improve quality and human rights standards in mental health and social care facilities.

QualityRights is now being introduced or expanded in 31 countries and is being scaled up in [Armenia](#), [Bosnia](#) and [Herzegovina](#), [Croatia](#), [Czechia](#), [Estonia](#), [Ghana](#), [Kenya](#), [Lebanon](#), [Lithuania](#), [Philippines](#), [Romania](#), [Slovakia](#) and [Turkey](#).

A key premise is respecting the human rights of people seeking support and considering their preferences rather than imposing coercive treatment.

ALCOHOL POLICIES A “GAME-CHANGER” TO ACHIEVE THE HEALTH-RELATED TARGETS OF THE SUSTAINABLE DEVELOPMENT GOALS

Globally, more than one in 20 deaths – 3 million people, mostly men – were caused by the harmful use of alcohol in 2016. Alcohol consumption is a causal factor in more than 200 disease and injury conditions.

Global progress has been insufficient and uneven. Alcohol is deeply entrenched in the social landscape in some societies; moreover, consumption is set to increase in some regions.

No progress has been made in the last decade in reducing total alcohol consumption per capita in the world.

The prevalence of heavy episodic drinking among adolescents fell by 2% (15–19 years of age) from 2010 to 2016. A similar decline was seen among adults (above 15 years of age) in the same period.

Evidence-based policy interventions, which have had remarkable success in a few countries, may reduce the burden of illness and death from noncommunicable diseases and could be a game-changer to achieve targets 3.4, 3.5 and 3.8 of the Sustainable Development Goals.

To provide fresh impetus for action, WHO introduced its [SAFER technical package](#) in 2018, which outlines five proven high-impact strategic actions, from restrictions on alcohol availability and advertising to pricing policies.

STRENGTHENING PREVENTION AND TREATMENT OF DRUG USE DISORDERS

With joint support from WHO and the United Nations Office on Drugs and Crime, support was provided to four countries in their efforts to prevent and manage opioid overdose deaths. The second updated edition of the International Standards on Drug Use Prevention was produced to improve the quality of drug prevention programmes. Nine countries implemented field testing of the International Standards for the Treatment of Drug Use Disorders and used the results for improving the quality of their treatment programmes.



NO PROGRESS HAS BEEN MADE IN THE LAST DECADE IN REDUCING TOTAL **ALCOHOL CONSUMPTION** PER CAPITA IN THE WORLD



VIET NAM PASSED AN ALCOHOL LAW THAT CONSIDERED WHO'S "BEST BUYS" AND INCLUDES A **MEASURE THAT PROTECTS WOMEN FROM VIOLENCE** CAUSED BY DRUNK FAMILY MEMBERS



WHO SUPPORTED **TIMOR-LESTE** IN DEVELOPING ITS FIRST NATIONAL **ALCOHOL CONTROL** POLICY AND **BHUTAN** IN DEVELOPING **ALCOHOL TAXATION**

WORKING WITH OTHER SECTORS FOR SAFER ROADS IN ADDIS ABABA



JOINT MEDIA AND ENFORCEMENT CAMPAIGNS HAVE **REDUCED** **DRINK-DRIVING BY 50%**

With support from WHO and other funding partners, the transport office of Addis Ababa City developed its first road safety initiative.

Ethiopia has one of the highest road traffic fatality rates – an average of 400 deaths per year.

An inter-agency road safety council, chaired by the deputy mayor, was established to provide strategic leadership across 11 governmental institutions.

The US\$ 22 million initiative focuses on five main strategies: changing people's behaviour, including by increasing seat belt and helmet use and reducing speeding and drink-driving; improving road infrastructure; promoting sustainable urban transit options; strengthening road safety policies; and advocating for improved vehicle safety standards.

WHO also worked with local police to strengthen the collection of road traffic accident statistics and with the Ministry of Health to improve the injury surveillance system in hospitals.

MORE THAN HALFWAY TO ZERO ROAD ACCIDENTS IN SWEDEN



SWEDEN'S VISION ZERO HAS INSPIRED SIMILAR POLITICAL COMMITMENTS IN MANY OTHER COUNTRIES

Following the implementation of WHO's road safety technical package, the number of road traffic deaths in Sweden has fallen by more than half even while the volume of traffic has increased dramatically. Sweden adopted a new bold political choice for road safety in 1997 known as Vision Zero.

The goal was that no one should be killed or seriously injured in a road accident.

ON THE ROAD TO SAVING LIVES

With support from WHO, between 2014 and 2019, 22 additional countries amended their laws on speed, drink-driving and failing to use motorcycle helmets, seat belts and child restraints in order to prevent road traffic deaths, covering an additional 1 billion people or 14% of the world's population.

WHO worked with partners to help governments to review road safety legislation and propose recommendations for strengthening it, such as mandating that all vehicle occupants wear a seat belt or age-appropriate child restraint.



THAILAND HAS GREATLY IMPROVED THE QUALITY OF ITS ROAD TRAFFIC REPORTING, WITH A NEW SYSTEM THAT COLLECTS DATA FROM THE POLICE, INSURANCE AND HEALTH RECORDS



THE NUMBER OF **ROAD TRAFFIC DEATHS** CONTINUES TO INCREASE, RISING FROM 1.25 MILLION IN 2013 TO 1.35 MILLION IN 2018



AFRICA HAS 2% OF THE WORLD'S CARS BUT 16% OF THE WORLD'S ROAD DEATHS, TOTALLING MORE THAN 300 000 EVERY YEAR. BUT SUCCESS STORIES CAN BE FOUND. IN **RWANDA**, CONCERTED NATIONAL EFFORTS ON ROAD SAFETY HAVE REDUCED DEATHS AND INJURIES BY ONE-THIRD AND WON INTERNATIONAL PRAISE





IN MOST COUNTRIES, THE **SCALE OF INVESTMENTS IS INSUFFICIENT** TO ACCELERATE PROGRESS TOWARDS THE NONCOMMUNICABLE DISEASE-RELATED TARGETS OF THE **SUSTAINABLE DEVELOPMENT GOALS**

CHALLENGES AND LESSONS LEARNED

Overall progress in all countries has been highly uneven. Remarkable progress has been seen in some countries, yet in most countries, the scale of investments is insufficient to accelerate progress towards the noncommunicable disease-related targets of the Sustainable Development Goals. Due to the complexity and challenging nature of noncommunicable diseases, many low-income and lower-middle-income countries still face significant challenges in the implementation of WHO-recommended interventions.

These challenges include a lack of national capacity, mechanisms and mandates for relevant authorities in facilitating and ensuring action across governmental sectors to:

- pursue policy coherence and effectively balance economic, trade and public-health related goals and interests in national responses in support of the Sustainable Development Goals;
- integrate the WHO-recommended interventions on noncommunicable diseases into primary health care and universal health care benefit packages;
- develop legislation on tax-related measures for tobacco products, alcoholic beverages and sugar-sweetened beverages;
- invite the food and beverage, alcohol, and pharmaceutical industries to strengthen their commitment and contribution to specific “asks” that meaningfully and effectively support the implementation of national noncommunicable disease responses;
- develop projects that can be submitted to international financing institutions;
- prevent interference in health policy-making by multinationals with vested interests.

KEY FIGURES FOR 2018–2019: NONCOMMUNICABLE DISEASES



Approved Programme budget:
US\$ 351 million

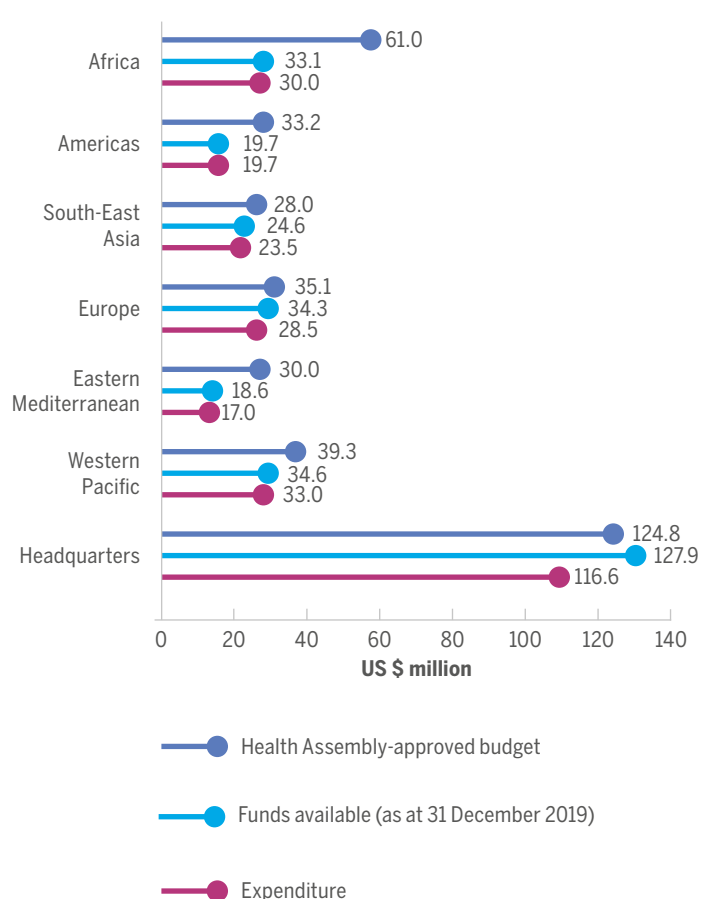


Funds available:
US\$ 293 million
(83% of Programme budget)

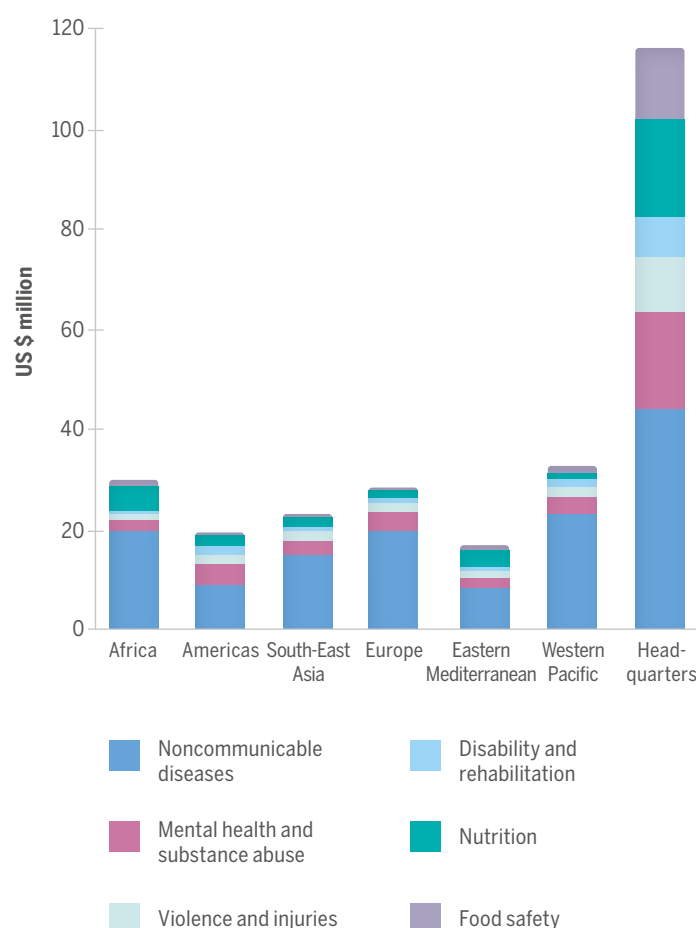


Expenditure:
US\$ 268 million
(76% of Programme budget,
92% of available resources)

BASE BUDGET, FUNDS AVAILABLE AND EXPENDITURE, BY MAJOR OFFICE (IN US\$ MILLION)

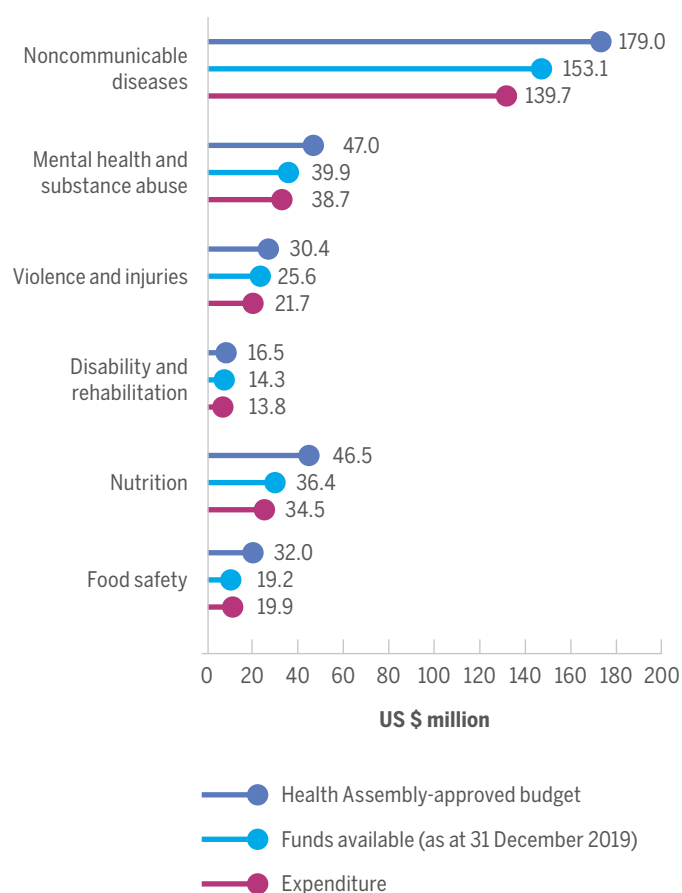


PROGRAMME BUDGET EXPENDITURE, BY MAJOR OFFICE AND PROGRAMME AREA (IN US\$ MILLION)

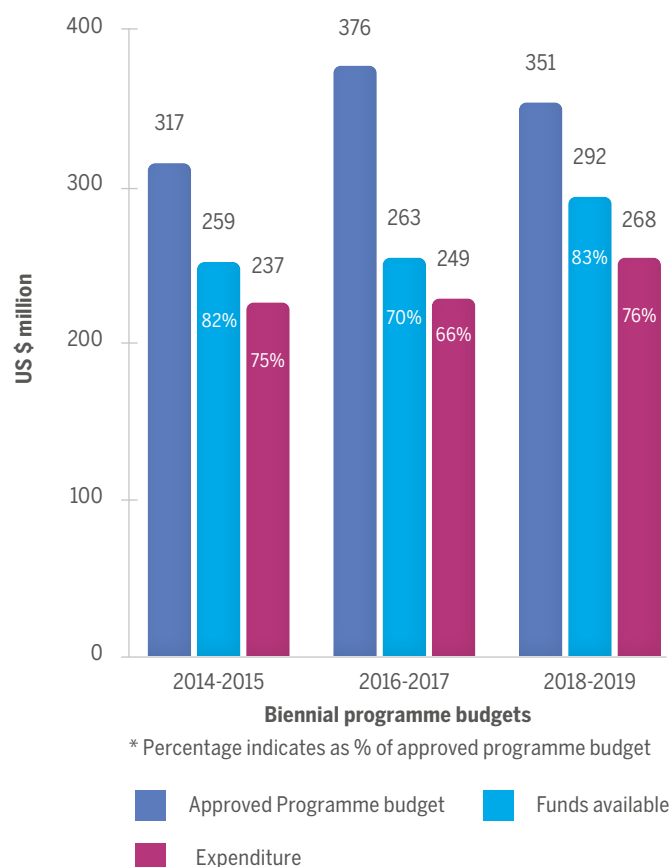


In 2018–2019, available funding, expenditure and alignment reached levels previously unseen in the Noncommunicable diseases category. This reflected an increasing recognition of the impact of noncommunicable conditions on health worldwide. The approved Programme budget 2018–2019 remained at a comparable level with those of previous bienniums; however, while previous budgets had been regarded as somewhat ambitious, in 2018–2019 the funding reached 83%, the implementation of the approved budget 76% and the implementation of available funds 92%.

BASE BUDGET, FUNDS AVAILABLE AND EXPENDITURE, BY PROGRAMME AREA (IN US\$ MILLION)



COMPARISON OF 3 BIENNIAL BASE PROGRAMME BUDGETS UNDER THE TWELFTH GENERAL PROGRAMME OF WORK

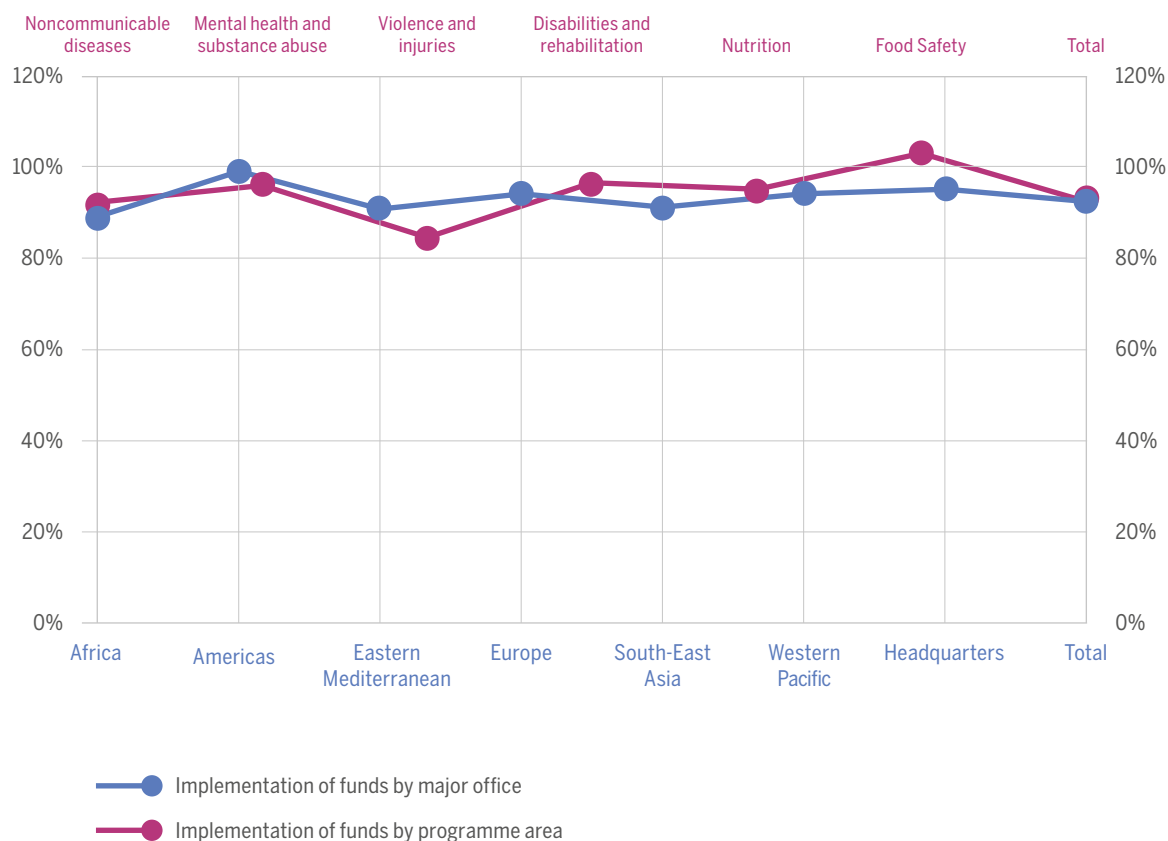


In absolute terms, WHO increased both the investment and the implementation of the Noncommunicable diseases category by 13% in 2018–2019 compared with 2014–2015. Thanks to those increased resource levels, better alignment was also achieved across major offices and programme areas.

Although overall levels of available resources and implementation continued to be based significantly on the Noncommunicable diseases programme area, a better balance across the budgeted levels of almost all programme areas was seen in 2018–2019 compared with previous bienniums. The high levels of average funds available and average expenditure in the Noncommunicable diseases category in 2014–2015 were caused by one-off donations to the Disability and rehabilitation and Nutrition programme areas, which also resulted in a greater variance across programme areas. The biennium 2018–2019 saw better performance in relative funding and expenditure levels compared with 2014–2015, even though a considerably higher level of the approved budget was approved.

That improved performance reflects recent and ongoing developments in the Noncommunicable diseases category. The reduction of funds available and expenditure relative to the approved Programme budget in 2016–2017 was due partly to a significant drop in voluntary contributions available in 2014–2015 in the African Region and the transfer into the

FUND IMPLEMENTATION, BY PROGRAMME AREA AND MAJOR OFFICE, 2018-2019 (IN PERCENT)

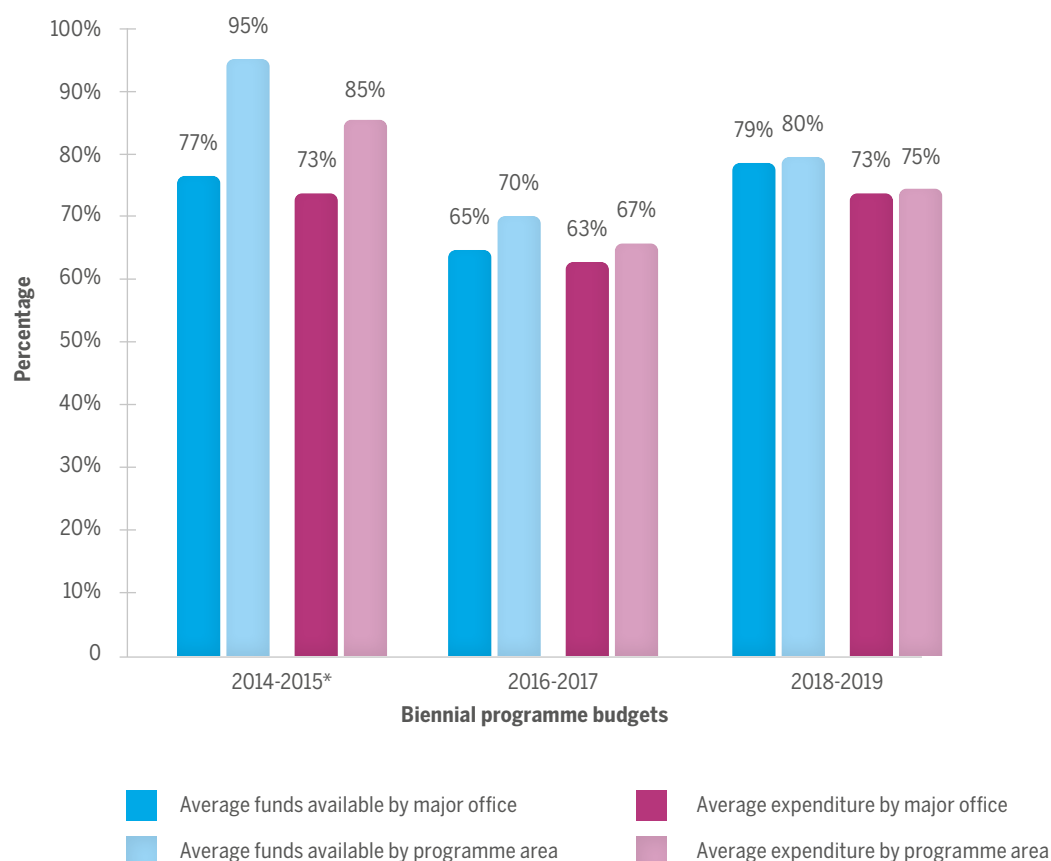


Noncommunicable diseases category of the Food safety programme area in 2017, which allowed programme areas related to noncommunicable conditions to be more closely aligned and to benefit from programmatic synergies in 2018–2019.

The higher levels of funding and implementation realized in 2018–2019 across most of the Noncommunicable diseases category demonstrated the Organization's strong commitment to ensuring that valuable work was undertaken during 2018–2019. One of the measures taken was to prioritize the Noncommunicable diseases category in terms of flexible funding: 48% of the funding for this category came from flexible funds, the highest level of flexible funding of all the technical categories (see Figure 5 in the Budget implementation summary). This flexible funding functioned as "seed funding" by attracting more funding on the basis of the demonstrable results that it generated. This process is expanding and has already attracted additional investments during the biennium of semi-flexible thematic funding (funds earmarked at a high level to priority areas but within which there is considerable discretion for deployment according to need). Those investments in turn are helping to generate further donor interest and as a result the needs for investment in the critical area of the Noncommunicable diseases category are starting to be met.

The implementation of available funds in the Noncommunicable disease category was above 90% in all major offices and programme areas, demonstrating the Organization's capacity to implement commitments.

COMPARISON OF 3 BIENNIAL BASE PROGRAMME BUDGETS UNDER THE TWELFTH GENERAL PROGRAMME OF WORK



* The Food safety programme area was not included in 2014–2015 as it was transferred to Noncommunicable diseases in 2016–2017.

Attention must be paid at both global and regional levels to ensure that there are sufficient resources to address the challenges of noncommunicable conditions in Africa and the Eastern Mediterranean in particular. The level of unspent resources at the end of the biennium also needs to be better managed in the future biennium, which will depend primarily on the predictability of the disbursement of funds and better management of the funding pipeline.

For further details on the Programme Budget funding, implementation for this category and achievements by programme areas including indicators, please refer to the WHO Programme Budget Portal (<http://open.who.int/2018-19/our-work/category/02/about/programme-outcomes> and <http://open.who.int/2018-19/home>).

PROMOTING HEALTH THROUGH THE LIFE COURSE

In 2018, **2.5 MILLION NEWBORNS DIED IN THE FIRST MONTH OF LIFE**. One third of those deaths occurred on the day of birth

UNSAFE WATER, SANITATION AND HYGIENE are responsible for some **830 000** annual diarrhoeal deaths

38% FEWER MATERNAL DEATHS in 2017 compared with 2000

NINE OUT OF TEN PEOPLE BREATHE POLLUTED AIR, which kills more than seven million people prematurely per year

42% FEWER NEWBORN DEATHS in 2018 compared with 2000

45% LOWER MORTALITY RATE for children under five years of age in 2018 compared with 2000

76 LOCATIONS (MOSTLY CITIES) have joined the BreatheLife Network

50 COUNTRIES (REPRESENTING 1 BILLION PEOPLE) have committed to achieve the WHO Air Quality Guidelines values

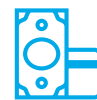
104 COUNTRIES have adopted a healthy ageing strategy



Approved Programme budget:
US\$ 384 million



Funds available:
US\$ 328 million
(83% of Programme budget)



Expenditure:
US\$ 292 million
(76% of Programme budget,
92% of available resources)



"We must engage communities and individuals, and work together with civil society organizations. We do not simply ask "what can you do for us in health? but "what can health do for you?"

DR CARISSA F ETIENNE
WHO Regional Director for the Americas



THE LIFE COURSE APPROACH **RECOGNIZES THE HEALTH CONCERNS OF DIFFERENT STAGES OF LIFE AND AGES:** EARLY CHILDHOOD DEVELOPMENT, WOMEN'S HEALTH DURING AND BEYOND REPRODUCTION, ADOLESCENCE AND HEALTHY AGEING, WHICH IS NOW THE FASTEST-GROWING LIFE STAGE. SOCIAL AND ENVIRONMENTAL FACTORS ALSO IMPACT HEALTH. **ADDRESSING THESE FACTORS CAN HELP HEALTH EQUITY, HUMAN RIGHTS AND GENDER EQUALITY.**



KEY ACHIEVEMENTS

MATERNAL MORTALITY DECLINING, BUT PROBLEMS PERSIST

For decades, reducing the deaths of mothers and their newborns remained a huge challenge, particularly in low-income settings. Young girls in fragile situations were particularly at risk. However, in the last decade dramatic progress has been made, driven by heightened political will, better data collection and more health facility births, among other reasons.

In 2017, the risk for a 15-year-old girl to die from a maternal cause (about 1 in 190) was almost 50% lower than it was in 2000.

Yet many problems persist, including weaknesses in health systems and acquiring accurate data. Many countries still lack well-functioning civil registration and vital statistics systems and where such systems do exist, reporting errors – such as misclassified data on death – pose a challenge.

In the biennium 2018–2019, all countries in the South-East Asia Region continued to make significant progress in reducing maternal mortality and are on track to achieve the Sustainable Development Goals targets. Evidence-based coverage of essential interventions increased in the Region, with 78% of mothers benefiting from institutional deliveries, 76% from antenatal care and 63% from postnatal care.

The **Region of the Americas** also saw progress in the biennium, with a marked decrease of absolute and relative social inequalities in infant mortality and maternal mortality. In the African Region, all countries except two have now introduced **Maternal Death Surveillance and Response**.

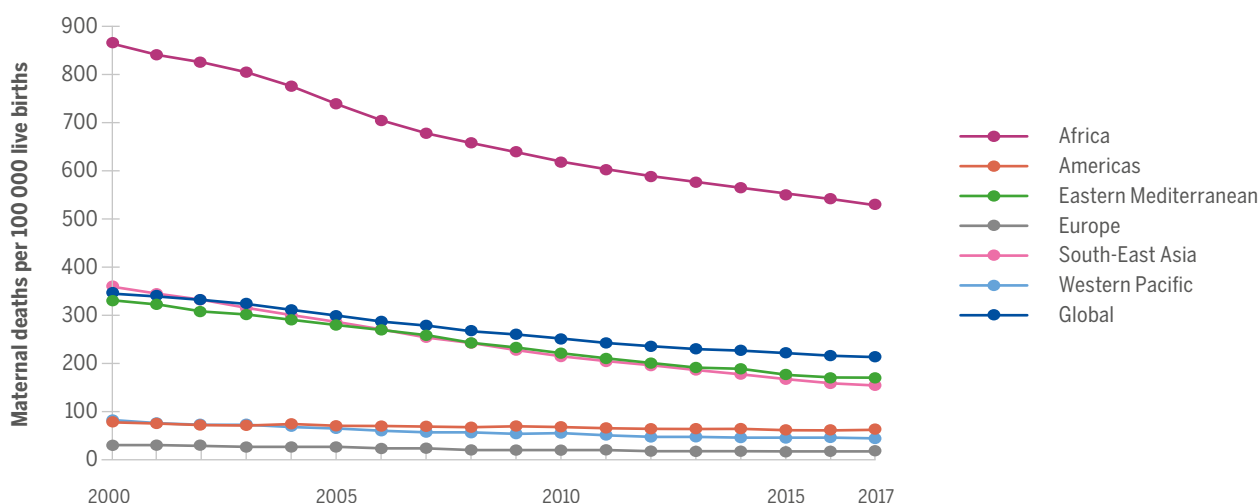


EVERY DAY IN 2017, MORE THAN **800 WOMEN DIED** FROM PREVENTABLE CAUSES RELATED TO PREGNANCY AND CHILDBIRTH



THE SUBREGION OF **SOUTHERN ASIA** ACHIEVED THE GREATEST OVERALL PERCENTAGE REDUCTION IN THE **MATERNAL MORTALITY RATE** BETWEEN 2000 AND 2017 – **ALMOST 60%**

MATERNAL MORTALITY RATIO BY WHO REGION, 2000-2017



Source: Trends in maternal mortality: 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization; 2019.



AFTER THE STRATEGY WAS IMPLEMENTED, THERE WERE **0 MATERNAL DEATHS DUE TO HAEMORRHAGE IN 2018 AND ONLY 1 IN 2019**

BRAZILIAN STATE REVERSES MATERNAL MORTALITY

If Karolene Gomes had not come to Balsas Regional Hospital in Maranhao state, Brazil, where she was correctly diagnosed with severe postpartum haemorrhage, she would have died. Nurses there had trained in a workshop on the zero maternal deaths by hemorrhage (ZMDH) initiative of the Pan-American Health Organization (PAHO).

The ZMDH initiative trains health professionals on protocols for major obstetric emergencies and covers legal frameworks, health information systems and bottlenecks that obstruct care.

For more than 20 years, Maranhao had Brazil's highest maternal

mortality rate. After the strategy was implemented, there have been promising results. In the Balsas regional health area covering 14 cities, there were 0 maternal deaths due to haemorrhage in 2018 and only 1 in 2019.

The Region for the Americas had proposed to develop the ZMDH initiative, including by (a) training national and local teams to handle obstetric haemorrhages; (b) developing and training national teams in the validation of the essential conditions of the maternal-perinatal services tool; (c) designing local improvement plans; and (d) monitoring results.



Progress made in the **Eastern Mediterranean** Region was set back by humanitarian crises that led to inadequate programme implementation. In response, suitable strategic plans and standard operation protocols were developed.

The met need for family planning, a key high-impact intervention in reducing maternal deaths and enabling women and couples to achieve their fertility intentions, increased among married or in-union women from 75% in 2000 to 78% in 2017.¹ Among all regions, the met need for family planning by modern methods is lowest by far in Africa, at 56% in 2017.¹ To reduce the unmet need for contraception, WHO implemented the “Umbrella” Project from 2015 until 2018, under which 47 countries have developed national guidelines and implementation strategies to ensure that rigorous evidence-based standards guide national policies and programmes.

STUDY FINDS “DEPO” INJECTABLE CONTRACEPTIVE SAFE

A large clinical research study conducted in four African countries by an international research consortium, including the Secretariat’s Human Reproduction Programme, found no significant difference in risk of HIV infection among women using one of three highly effective, reversible contraceptive methods. Published in the *Lancet*,² the study showed that each method had high levels of safety and effectiveness in preventing pregnancy, with all methods well accepted by the women using them. Combining this information with other available evidence, WHO released updated recommendations on the use of contraception by women at high risk of HIV infection.

AMBITIOUS TARGET TO ELIMINATE CERVICAL CANCER

Cervical cancer is a vaccine-preventable disease and is curable if detected early and adequately treated. The WHO Director-General issued a Call to Action in May 2018, which argued for renewed political will to eliminate cervical cancer. A global strategy was developed to eliminate cervical cancer as a public health problem by 2030, with three ambitious targets.

MATERNAL DEATHS REDUCED IN MOROCCO

High political commitment to maternal health helped Morocco reduce maternal mortality by 77% over a 25-year period, to 73 per 100 000 live births in 2017. A national strategy emphasized high-impact interventions and expanding coverage. Mobile clinics and free reproductive health services helped address inequities between rural and urban settings. Referral care was improved, using ambulances and even helicopters in mountainous areas, with mobile health technology used for follow-up care. A maternal death surveillance system and digital health helped improve audits and accountability.



RENEWED POLITICAL WILL
TO **ELIMINATE CERVICAL
CANCER**



HEAT-STABLE CARBETOCIN
WAS APPROVED FOR
INCLUSION IN THE WHO'S
LIST OF **ESSENTIAL
MEDICINES**. IT IS AS
SAFE AND EFFECTIVE
AS **OXYTOCIN** IN
PREVENTING POSTPARTUM
HAEMORRHAGE

¹ United Nations Department of Economic and Social Affairs, Population Division, World Fertility and Family Planning 2020.

² HIV incidence among women using intramuscular depot medroxyprogesterone acetate, a copper intrauterine device, or a levonorgestrel implant for contraception: a randomised, multicentre, open-label trial: Evidence for Contraceptive Options and HIV Outcomes (ECHO) Trial Consortium, *Lancet* 2019; 394: 303–13.



92% OF FULL-TERM NEWBORNS NOW RECEIVE SKIN-TO-SKIN CONTACT IN HEALTH FACILITIES THAT HAVE INTRODUCED EENC

NEWBORN DEATHS DECLINE IN MONGOLIA

In Mongolia, 92% of full-term newborns now receive skin-to-skin contact in health facilities that have introduced EENC, while 82% of babies in such facilities remain in contact until the first breastfeed. In 2018, neonatal mortality fell to 8.7 per 1000 live births.

It may seem obvious that the natural place for a newborn baby is on the mother's chest, given the huge benefits of skin-to-skin contact. Yet that "first embrace" immediately after birth is not

always the norm. Such was the case in Mongolian hospitals in 2014 – it was not a standard practice.

WHO helped introduce and scale up evidence-based interventions. EENC was implemented in 25 hospitals attending to most of the births nationwide. These hospitals have also established quality improvement mechanisms to sustain quality of care, as well as annual implementation reviews conducted by the Ministry of Health.



SOME 13 COUNTRIES ARE IMPLEMENTING **BIRTH DEFECTS SURVEILLANCE** AT NATIONAL LEVEL

BIRTH DEFECTS SURVEILLANCE STRENGTHENED IN THE AMERICAS

Birth defects surveillance has been strengthened through cooperation with countries, training and advocacy. The emergence of the Zika virus contributed to establishing national surveillance systems. An advocacy document,

Present and Future of Birth Defects Surveillance in the Americas, was launched, presenting the Region's situation and challenges. Some 13 countries are implementing birth defects surveillance at national level.



AFTER TWO YEARS, MORE THAN 12 000 VISITS HAVE BEEN MADE TO FAMILIES IN **CONFLICT-AFFECTED AREAS**

IMPROVED ACCESS TO NEWBORN CARE IN CONFLICT AREAS

In 2017, WHO and the Ministry of Health of the Syrian Arab Republic launched a new initiative providing training for community health workers to make home visits to guide mothers on the care of

newborns in areas where access to health care is very limited. After two years, more than 12 000 visits have been made to families in conflict-affected areas and 300 newborns identified for referral.

WHO-COORDINATED RESEARCH LEADS TO INTERVENTION SCALE-UP

Up to 80% of all neonatal deaths are preterm or low birth weight babies. **Kangaroo mother care** has been known for over two decades to be an effective intervention, reducing deaths by 40% among babies under 2 kilograms. Yet global coverage of this intervention remains very low, at less than 5%.

WHO has coordinated implementation research at seven sites in **Ethiopia** and **India**, covering 8 million people, in order to develop and evaluate scale-up models. The intervention aimed to collect and use qualitative, quantitative and quality data to help improve implementation. Evaluation of the final model showed 60–80% coverage with quality achieved, which led to the scale up of this model.

KANGAROO CARE EXPANDED

Newborn mortality in the **Western Pacific** Region is estimated to have decreased by 8–39% in nine high-burden countries since 2013. Survey or national surveillance data show improved trends in breastfeeding initiation or exclusive breastfeeding in the first month of life in four countries.

Much work has been done to scale-up quality **early essential newborn care** (EENC). Around 35 000 staff were coached on EENC and almost 6000 facilities are now implementing EENC – the latter having increased by about 80% since 2017.

Following requests from countries, kangaroo mother care was introduced in all nine countries, expanding to 278 hospitals – almost two thirds of national, regional and provincial hospitals in the nine countries of the Region, excluding China. About 68% of hospital staff providing childbirth and newborn care services were coached in kangaroo mother care in hospitals with data. Now, 91% of babies receive skin-to-skin contact in health facilities that introduced EENC, an improvement over 2017.

WHO provided technical assistance to countries to achieve this scale-up. It developed programmatic guides and supported countries to roll out coaching for health workers on EENC and kangaroo mother care, establish quality improvement approaches and conduct routine monitoring to inform programming. Countries were also supported to develop national policies and protocols aligned with global evidence and to secure political commitment and domestic funding.



INCREASING PROPORTION
OF INFANTS **EXCLUSIVELY
BREASTFED FOR THE
FIRST SIX MONTHS OF
LIFE**



UNDER FIVE MORTALITY HALVED IN AFGHANISTAN

Between 2000 and 2018, the mortality of children under the age of five was reduced by 52% in Afghanistan. The key enabling factors for improvement were strong national stewardship; a focused national health policy based on primary health care; outsourcing for implementation of the basic package of health services and essential hospital services; and international funding. The quality of health services was monitored by the Ministry of Public Health and incentive-based performance management was introduced for service-provider nongovernmental organizations.

WHO provided support in developing evidence-based policies, clinical service guidelines, training packages and provider capacity-building. WHO supported the annual vaccination of 12 million children and the treatment of 52 000 malnourished children.



MORTALITY OF CHILDREN UNDER THE AGE OF FIVE WAS **REDUCED BY 52% IN AFGHANISTAN**



SHARING KNOWLEDGE ON CARE FOR MOTHERS AND BABIES

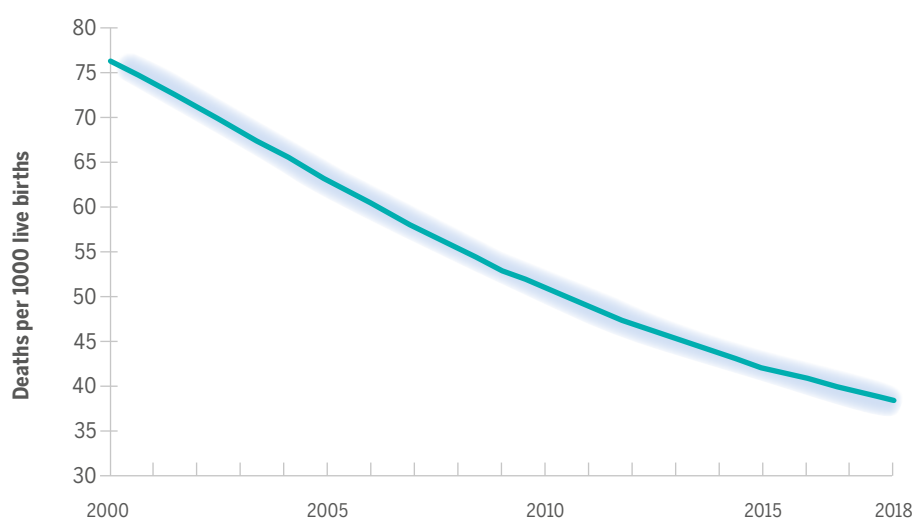
The Network for Improving Quality of Care for Maternal, Newborn and Child Health is a partnership of governments, partners and funding agencies aiming to halve maternal and newborn deaths and stillbirths in participating health facilities by the end of 2022 through good quality, people-centred care. The 11 member countries of the Network – **Bangladesh, Côte d'Ivoire, Ethiopia, Ghana, India, Kenya, Malawi, Nigeria, Sierra Leone, the United Republic of Tanzania and Uganda** – are taking action to improve the quality of care and are monitoring data.

WHO serves as the secretariat and provides technical support to countries. To capture and share lessons learned, WHO established a global learning network of 900 health practitioners and decision-makers. The Network website provides a platform for sharing resources, know-how and best practices that includes a knowledge library, a series of webinars and podcasts and a community of practice forum for discussing and troubleshooting issues.

CHILD MORTALITY RATES IMPROVING

Since 2000, child mortality rates have declined by nearly half, mostly due to improved access to affordable, quality health services. The highest risk of death for children is at the neonatal stage, for which global mortality has declined, albeit more slowly than for all children and children from 1 to 59 months of age. In 2018, as many as 2.5 million newborns died.

UNDER-FIVE MORTALITY RATE



SINCE 2000, CHILD MORTALITY RATES HAVE **DECLINED BY NEARLY HALF**

— Under-five mortality rate
Shaded areas represent lower and upper bounds.

Source: Levels & Trends in Child Mortality: Report 2019-Estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation. New York: United Nations Children's Fund; 2019. Shaded areas represent lower and upper bounds.



AT LEAST 30 COUNTRIES
HAVE HELD ACTIVITIES
TO IMPLEMENT THE
NURTURING CARE
FRAMEWORK FOR EARLY
CHILDHOOD DEVELOPMENT

EARLY CHILDHOOD DEVELOPMENT PROMOTED IN AFRICA

Following the 2018 launch of the Nurturing Care Framework, 30 countries held activities to strengthen their national strategies in line with the strategic actions proposed. Rapid learning is taking place in the area of health system strengthening in support of nurturing care in east and southern Africa, where work is being carefully documented in countries such as **Ethiopia, Kenya, Mozambique** and **Zambia**. WHO is working with partners to translate experiences into operational guidance for use in other countries.

BETTER HEALTH SERVICES FOR AFRICAN ADOLESCENTS

Three years after the launch of the **Global Accelerated Action for the Health of Adolescents (AA-HA!)**, 36 countries in the African Region are using it to plan, implement and increase access to quality services for adolescents.

In collaboration with partners, WHO is supporting an innovative approach to strengthen district health systems, improve the performance of providers and ensure better access of adolescents to health services in the **Democratic Republic of the Congo** and **Ethiopia**. In **Zimbabwe**, the assessment of health facilities using WHO standards resulted in 309 health facilities being accredited as adolescent-friendly.

WHO is also spearheading innovation in collecting and analysing data on quality health care services for adolescents via a web platform, which has been introduced in two early adopter countries, **Colombia** and **Ghana**.



HEALTHY AGEING GROWING IN PROMINENCE

Political commitment to healthy ageing has dramatically increased across all regions. Case studies in **Chile, China, Finland, Ghana, India, Qatar, Singapore** and **Thailand** are documenting how data and evidence are informing policies and programmes for older adults. **Pakistan** has raised funds for a national project to protect the rights of older persons with disabilities for Afghan refugees.

WHO launched the Integrated Care for Older People (ICOPE), an evidence-based package of tools to help implement a person-centred model of care. Member States in the **African Region**, the **Region of the Americas**, the **South-East Asia Region** and the **Western Pacific Region** have begun adapting the ICOPE tools, engaging in training programmes for health professionals to identify, reverse or slow declines in older adults' physical and cognitive capacities and supporting person-centred goals.

The WHO Global Network for Age-friendly Cities and Communities, which supports local leaders to identify and address barriers to the health and well-being of older people, has expanded to 1000 cities and communities in 42 countries. WHO has launched an online training course for government officials and civil society, entitled Healthy Ageing for Impact in the 21st Century.



DATA AND EVIDENCE ARE INFORMING POLICIES AND PROGRAMMES FOR OLDER ADULTS

ON TRACK TOWARDS A NATIONWIDE LONG-TERM CARE SYSTEM FOR OLDER PEOPLE

In 2018, the Russian Federation launched a multistage pilot scheme to establish a long-term care system for older people, following a national strategy. An estimated 1.8 million people need such services in the Russian Federation.

In 2020, the system will cover 18 territories and the goal is to establish nationwide coverage by 2024.

WHO is applying a multisectoral approach to support the country. A coordinating working group for long-term care was established with the ministries of health, labour and social protection and

other stakeholders. WHO provides technical expertise and convenes meetings of key national and international experts to support the development of the national long-term care system.



IN 2020, THE SYSTEM WILL COVER 18 TERRITORIES AND THE GOAL IS TO ESTABLISH NATIONWIDE COVERAGE BY 2024





**NINE OUT OF TEN PEOPLE
BREATHE POLLUTED AIR,
WHICH KILLS MORE THAN
SEVEN MILLION PEOPLE
PREMATURELY PER YEAR**

NEW STRATEGY ON HEALTH, ENVIRONMENT AND CLIMATE CHANGE

The 2019 WHO global strategy on health, environment and climate change provides a vision and a way forward for responding to environmental health risks. It aims to ensure safe, enabling and equitable environments for health and provide an overall framework to guide action.

A new plan of action on climate change and health in small island developing States raises political engagement, gathers evidence and helps mobilize funding to strengthen the climate resilience of health systems serving some of the most vulnerable and isolated populations in the world.

COUNTRIES COMMIT TO CLEAN AIR

WHO's leadership was crucial in driving forward various environmental commitments in the biennium. At the **United Nations 2019 Climate Action Summit**, 50 countries, representing over 1 billion people, answered WHO's call to provide citizens with clean air by 2030 and committed to achieve the **WHO Air Quality Guidelines** values. This reinforces the commitments of the first **WHO Global Conference on Air Pollution and Health**, held in 2018, at which 26 countries committed to meet WHO air quality guidelines through interventions such as scaling up air quality monitoring and conducting related research.



THE CAMPAIGN
COMBINES **PUBLIC
HEALTH AND CLIMATE
CHANGE EXPERTISE**
WITH GUIDANCE
ON IMPLEMENTING
SOLUTIONS TO AIR
POLLUTION, INCLUDING
INTERSECTORAL
APPROACHES

BREATHELIFE NETWORK GROWS

WHO's **BreatheLife campaign** – which raises awareness around air pollution, its health impacts and effective interventions – continued to grow, reaching 76 locations (mostly cities) impacting nearly 300 million people. The campaign combines public health and climate change expertise with guidance on implementing solutions to air pollution, including intersectoral approaches.

WHO coordinates the BreatheLife campaign with three partners – the Climate and Clean Air Coalition, the United Nations Environment Programme (UNEP) and the World Bank – and works with them to advance implementation of the WHO Air Quality Guidelines by sharing best practices; expanding monitoring efforts; keeping citizens informed through technical support; and providing resources to raise awareness while mobilizing communities to take local action.

WHO SUPPORTS FIRST AFRICAN CITY TO JOIN BREATHELIFE

WHO estimates that every year more than 28 000 people, including over 4000 children under five years of age, die from air pollution in Ghana. The use of polluting fuels for transport and cooking and the burning of uncollected waste and e-waste exacerbate pollution.

Through the WHO Urban Health Initiative, which aims to address the health impacts of air pollution through sectoral policy interventions, Accra became the first African city to join the BreatheLife network. The campaign raised community awareness and built capacity to demand interventions from city authorities on sources of local air pollution.

It has generated significant local media attention. Factories and dumpsites that were major polluters were closed following community action. Air quality monitoring increased from 15 locations to 32 sites.

WHO developed three strategic documents and guidelines using health and economic assessments of sectoral policy interventions: the Accra Resilience Strategy; a climate change action plan to combat the perennial problem of flooding and the impact of climate change; and a new air quality management plan for the Greater Accra Metropolitan Region.

IMPROVING WATER, SANITATION AND HYGIENE SERVICES AT HEALTH CARE FACILITIES

The Seventy-second World Health Assembly adopted resolution WHA72.7 to improve safe water, sanitation and hygiene (WASH) services in health facilities globally, noting that WASH was critical to prevent infections. Currently, 1 in 4 health care facilities lacks basic water services and 1 in 5 has no sanitation services. To date, WHO has received more than 100 commitments from all stakeholder groups to improve WASH in health facilities, including from 30 countries that have already made significant progress to implement their commitments. Action to support existing commitments also continued at the regional levels.



AIR QUALITY

MONITORING INCREASED FROM 15 LOCATIONS TO 32 SITES



100 COMMITMENTS

FROM ALL STAKEHOLDER GROUPS TO **IMPROVE** WASH IN HEALTH FACILITIES

SAFE SANITATION SYSTEMS PREVENT DISEASE AND SAVE LIVES IN INDIA

> 300 000
deaths
and
> 14 m
**disability-adjusted
life years averted**
from eliminating open
defecation
in India

(WHO burden of disease estimates)

and even **greater gains**
will come with **safely
managed services**

2019

WHO/World Bank/ ILO/WaterAid
report launched
to improve conditions
for sanitation workers

sanitation safety
planning scaled up through
training hubs

data and action
for WASH in health facilities
supported by WHO

rapid progress
on ending open
defecation and new
ambition
of safely managed
sanitation services
announced at Mahatma
Gandhi Conference

WHO launches new
**guidelines
on sanitation
and health**
to maximize health
benefits of safe services

2018

Transparent
**analysis of
inputs and
financing
flows**
by Government
of India

WHO **GLAAS**
and **TRACKFIN**
tools used

**Swachh
Bharat**

(clean India)

programme launched
by Prime Minister

> US\$ 20 bn
**invested
domestically**
in rural sanitation

> 100 m
new latrines
to be constructed to end
open defecation in 5
years

2014

> 50%
of all people **defecating
openly** are in India –
437 m people or one third of
all Indians

(WHO/UNICEF report, 2014)



48 COUNTRIES HAVE COMMITTED TO LEGISLATE OR STRENGTHEN CONTROLS ON LEAD PAINT

POWERING UP WITH PARTNERS

Some 48 countries have committed to legislate or strengthen legal controls on lead paint in a project funded by the Global Environment Facility and by WHO, UNEP and other partners, which are working to draft or revise mandatory standards, regulations or laws.

WHO and other members of the United Nations family launched the **Health and Energy Platform for Action** in 2019. The Platform will strengthen political and technical cooperation between the health and energy sectors to accelerate the transition to clean energy, with an initial focus on clean cooking and the electrification of health care facilities.

INCREASING FOCUS ON EQUITY IN HEALTH

Significant work on equity has been done in the European Region. Countries committed to accelerate action to reduce inequities across government sectors and to scale up health sector responses. Premature mortality from noncommunicable diseases among men in the European Region was a main trigger of the **WHO Strategy on the health and well-being of men in the European Region**.

Finally, the **WHO Regional European Health Equity Atlas** was launched to capture country trends and status in the area of health equity, determinants and investment trends, and the uptake and impact of 53 policies.

In the African Region, 21 country teams now have improved skills in barrier assessment of adolescent health programmes to identify disadvantaged adolescents. Actions to improve service coverage among them were supported in **Ethiopia, Nigeria** and the **United Republic of Tanzania**.



21 COUNTRY TEAMS NOW HAVE IMPROVED SKILLS IN BARRIER ASSESSMENT OF ADOLESCENT HEALTH PROGRAMMES TO IDENTIFY DISADVANTAGED ADOLESCENTS

CHALLENGES AND LESSONS LEARNED

Although great progress has been made in reducing maternal and newborn mortality, it is insufficient to meet the global targets of the Sustainable Development Goals. Longstanding problems persist. Pneumonia and diarrhoea are still leading killers of children, while unsafe abortion causes 5–13% of maternal deaths. Most maternal deaths still occur in sub-Saharan Africa.

In addition, women, children and adolescents increasingly face complex challenges, such as the growing burden of chronic noncommunicable diseases and challenges related to inequities, changing demographics and disease patterns. Conflicts can exacerbate health inequalities. Mental illness is associated with a significant burden of morbidity and disability and gender is a critical determinant of mental health. Unipolar depression affects twice as many women as men.

Significantly, poor-quality care is linked to a greater share of excess mortality than lack of access to health services. Therefore, greater attention is required to enhance the effective coverage and quality of care for women, children and adolescents.

KEY FIGURES FOR 2018–2019: PROMOTING HEALTH THROUGH THE LIFE COURSE



Approved Programme budget:
US\$ 384 million



Funds available:
US\$ 318 million
(83% of Programme budget)



Expenditure:
US\$ 292 million
(76% of Programme budget,
92% of available resources)

THE UNDP/UNFPA/UNICEF/WHO/WORLD BANK SPECIAL PROGRAMME OF RESEARCH, DEVELOPMENT AND RESEARCH TRAINING IN HUMAN REPRODUCTION



Approved Programme budget:
US\$ 68.4 million

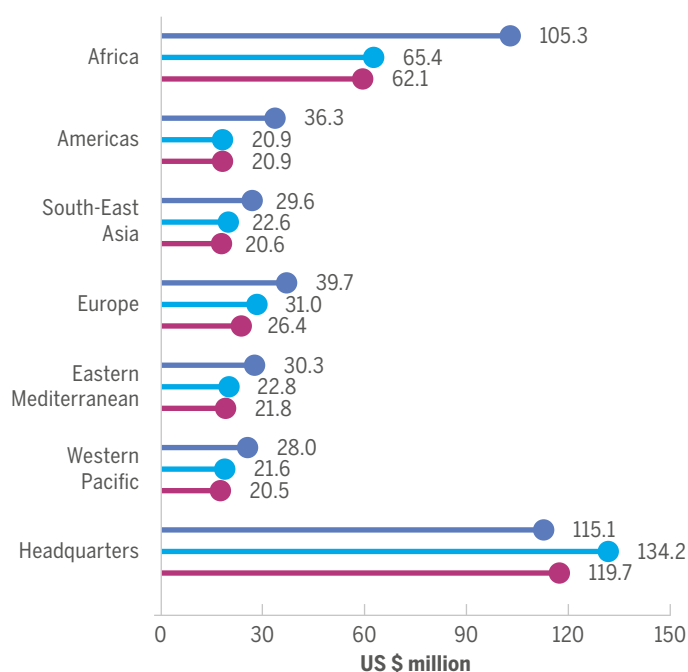


Funds available:
US\$ 89.5 million
(131% of Programme budget)



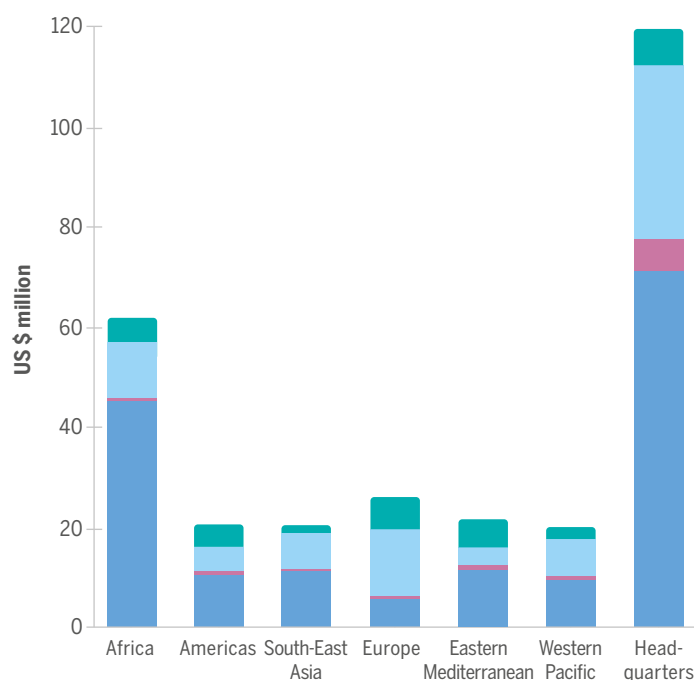
Expenditure:
US\$ 68.3 million
(100% of Programme budget,
76% of available resources)

BASE BUDGET, FUNDS AVAILABLE AND EXPENDITURE, BY MAJOR OFFICE (IN US\$ MILLION)



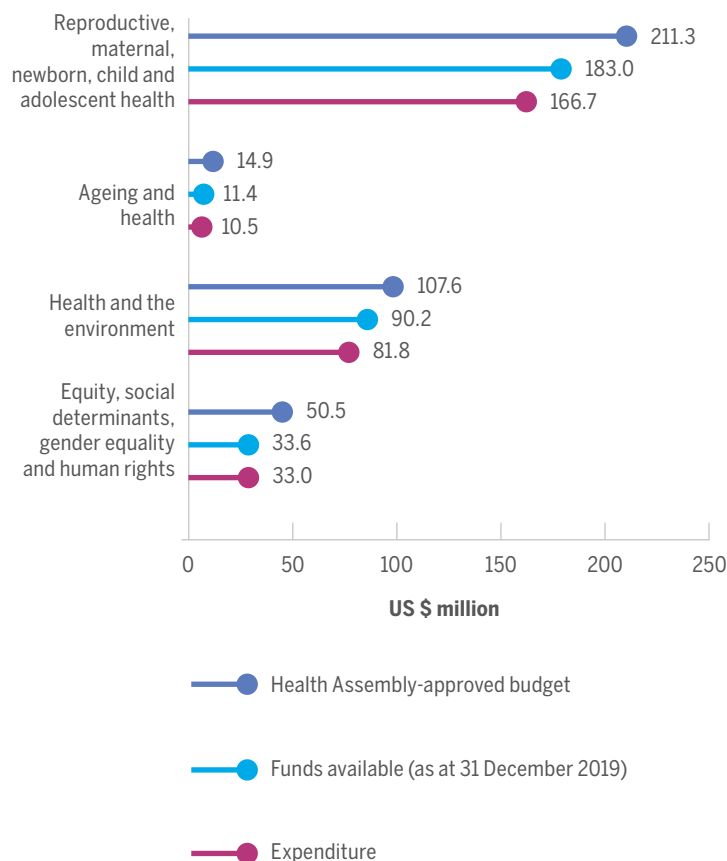
● Health Assembly-approved budget
● Funds available (as at 31 December 2019)
● Expenditure

PROGRAMME BUDGET EXPENDITURE BY MAJOR OFFICE AND PROGRAMME AREA (IN US\$ MILLION)

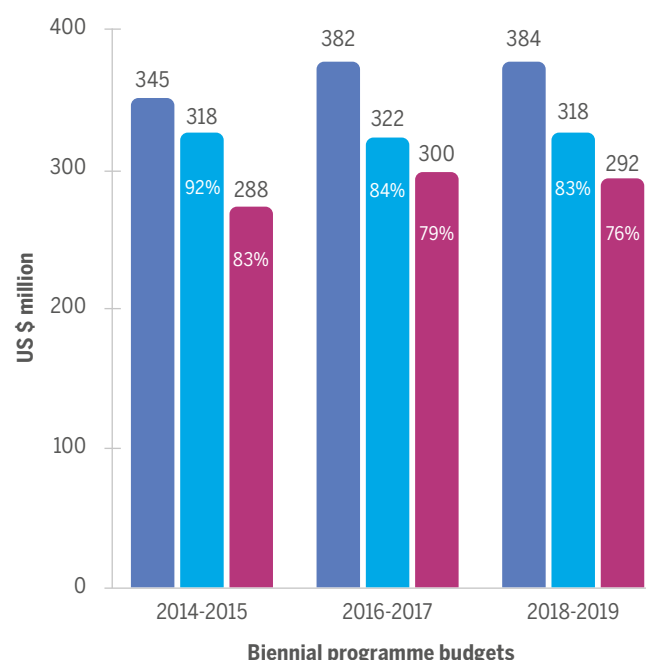


■ Reproductive, maternal, newborn, child and adolescent health
■ Health and the environment
■ Ageing and health
■ Equity, social determinants, gender equality and human rights

BASE BUDGET, FUNDS AVAILABLE AND EXPENDITURE, BY PROGRAMME AREA (IN US\$ MILLION)



COMPARISON OF 3 BIENNIAL BASE PROGRAMME BUDGETS UNDER THE TWELFTH GENERAL PROGRAMME OF WORK (IN US\$ MILLION)



* Percentage indicates as % of approved programme budget

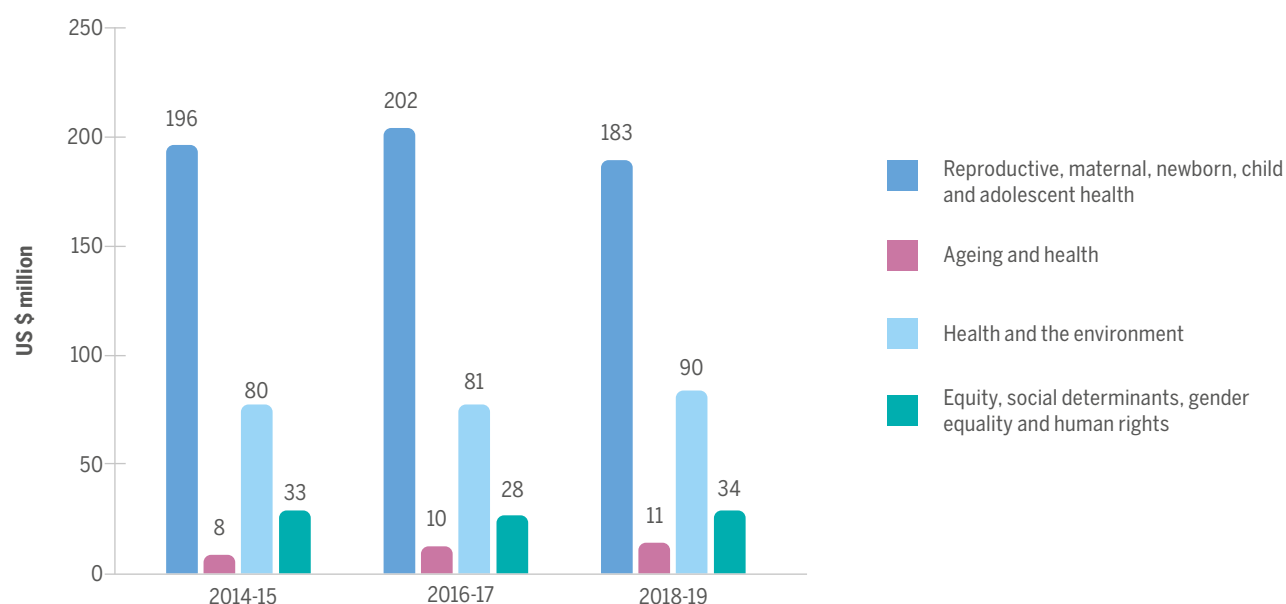
In 2018–2019, the Promoting health through the life course category had a global funding level of 83% compared to its approved budget of US\$ 384 million. Together with the Noncommunicable diseases and Health emergencies categories, it was the lowest-funded category in the base programme budget.

The lower level of funding was partly explained by the fact that the increased budget level of this category was not matched by increased donor commitment: although the budget increased by 11% between 2014–2015 and 2018–2019, funding remained at the same level in absolute terms at the category level.

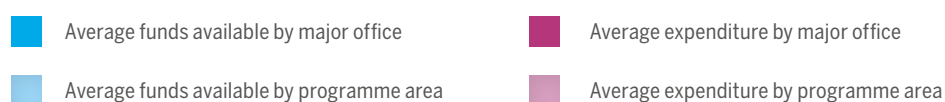
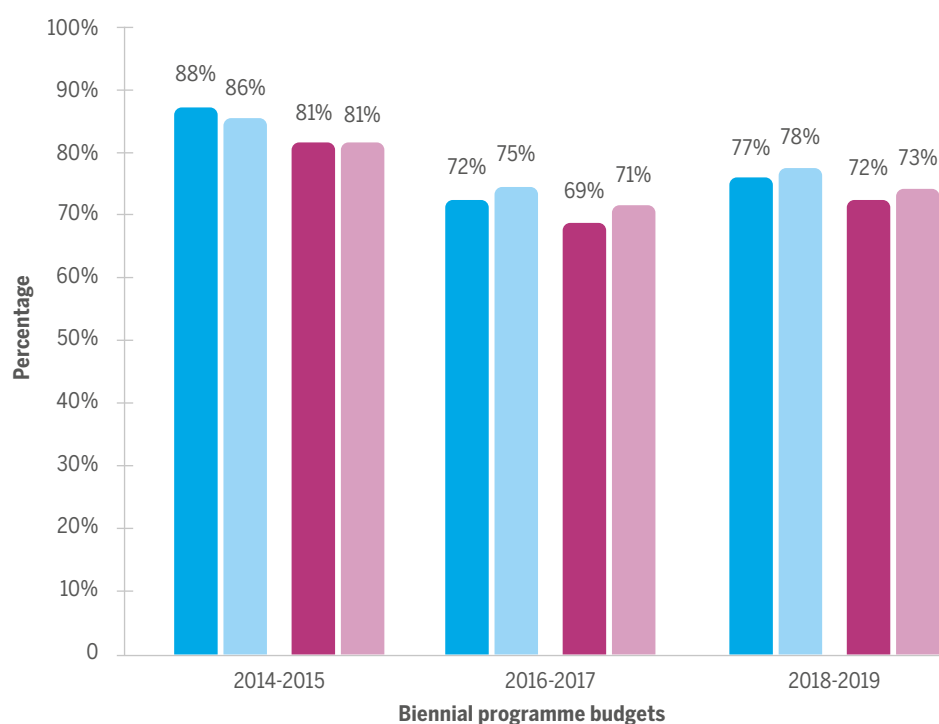
At a more detailed level, the funding of most programme areas remained at the same level over the past three bienniums, with the exception of the Reproductive, maternal, newborn, child and adolescent health programme area, which decreased significantly from 2016–2017 to 2018–2019 as a result of the non-extension of a major grant of US\$ 25 million targeting several countries of the African Region. This highlighted once again the vulnerability of WHO's dependence on only a few major donors.

To compensate for the insufficient voluntary funding of the category, the Secretariat prioritized the Promoting health through the life course category in its distribution of flexible funding, allocating it the second largest share of flexible funds among technical categories. The level of financing from the flexible and thematic funds increased in 2018–2019 by more than 7% compared with 2016–2017, which allowed the financing of this category to be sustained at the same level in absolute terms.

AVAILABLE FUNDING ACROSS 3 BIENNIAL BASE PROGRAMME BUDGETS UNDER THE TWELFTH GENERAL PROGRAMME OF WORK, BY PROGRAMME AREA (IN US\$ MILLION)



COMPARISON OF 3 BIENNIAL BASE PROGRAMME BUDGETS UNDER THE TWELFTH GENERAL PROGRAMME OF WORK



Despite efforts to finance the Promoting health through the life course category with a larger share of flexible funds, the uneven funding distribution pattern within this category has not been fully addressed. In 2018–2019, the funding levels of regional offices ranged between 60% and 78%, while at headquarters it was 117%. The disparity in funding was partly attributable to the different scope of work delivered by headquarters and the regional offices. The headquarters budget in this category contained a significant component of research in the Reproductive, maternal, newborn, child and adolescent health programme area, which was well funded and was performed solely at headquarters. Indeed, the largest share of expenditure at headquarters was in this programme area, representing about 40% of available funds and expenditures. There is a need to continue efforts to adequately finance all areas of the Promoting health through the life course category, with particular attention to regional and country levels, which cannot be accomplished exclusively through corporate flexible funds.

On the positive side, although the financing of the regional offices was low, it was better aligned between the regional offices in 2018–2019 than in the previous bienniums of the Twelfth General Programme of Work. There was also a better alignment of financing among programme areas. The implementation of the approved budget 2018–2019 was at a similar level for all regional offices, while the implementation of available funding was more than 90% for all major offices.

For further details on the Programme Budget funding, implementation for this category and achievements by programme areas including indicators, please refer to the WHO Programme Budget Portal (<http://open.who.int/2018-19/our-work/category/03/about/programme-outcomes> and <http://open.who.int/2018-19/home>).

LEADERSHIP AND ENABLING FUNCTIONS

In 2018–2019, **MORE THAN 70%** of WHO's contributions were specified. WHO needs to increase its funding flexibility

MOPAN assessment reports that capacity and capability are not even across countries and not always adequate to meet needs

WHO has to mobilize **US\$ 14.1 BILLION** over 2019–2023 to finance the implementation of GPW13

In 2018–2019, 80% of total contributions to WHO came from **20 DONORS ONLY**. WHO needs to broaden its donor base

12 MULTILATERAL HEALTH, development and humanitarian agencies signed **THE GLOBAL ACTION PLAN FOR HEALTHY LIVES AND WELL-BEING FOR ALL** to accelerate the implementation of the health-related Sustainable Development Goals

35 MILLION PEOPLE WHO provided with essential medicines and medical supply at hospital facilities in 2018–19

15 MILLION PEOPLE WHO provided with Noncommunicable diseases kits to manage the most commonly encountered NCDs in primary health care in emergency settings in 2018–19

All **193 UNITED NATIONS MEMBER STATES** are unified on a common and comprehensive commitment to achieve universal health care

19 MILLION PEOPLE WHO reached with a package of essential medicines to treat the most common diseases at primary health care level in emergency settings in 2018–19

Percentage of **WHO FEMALE STAFF HOLDING** long-term appointments as international professional staff has increased from **40%** in 2010 to **46%** in 2019

WHO's **COUNTRY-LEVEL BUDGET INCREASED** from 39% in 2018–2019 to 44% for 2020–2021



Approved Programme budget:
US\$ 716 million



Funds available:
US\$ 712 million
(99% of Programme budget)



Expenditure:
US\$ 691 million
(97% of Programme budget,
97% of available resources)



"I envision a world in which everyone can live healthy, productive lives, regardless of who they are or where they live. Achieving this vision will require a strong, effective WHO – fit for the 21st century – that belongs to all, equally. We need a WHO that is efficiently managed, adequately resourced and results-driven."

DR TEDROS ADHANOM GHEBREYESUS
WHO Director-General



WHO HAS **STRENGTHENED ITS VOICE**, ADVOCATING FOR ACCELERATED PROGRESS ON KEY HEALTH ISSUES

A NEW BRAND OF LEADERSHIP

Through the leadership of the Director-General, supported by the Regional Directors, WHO has strengthened its voice, advocating for accelerated progress on key health issues, including universal health coverage, global health security, implementation of Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages), antimicrobial resistance and other issues. WHO has elevated its health diplomacy to the highest levels of government at national and global levels and in regional political bodies, such as the G20, the G7 and the African Union, resulting in concrete commitments to promoting the health agenda within and beyond the health sector.



AT THE **UNITED NATIONS GENERAL ASSEMBLY** IN SEPTEMBER, WORLD LEADERS ADOPTED THE HISTORIC POLITICAL DECLARATION ON **UNIVERSAL HEALTH COVERAGE**

WHO'S LEADERSHIP IN ACTION

2019 was a landmark year for WHO's key priority of universal health coverage. At the United Nations General Assembly in September, world leaders adopted the historic political declaration on universal health coverage, calling on countries to accelerate efforts to fulfil their commitments to realize universal health coverage and the other health-related targets in the Sustainable Development Goals. For the first time, all 193 United Nations Members are unified around a common and comprehensive commitment.

WHO leadership played a key role at the Inter-Parliamentary Union Assembly in 2019, at which legislators from 140 countries adopted a comprehensive resolution on universal health care. They pledged to leverage the power of parliaments to translate political commitment into laws, policies, programmes and results.

To demonstrate WHO's diplomacy in action, WHO was able to advance health on the global agenda at the G20 summit held in Japan in June 2019. For example, during the recent Japanese presidency of the G20, Japan convened the first joint meeting of G20 ministers of health and ministers of finance. The G20 Health and Development Partnership issued a call to action, recommending investing in health innovation and delivering Sustainable Development Goal 3 and universal health coverage by 2030 through stronger collaboration among G20 health and finance ministers. It reinforced the need for the wealth and health of nations to be united in delivering inclusive economic growth and social equity among G20.

WHO's leadership focus has widened during the last two years. While continuing to strengthen partnerships with health ministries, WHO has stepped up engagement with other sectors, including the agriculture, development, foreign affairs and finance sectors. It has embraced a whole-of-government and all-of-society approach to raise health high in the agenda.

THE NEW STRATEGY TO DELIVER IMPACT TO PEOPLE

WHO's new strategic plan, the **Thirteenth General Programme of Work 2019–2023 (GPW 13)** was endorsed by the Health Assembly in May 2018.

GPW 13 clearly articulates WHO's mission to promote health, keep the world safe and serve the vulnerable. It is structured around three interconnected strategic priorities for 2019–2023: achieving universal health coverage addressing health emergencies, and promoting healthier populations. These priorities are linked to the bold triple billion targets and supported by three strategic shifts: stepping up WHO leadership, driving public health impact in every country and focusing on global public health goods. GPW 13 also outlines the organizational shifts that are needed to ensure that WHO is fit-for-purpose to pursue the ambitious triple billion targets.

COMMUNICATIONS: HAND IN GLOVE WITH LEADERSHIP

Effective communications go hand in glove with effective leadership. WHO has made a significant investment to meet the growing need for information, advice and guidance for its key audiences and is strengthening its public voice, to advocate and deliver on WHO's mission.

The **WHO Strategic Communications Framework** describes an approach to establishing effective, integrated and coordinated communications so that WHO information, advice and guidance are shared across a broad range of health issues. WHO's communications have been strengthened to focus on making evidence-based public health messages accessible, relevant, timely and understandable – targeting decision makers, health workers, care providers and the public.

NEW PLATFORMS TO REACH A BROADER AUDIENCE

WHO's presence on social media – Twitter, Facebook and LinkedIn – has grown significantly over the biennium, with close to 6 million followers on both Twitter and Facebook and now almost 0.5 million followers on a new platform, TikTok. WHO's public health experts worldwide frequently engage with audiences through interviews and briefings on Facebook Live, while the Director-General was personally communicating with more than 1 million followers on Twitter with the handle “Dr Tedros”. The WHO website, which provides universal access to WHO's global public health goods and information products, received more than 600 million visitors over the biennium.

WHO'S BOLD TRIPLE BILLION TARGETS:

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



CLOSE TO **6 MILLION FOLLOWERS** ON BOTH TWITTER AND FACEBOOK AND NOW ALMOST 0.5 MILLION FOLLOWERS ON A NEW PLATFORM, TIKTOK

PARTNERING FOR IMPACT

WHO's strength lies in harnessing the capacities of different partners and bringing them together to achieve health impacts. During the biennium, WHO utilized innovative ways of partnering.

Stronger collaboration, better health: global action plan for healthy lives and well-being for all was launched on 24 September 2019 at the United Nations General Assembly. The global action plan was coordinated by WHO to deliver better and more streamlined support to countries over the next 10 years and accelerate progress towards universal health coverage and the implementation of the health-related Sustainable Development Goals. Responding to a call by Germany, Ghana and Norway, with support from the United Nations Secretary-General, WHO brought together 12 multilateral health, development and humanitarian agencies as signatories to the global action plan.

WHO continues to build global momentum to tackle **antimicrobial resistance**. Significant steps taken include a joint tripartite workplan, aligned roadmap and a Memorandum of Understanding signed by WHO, the Food and Agriculture Organization of the United Nations and the World Organisation for Animal Health. In addition, a funding vehicle, the Antimicrobial Resistance Multi-Partner Trust Fund, has been established through 2024 to catalyse action at the national level.

Innovative health partnerships are frequently needed to widen WHO's reach of work and influence. One such example is the partnership with soccer's world governing body, **FIFA**. Announced in October 2019, the two global bodies will collaborate on projects targeting children and young adults in order to empower these groups to lead an active and healthy life.

WHO is amplifying norms and standards via new technology. **Google Fit**, an application monitoring physical activity, was developed jointly by WHO and Google to incorporate two activity goals based on WHO's physical activity recommendations – measuring physical movement (move minutes) and assessing fitness (heart points).

WHO is proactively promoting collaboration, mobilizing partnerships and encouraging the efforts of different health actors to respond to national and global health challenges. These engagements are being pursued to support Member States' efforts and fulfil the Organization's mandate. They have been reviewed and implemented in accordance with WHO's policies and rules, including the **Framework of Engagement with Non-State Actors**. This provides a firm basis for strengthening engagement and helps balance risks against expected benefits, while protecting and preserving WHO's integrity, reputation and public health mandate.





THE STRATEGY'S 4 PILLARS

- **EMPLOY** TAILORED APPROACHES TO GROW, DIVERSIFY AND PROTECT FUNDING FROM GOVERNMENT DONORS
- **BUILD** EFFECTIVE PARTNERSHIPS AND GROW FUNDING FROM PHILANTHROPIC DONORS
- **PROTECT** AND GROW FUNDING FROM FUNDS, BANKS, AND MULTILATERALS
- **EXPLORE** AND EXPLOIT FUNDING POTENTIAL OF REVENUE

BIGGER, MORE FLEXIBLE AND PREDICTABLE FINANCING FOR GPW 13

Implementing the new vision of GPW 13 requires innovative ways of engaging contributors and mobilizing financing. The Secretariat has made substantial efforts to review its processes for contributor engagement and to mobilize resources to match the new vision, strategy and organizational shifts.

Many enhancements have been made based on reviews, including with respect to partner engagement teams, tailoring engagement with the funding profiles of contributors; integrated contributor engagement plans; and options for contributors to provide direct funding.

As a result, WHO has seen a higher level of flexibility in funding and greater predictability.

The new **resource mobilization strategic framework for 2019–2023** was developed in 2019 for presentation to the Executive Board in January 2020. The strategy aims to innovate how WHO is mobilizing resources.

The Secretariat is also investing in the **Contributor Engagement Management** system to better manage the end-to-end resource mobilization and grants management process. The use of the new system is expected to begin by the end of 2020.

DRIVING IMPACT IN EVERY COUNTRY

Every effort to strengthen leadership, innovate partnerships and redesign processes is geared towards driving impact in countries. The development of the Programme budget 2020–2021 immediately operationalized the “country impact first” principle. The WHO planning process was redesigned to achieve this objective. Process innovations were introduced, including the integrated country support plans, which consolidated support at all levels of the Organization for one purpose – helping countries to deliver on their priority health outcomes. The other important innovation is the prioritization of the global public health goods. The **country support plans** informed the development of WHO’s first-ever list of global public health goods to be developed during the biennium to meet the needs of Member States.

STRENGTHENING WHO FIT TO DELIVER AT COUNTRY LEVEL

The ultimate test of a country-focused strategy is whether the Organization has the right capacity on the ground to effectively identify needs, deliver support and make the best use of the resources available to deliver results at the country level.

As one of the first steps to achieve this objective, WHO’s regional offices launched **functional reviews** – a structured methodology to assess how to best align WHO’s workforce at the country level to the health situation, needs, priorities and strategic direction.

Functional reviews were completed in 47 country offices in the African Region and 17 country offices in the Eastern Mediterranean Region, while the South-East Asia Region completed programmatic and administrative reviews in all 11 country offices. The European and Western Pacific regions carried out reviews of management and administrative and programmatic functions as part of a continuous improvement process. These reviews informed planning for stronger country offices, with adaptations to the priorities and needs of host Member States and the partner community.

The functional reviews highlighted the critical need and direction for revamping country office capacities to implement GPW 13 and deliver on WHO's normative and leadership roles. They also led to realignment of the workforce and the identification of concrete resource gaps.



AFRICAN REGION
all 47 country offices
Functional reviews



EASTERN MEDITERRANEAN
17 country offices
Functional reviews



EUROPEAN REGION
6 country offices
Management and administration reviews



SOUTH-EAST ASIA REGION
all 11 country offices
Programme and administration reviews



WESTERN PACIFIC
15 country offices
Management and programmatic reviews

"THE TWO-WEEK FUNCTIONAL REVIEW WORKSHOP WAS AN EXCELLENT OPPORTUNITY TO **STRENGTHEN THE INTERNAL MANAGEMENT SYSTEM**, REFLECT ON WHO COUNTRY OFFICE INTERNAL STRENGTHS AND ADDRESS THE CONCERNS AND RECOMMENDATIONS OF DONORS AND HEALTH PARTNERS IN THE COUNTRY. WE MANAGED TO DEVELOP AN INVESTMENT CASE AND REPOSITION WHO TO **COMMUNICATE BETTER.**"

WHO Representative,
United Republic of Tanzania



IN ITS ASSESSMENT, WHICH WAS CONCLUDED IN 2019, **MOPAN GAVE WHO A HIGHLY SATISFACTORY OR SATISFACTORY RATING FOR ALL 12 KEY PERFORMANCE INDICATORS**. KEY WHO STRENGTHS INCLUDE: A CLEAR LONG-TERM VISION THAT IS ALIGNED WITH GLOBAL DEVELOPMENT GOALS; ITS UNIQUE ROLE IN PROVIDING NORMATIVE GUIDANCE IN ADDITION TO TECHNICAL EXPERTISE AND ENGAGEMENT; AND ITS ABILITY TO BRING DECISION-MAKING CLOSER TO COUNTRIES

TRANSFORMING WHO FOR BETTER DELIVERY

WHO has embarked on an ambitious transformation process. During the biennium, the transformation initiative focused on the internal functioning of the Secretariat driven towards the delivery of the triple billion targets. The transformation objectives consist of: (i) optimizing and harmonizing core WHO processes, (ii) developing and implementing a new WHO-wide operating model, (iii) establishing a new approach to partnerships, and (iv) promoting an impact-focused, collaborative and agile culture.

Transformation highlights for 2018-2019:

- **GPW 13** – a new WHO strategy with a clear mission
- **Programme budget 2020–2021** - starts with country-driven country support plans, thereby gearing all of WHO to help countries achieve impact; prioritizes global public health goods; and pushes the Organization to adopt an integrated results framework.
- **13 redesigned core processes** - harmonized across three levels, they cover (i) six technical functions (norms and standards, research, policy dialogue, data, innovation and technical cooperation); (ii) three external relations functions (resource mobilization, external communications and internal communications); and (iii) four business functions (planning and budget, supply chain, recruitment and performance management).
- **New WHO-wide operating model** - realizes the vision of working seamlessly to deliver GPW 13 and align all major offices to four common pillars (programmes, emergencies, business operations and external relations).
- **New structure aligned across the major offices** - 75 WHO country offices have had functional reviews in three regions (Africa, South-East Asia and Eastern Mediterranean).

The implementation of the **new integrated results framework and measurement system** helps strengthen information systems and data in countries to guide decisions, solve issues and better support WHO to deliver impacts in countries. The GPW 13 output scorecard, a significant innovation in monitoring, allows every office to track performance.

DELIVERING THE NORMATIVE AND DATA PRODUCTS THAT THE WORLD NEEDS

The first-ever structured prioritization of global public health goods led to the identification of 329 normative and data products that WHO will deliver to achieve health impacts.

The aim is to deliver global public health goods based on the best available evidence and in ways that will deliver impacts to benefit people's health. The initiative involves:

- putting in place a rigorous process for prioritizing norms and standards and data products to be produced by WHO, with the prioritization based on clearly-articulated needs in countries, mandates from Health Assembly resolutions and emerging strategic needs
- putting in place a quality assurance mechanism to ensure that products are delivered based on the best available evidence and the resources required
- aligning the delivery of norms and standards and data products produced across the three levels of the Organization in line with roles and responsibilities to avoid duplication.

OUTPUT SCORECARD: INNOVATION IN MEASURING PERFORMANCE

The Secretariat is making a bold shift in measuring its accountability for results. Instead of measuring a single dimension through the usual set of indicators, the GPW 13 output scorecard will measure performance assessing six dimensions: (1) effective delivery of leadership in health; (2) effective delivery of global public health goods; (3) effective delivery of technical support to countries; (4) integration of gender, equity and human rights; (5) delivering value for money; and (6) achieving results in ways leading to impacts.

Measuring results across these six comprehensive dimensions will allow WHO to make a more holistic assessment of its performance. This will be applied to the performance assessment at the end of 2020.

The scorecard will be used by different offices and teams to track progress and identify issues early on, enabling timely decisions to improve performance.



PRIORITIZATION OF **GLOBAL PUBLIC HEALTH** GOODS LED TO THE IDENTIFICATION OF **329 NORMATIVE AND DATA PRODUCTS** THAT WHO WILL DELIVER TO ACHIEVE HEALTH IMPACTS.



EFFORTS WERE MADE TO FIGHT AGAINST SEXUAL EXPLOITATION AND ABUSE. A NEW **POLICY ON SEXUAL HARASSMENT** IS BEING DEVELOPED AND A COMMUNICATIONS STRATEGY WAS DEVELOPED IN 2018 TO RAISE AWARENESS AMONG ALL STAFF, COLLABORATORS, DONORS AND BENEFICIARY POPULATIONS

DELIVERING WITH HIGH STANDARDS OF ACCOUNTABILITY AND INTEGRITY

In recent years, significant gains have been made to improve accountability within the Organization. The 2017–2018 report of the Multilateral Organization Performance Assessment Network (MOPAN) on WHO recognized this progress. The structures, mechanisms, rigorous standard operating procedures, policies and plans that have been put in place have contributed to this progress. These improvements are ensuring not only that the Organization is better focused on achieving targets but also that it has the means to track and assess whether the targets are being in full compliance with the rules, regulations, policies and legal parameters within which it operates. Systems to ensure evaluation, compliance and audit, as well as investigation and legal functions, are well established and have operational independence. The Ombudsman's role, ethics and investigation functions aim to ensure that WHO's management and staff undertake their work with the highest standards of professional and ethical conduct.

The establishment of a process to begin to anchor organizational learning, taking into consideration the consolidated findings and recommendations of different audit, evaluation and review exercises, was a major step forward for the Organization.

Those functions have combined to address all facets of accountability – accountability for results; accountability for resources; accountability for adherence to the various normative standards that define the Organization's work in pursuit of these results; and ultimately accountability to the people of the world. These help WHO to focus not only on delivering results but on delivering them while upholding its **core values**.

MANAGING RISKS TO DELIVERY RESULTS

The successful implementation of GPW 13 requires a fit-for-purpose risk management approach. WHO is in the process of defining an enhanced and more ambitious **enterprise risk management** approach. In 2019, a concept note was developed that aims to strengthen the Organization's risk culture while ensuring that risk management is effectively embedded in the accountability mechanisms for delivering results.

WHO values charter

Our values
Our DNA



Trusted to serve public health at all times



Professionals committed to excellence in health



Persons of integrity



Collaborative colleagues and partners



People caring about people

EVOLVE, ENABLE, SIMPLIFY: NEW FOCUS OF MANAGEMENT AND ADMINISTRATION

Management and administration works to achieve the same mission of WHO and the same triple billion targets by making the Organization as effective and efficient as possible to carry out its core mandates.

A significant amount of improvements and innovations were made in 2018–2019, based on routine assessments and reviews and audits, continuous improvement efforts and transformation initiatives in the area of management and administration. Improvements during the biennium in the area of management and administration have been driven by the Organization's emphasis on evolving, enabling and simplifying in order to strengthen its capacity for better delivery.

TURNING WHO INTO AN EFFECTIVE OPERATIONAL AGENCY IN EMERGENCIES

Procurement and logistics under very challenging situations

WHO procurement confronted another challenging biennium, during which the workload of global requests increased by 18% due to increased demands in emergencies. The total amount of goods procured was estimated at US\$ 502 million, driven by 22 697 purchase orders. The total procurement of services was estimated at US\$ 1.57 billion, driven by 61 537 purchase orders and 7392 global shipments. The bulk of the workload increased threefold in the last quarter of the biennium. Despite these challenges, WHO's Global Procurement and Logistics harnessed its dedicated workforce to manage the surge. A clear example of this was the zero stock-out during the successful response to the Ebola outbreak in the Democratic Republic of the Congo despite the challenging operational conditions.

DUBAI HUB GETTING THE RIGHT PRODUCTS, TO THE RIGHT PLACE, AT THE RIGHT TIME

29 shipments to 9 countries

Medicines, medical devices, stationary and guidelines that comprise the **Interagency Emergency Health Kit**

268
metric tonnes

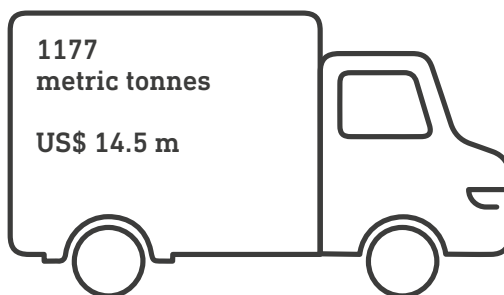


125 shipments to 21 countries

Additional items responding to cardiovascular diseases and mental health

1177
metric tonnes

US\$ 14.5 m



2015

- unpredictable closures of ports, routes and warehouses
- managing funding with short validity

2016–2017

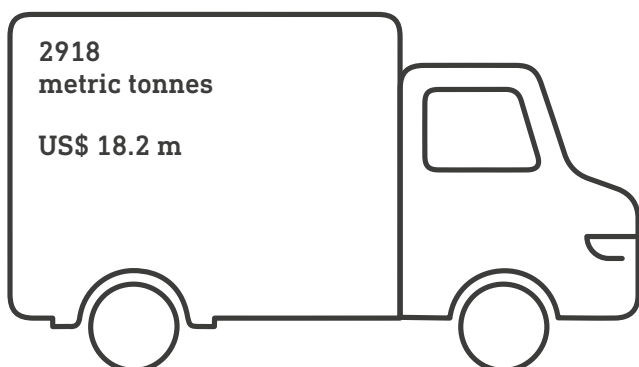
- need for temperature-controlled storage for perishable medical products
- complex environment, e.g. 125 check points between border of Oman and Yemen

179 shipments to 26 countries

Additional items including ambulances, mobile clinics, generators and also the recently prequalified Ebola vaccines

2918
metric tonnes

US\$ 18.2 m



Response to emergencies, including:



drought in
Afghanistan
and Pakistan



cyclone in
Mozambique,
Malawi & Zimbabwe



cholera
outbreak
in Yemen



humanitarian
emergency in Venezuela
(Bolivian Republic of)

2018–2019

- standardized shelf-life acceptance and shipping documents worldwide
- reduced cost replacing air transport with cold chain on ground with live monitoring of temperature and GPS – down to –80 °C for Ebola vaccine
- increased capacity enables rotation of stocks between emergencies to repackaging essential kits and reduce lead times

CHALLENGING EMERGENCY PROCUREMENT FOR YEMEN

The situation in Yemen required the largest and most challenging emergency procurement operation in a conflict zone. Faced with the challenge of internal conflicts, the fragmentation of government, unexpected closures and hijacks of ports, routes and warehouses and short-term funding, WHO had to overcome a number of overwhelming procurement challenges.

In 2019, Global Procurement and Logistics worked closely with regional and country offices to standardize shelf-life acceptance and shipping documents. Weekly pipeline meetings with the Yemen WHO country office were held. A dedicated tracking tool was implemented to enhance pipeline visibility. In August 2019, a supply chain working group was formed in Dubai to coordinate efforts to maximize the use of the Dubai

hub. The end-result was that 1005 confirmed shipments, responding to 1138 purchase orders and worth US\$ 113.7 million, were delivered to Yemen with an acceptable and useful shelf-life.

This the equivalent of 22.6% of the total value of WHO goods procured during the biennium.

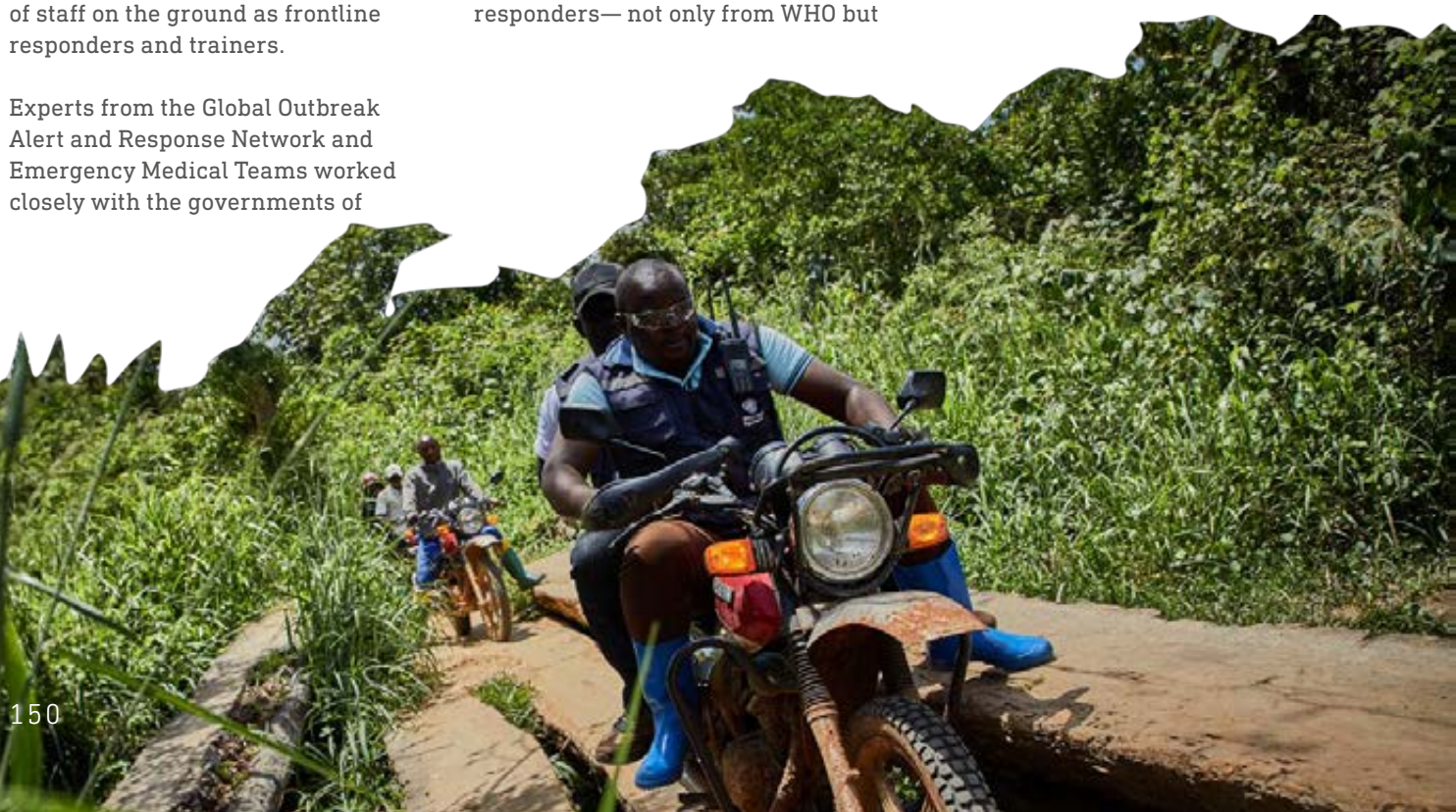
PUTTING BOOTS ON THE GROUND

The Ebola outbreak that began in the Democratic Republic of the Congo in August 2018 was one of the most complex and dangerous outbreaks. Despite the high security threats, WHO deployed hundreds of staff on the ground as frontline responders and trainers.

Experts from the Global Outbreak Alert and Response Network and Emergency Medical Teams worked closely with the governments of

the Democratic Republic of the Congo and neighbouring countries to strengthen their operational readiness to detect and respond to imported cases. WHO was able to maintain sufficient numbers of responders— not only from WHO but

also from the Government, partners and the local population. WHO was able to mobilize and keep safe 630 high-performing staff to support the response to the Ebola outbreak.



IT enabling preparedness and response

The digital landscape of the WHO Health Emergencies Programme has undergone continuous improvements in the past three years. Working closely with a dedicated team within the **Incident Management Team**, the WHO Health Emergencies Programme has developed a strategic portfolio of effective digital management tools.

Go.Data is an outbreak investigation tool for field data collection during public health emergencies. The tool, which is adaptable to a wide range of outbreak scenarios, includes functionality for case investigation, contact follow-up and the visualization of chains of transmission. It is managed by the Global Outbreak Alert and Response Network and is used by outbreak responders to investigate diseases with human-to-human spread such as Ebola, SARS and COVID-19. **Albania, Bangladesh, Democratic Republic of the Congo, France** and **Uganda** have deployed the Go.Data tool.

e-SPAR provides an easy and standardized way for States Parties to perform the self-assessments and annual reporting required under the International Health Regulations (2005). Information received via e-SPAR enables stakeholders to make fact-based risk assessments during health emergencies. Launched in June 2019, it resulted in the highest reporting (93%) of self-assessments – 183 of the 196 self-assessments submitted by States Parties.

EMS2 is a system that provides seamless, timely and actionable information flows across and between all actors working in the health emergency management cycle. A unique characteristic is its ability to upgrade and integrate existing emergency management systems.

Staff health and well-being first

Based on lessons learned from the 2014 Ebola outbreak, **Staff Health and Wellbeing** took its professionalism to the field in order to protect and promote the health, safety and well-being of those involved in the Ebola response. Staff health and well-being personnel from headquarters and the African Region were deployed to the **Democratic Republic of the Congo** to establish a vaccination clinic, conduct health risk assessments, visit and evaluate health care facilities and deliver training. WHO conducted:

- 1412 vaccinations against rabies, typhoid, hepatitis A and B, diphtheria pertussis tetanus (DPT), measles, mumps and rubella (MMR), yellow fever and meningitis
- 22 non-Ebola and two Ebola medical evacuations
- 2239 primary health care consultations and 2648 psychosocial sessions
- distribution of more than 500 travel medical kits and 390 mosquito nets to personnel.



**“THE MOST
IMPORTANT
ASSET OF THE
ORGANIZATION IS
ITS STAFF”**

Dr Tedros Adhanom
Ghebreyesus,
WHO Director-General



THE PERCENTAGE OF WOMEN HOLDING LONG-TERM APPOINTMENTS IN THE PROFESSIONAL AND HIGHER CATEGORIES INCREASED **FROM 44.4% IN 2017 TO 45.4% IN 2018**

A MOTIVATED AND FIT-FOR-PURPOSE WORKFORCE

The commitment to build a motivated and fit-for-purpose workforce resulted in the introduction of new career and development opportunities for staff and the establishment of a new and expanded **Human Resources and Talent Department**.

One Organization – One workforce

The **Short Term Developmental Assignment**, a policy that WHO started implementing in 2018, aims to provide opportunity for staff exchanges across WHO. It allows the Organization to share its workforce by supporting units and teams to fill temporary gaps and address sudden surges in work demands. It provides an opportunity for staff to obtain on-the-job development in another level, office or team. It is an effective staff development mechanism and promotes a dynamic workforce continuing to learn and to exchange ideas. After just over a year of implementation, about 125 staff have been deployed through this mechanism.

Strength in diversity

Building the capacities of female staff members at junior levels so that they can aspire to higher managerial positions is a human resource strategic priority of the Organization. Outreach initiatives have been implemented in collaboration with Member States, including in the African and Western Pacific regions. Efforts are also being made through career counselling, mentorship and leadership pathway programmes.

INVESTING IN FUTURE LEADERS IN HEALTH

WHO Academy

WHO Academy, a unique virtual learning hub, is hosted in Lyon. The WHO Academy is being developed to support the learning and development needs of WHO staff and stakeholders to progress towards WHO's "triple billion" targets. The Academy aims to reach 10 million people by 2023 via a state-of-the-art digital learning experience platform embedded in the six WHO regions. It will feature high-tech learning environments, a world-class health emergency simulation centre and collaboration spaces for learning co-design, research and innovation.

Global Internship Programme

The WHO Global Internship Programme is building future leaders in public health through professional training and capacity-building opportunities across the Organization.

Supported by the Health Assembly through resolution WHA71.13 of 26 May 2018, the Organization has changed its approach to internship. It has established a centralized and transparent process aimed at selecting the most deserving interns, regardless of their country of origin, and promoting gender equity. This entailed revamping

the selection process and providing financial support. Interns are now provided with medical insurance, lunch vouchers in the most expensive duty stations and, from 2020, living allowances if needed.

The percentage of interns from low and middle-income countries increased to about 30% in 2019 overall, with an increased number of interns in headquarters raising that average even higher.



THE NUMBER OF WOMEN
HOLDING SENIOR POSITIONS
AT HEADQUARTERS
INCREASED **FROM 37% IN
2017 TO 41% IN 2018**

The implementation of the **EMERGE** programme at 13 Geneva-based United Nations agencies has been an innovative initiative to tap into the leadership potential of female staff members within the United Nations system by developing a deeper understanding of the inter-connections between sex, gender, culture and leadership. It enables female staff to draw on networks and cultivate strong connections with peers from across the United Nations system to help address challenges affecting their performance and career development.

CHALLENGES AND LESSONS LEARNED

To implement GPW 13 and attain the health-related Sustainable Development Goals, WHO needs to become an Organization that is fit-for-purpose in the 21st century and that works seamlessly across its programmes major offices and three levels to make a measurable improvement in the health of all people. WHO must ensure the technical excellence that results in improvements in health in order to help all people to achieve healthy and productive lives, no matter who they are or where they live. The world needs a WHO that is clearly focused on driving impact in every country.

To achieve this, WHO is continuing to transform by pursuing fundamental changes to reposition, reconfigure and capacitate the Organization. Within the broader purview of United Nations reform, this includes ensuring that its normative and technical work is of an even higher quality, is more clearly focused on the needs, demands and expected actions of Member States and translates directly into results at country level.

While WHO continues to be challenged, it also has mechanisms in place to learn lessons. WHO is changing, but it needs to do so even more boldly. Globally and in many countries, WHO is improving its leadership and partnership in health. However, its external engagements need to progress further towards a more integrated and strategic approach, including through specific engagement strategies for non-State actors. Despite considerable efforts to shift its financing model, WHO remains reliant on a small number of donors. The Organization needs to continue scaling up its dialogue with donors to mobilize better quality resources that can be used more flexibly to pursue intended results and adapt to changing needs and situations. This necessitates the building of trust.

More budgets are allocated at country level, but this has yet to translate into sustainable increases in financing and capacity at the country level. MOPAN highlights in its recent assessment report that capacity and capability vary across the levels of the Organization and are not always adequate to meet needs and expectations.

Some fundamental changes in organizational structure have been made but the changes to ways of working have yet to be imbedded in day-to-day operations. Significant changes have been made in order to build a motivated and fit-for-purpose workforce, but more needs to be done to realize the eventual aim of a more agile and mobile workforce, with its accountability for results strengthened.



MOPAN HIGHLIGHTS IN
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EXPECTATIONS

Success has been achieved in sharpening the focus on impacts, especially at the country level, yet the technical challenges to measurements remain and the culture of results has yet to be imbedded.

As the management and administration continue to evolve and simplify its operations and deliver value for money, it needs to better enable the seamless delivery of technical work. During the COVID-19 pandemic, WHO's leadership and enabling functions have been tested to their limits. WHO's work is wide-ranging and stretches far beyond stopping epidemics. Its work to reduce maternal and child deaths, end communicable diseases, eradicate polio, make health systems in countries more resilient, provide health services to displaced populations and reduce the risk factors for noncommunicable diseases has not stopped. Management and administration that enables technical work to happen while dealing with increased demands of the COVID-19 pandemic for logistics and procurement for the immediate and large-scale deployment of human resources to support the operations in countries is stretching the enabling functions.

The accountability mechanisms continue to ensure that transactions, activities, processes and procedures are carried out as effectively as possible and in keeping with the highest standards of professional and ethical conduct. More than ever before, the Organization is being challenged to further strengthen these functions across the three levels of the Organization. Therefore, as part of the current transformation process, the Director-General has embarked on a journey to review and further strengthen these functions, where required, in order to ensure that they are both individually "best in class" and work together collectively to help WHO deliver on its GPW 13 and Sustainable Development Goal commitments. In 2019, the investigations function was the first of the areas to conduct a benchmark driven "best in class" review, which made recommendations on strengthening both structural and resourcing functions.



KEY FIGURES FOR 2018–2019: LEADERSHIP AND ENABLING FUNCTIONS



Approved Programme budget:
US\$ 716 million

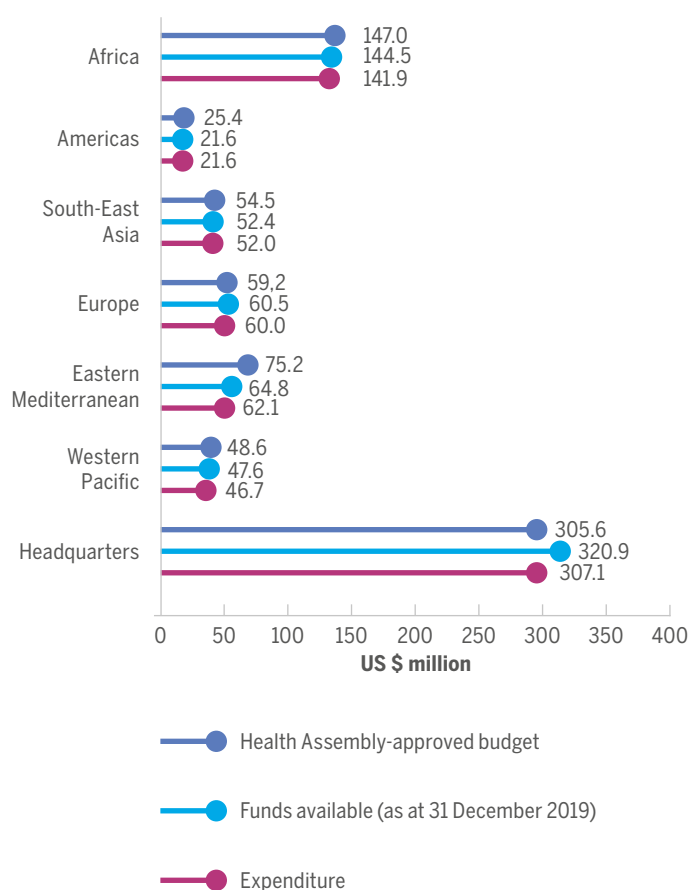


Funds available:
US\$ 712 million
(99% of Programme budget)

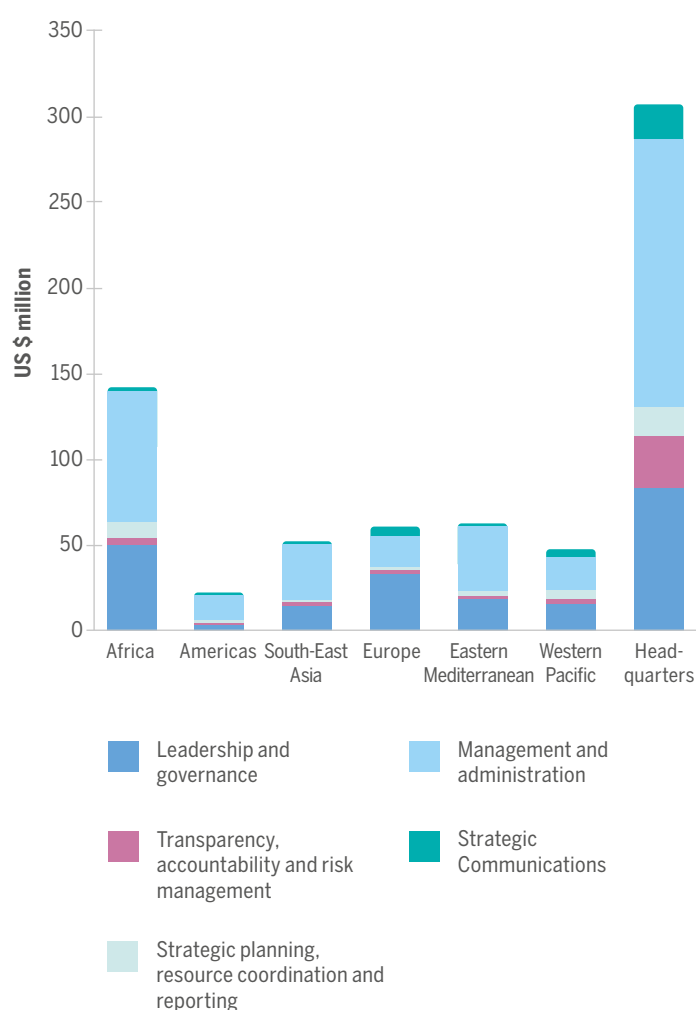


Expenditure:
US\$ 691 million
(97% of Programme budget,
97% of available resources)

BASE BUDGET, FUNDS AVAILABLE AND EXPENDITURE, BY MAJOR OFFICE (IN US\$ MILLION)

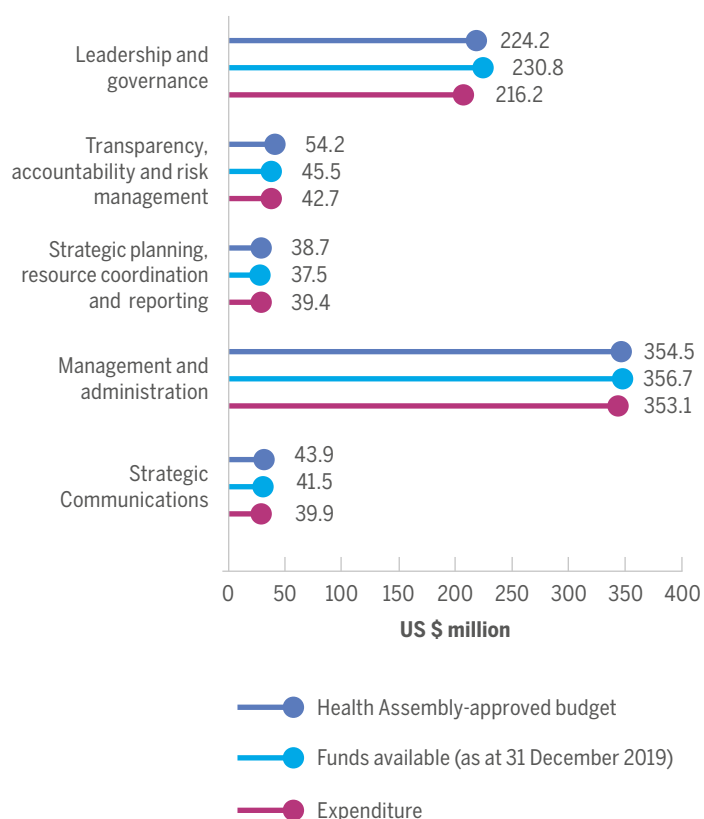


PROGRAMME BUDGET EXPENDITURE BY MAJOR OFFICE AND PROGRAMME AREA (IN US\$ MILLION)

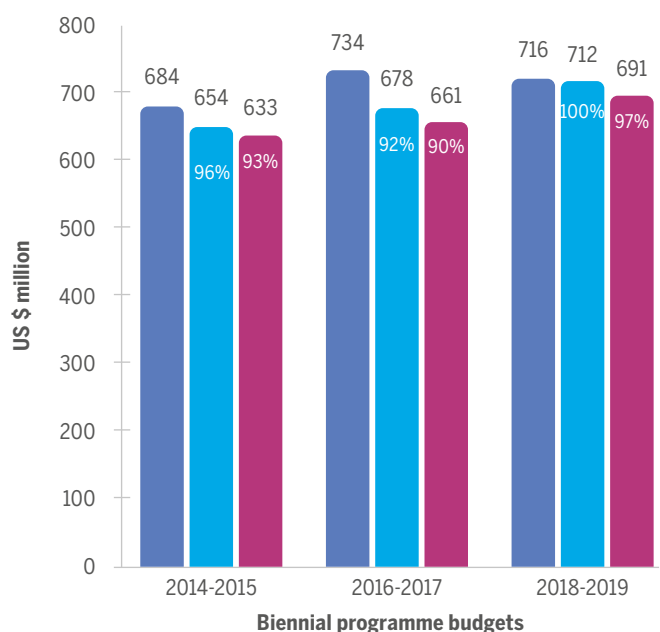


The key element in the financial picture of the Leadership and enabling functions category during 2018–2019 was the close alignment to approved budget levels of both funding and expenditure across programme areas and major offices. This reflected the stated commitment of the World Health Assembly to reaffirm the need for enabling functions to be adequately financed across all levels and capable of providing a consistent service of good quality across the Organization.

BASE BUDGET, FUNDS AVAILABLE AND EXPENDITURE, BY PROGRAMME AREA (IN US\$ MILLION)



COMPARISON OF 3 BIENNIAL BASE PROGRAMME BUDGETS UNDER THE TWELFTH GENERAL PROGRAMME OF WORK (IN US\$ MILLION)



* Percentage indicates as % of approved programme budget

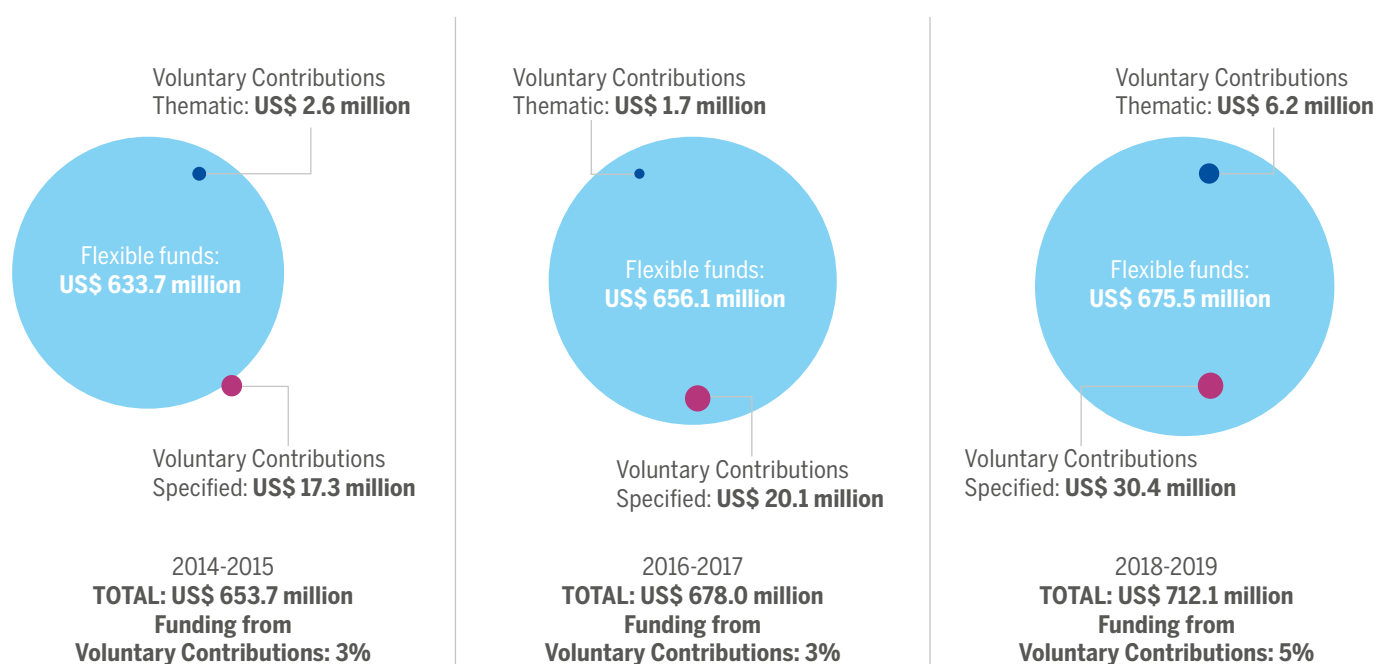
■ Approved Programme budget ■ Funds available
 ■ Expenditure

By far the greatest levels of budget, funding and expenditure in the Leadership and enabling functions category were seen at headquarters. This stemmed from the large costs of governance functions managed there (Leadership and governance programme area) and the provision of several centralized functions managed by headquarters for the benefit of the rest of WHO, including the Global Service Centre in Kuala Lumpur; accounting services; many of the IT platforms used, especially the Global Management System (Management and administration programme area); policy development (Leadership and governance programme area); the coordination of global planning and budgeting; legal and audit functions; and many other functions. These were complemented in many cases through global functional networks that included all major offices. That approach allowed WHO to ensure a core set of enabling functions that underpinned its technical work across the globe.

When considered in the light of the overall trend across the period of the Twelfth General Programme of Work 2014–2019, the financing and implementation of the Leadership and enabling functions category improved significantly in 2018–2019 in terms of absolute funding and implementation levels, while the averages by programme area and major office were the highest of the three bienniums.

Across the three bienniums of the Twelfth General Programme of Work, the Organization committed a significant level of flexible resources to the Leadership and enabling functions category (from 97% of total funding in 2014–2015 to 95% in 2018–2019). This was due to the relative lack of interest among the traditional donors in funding this category. However, in 2018–2019, the voluntary contributions to this category increased by almost 70% compared with 2016–2017, increasing from US\$ 21.8 million to US\$ 36.6 million. That trend continued in 2018–2019 due to the creation of the thematic funding

OVERALL FUNDING UNDER THE TWELFTH GENERAL PROGRAMME OF WORK, BY FUND TYPE (IN US\$ MILLION)



category, which has seen a significant increase. Donors took an active interest in work concerning WHO's leadership in achieving Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) in terms of ensuring transparency, accountability, compliance and evaluation. Even if the absolute amounts were not very high compared with those received in other categories, the support provided could well act as seed funding, which could then attract increased investment and engagement from more donors and partners.

Among regional offices, the African Region operated at a much higher budget level in the Leadership and enabling functions category than those seen in other regions. This was partly due to the higher operational requirements in that region, which was related to management reform among other reasons, including the functional reviews of country offices. About 30% of the total available voluntary contributions in 2018–2019 to this category were used to fund the African Region, including a significant grant from donor sources for the reform and functional reviews. The Eastern Mediterranean Region was the least well resourced but it was still funded to a level of 87%, with expenditure at 83% of the approved budget level. At headquarters, although there were indications that more funds would be needed as compared with the approved Programme budget (US\$ 321 million versus US\$ 306 million), the expenditures were kept to the level of the approved budget through careful budget and resource management.

Close to 100% implementation of the Leadership and enabling functions category of the Programme budget in 2018–2019 by most major offices shows that the main challenge presented by this category is to ensure not only adequate financing and efficient implementation of funds but also adequate budget levels across all major offices so that consistent service of a good quality continues to be provided across the Organization.

For further details on the Programme Budget funding, implementation for this category and achievements by programme areas including indicators, please refer to the WHO Programme Budget Portal (<http://open.who.int/2018-19/our-work/category/06/about/programme-outcomes> and <http://open.who.int/2018-19>).

