



HEALTHIER
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Triple Billion Targets



WHO Results Report

Programme Budget 2018-2019

Mid-Term Review

WHO Results Report

Programme Budget 2018-2019

Mid-Term Review



World Health
Organization

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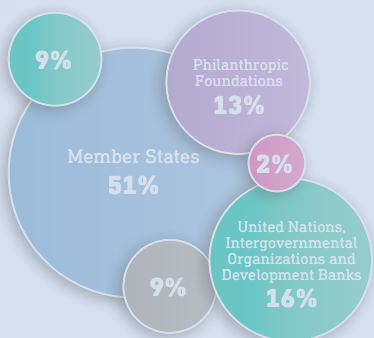
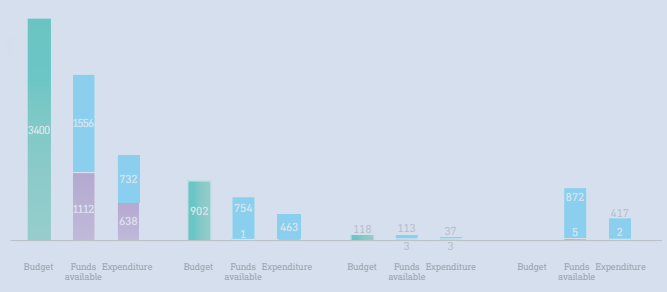
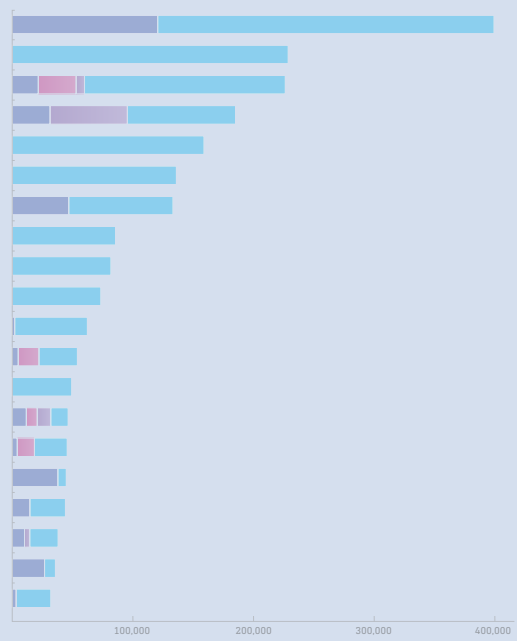
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Director-General's foreword

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Dr Tedros Adhanom Ghebreyesus,
Director-General



Results are the heart of what WHO does. Everything we do – from developing treatment guidelines and holding expert review meetings, to responding to outbreaks and other health emergencies – is about delivering an impact in the lives of the people we serve.

Impact is also the essence of the Thirteenth General Programme of Work, 2019–2023 (GPW 13), with its “triple billion” targets, and of the Sustainable Development Goals on which GPW 13 is based. The approval of GPW 13 by Member States at the Seventy-first World Health Assembly was one of the major achievements of 2018.

But strategies are one thing – results are another. This WHO results report for 2018 highlights what WHO is achieving, describing how, for example:

- **on universal health coverage** – with support from WHO, countries including Egypt, India, Kenya and the Philippines made decisive steps towards expanding coverage and preventing catastrophic spending on health;
- **on emergencies** – WHO investigated, and where necessary responded to, 481 emergencies and potential emergencies in 141 countries, including two outbreaks of Ebola virus disease in the Democratic Republic of the Congo and the world's worst cholera outbreak in Yemen;

- **on healthier populations** – the Organization raised awareness and reinforced measures to reduce tobacco use, eliminate artificial *trans* fatty acids, address antimicrobial resistance and reduce air pollution.

We can feel proud of these results. But none of them are possible without the support of Member States and partners.

I'm also particularly proud of the people in our Organization who delivered these results. I want to sincerely thank our staff who are enormously dedicated and expose themselves to personal risk in the conduct of their work.

In particular, I want to pay tribute to my brother, Dr Richard Mouzoko. He was killed this year in the line of duty while delivering results. He is a global health hero and represents the best of WHO. I dedicate this Results Report to Dr Mouzoko and his family – and to all our colleagues who have died while performing their duties – for their sacrifice.

Without WHO, the world would be much worse off. And yet, this great Organization has still not completed its journey towards delivering its full potential.

I look forward, therefore, to reporting even better results in the years to come as we work together to promote health, keep the world safe, and serve the vulnerable.

”

Executive summary

WHO turned 70 in 2018. Looking back over its history, it is clear that the Organization has achieved a lot: smallpox had been eradicated; polio is on the brink of eradication; the AIDS epidemic is in decline; a breakthrough convention on tobacco control has been passed – just to name a few landmark achievements.

At the same time, WHO must continue to evolve to achieve even greater impact. This is why, in May 2018, Member States approved a new strategy for WHO – the Thirteenth General Programme of Work, 2019–2023 – steering WHO to a data-driven, results-oriented, country-focused trajectory. GPW 13 introduced a **new mission**: promote health, keep the world safe, and serve the vulnerable. To bring this to reality, bold **triple billion targets** were set:

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

Such ambitious targets, which are fully aligned with the Sustainable Development Goals, require reshaping WHO. The year 2018 was dedicated to reorienting the Organization towards this new strategic direction.

The targets also require partnerships. In 2018, WHO was asked to lead the Secretariat for the **Global Action Plan for Healthy Lives and Well-being for All**, which includes the commitment of 12 signatory agencies to accelerate progress towards Goal 3 through enhanced collective action at the global and country level.

The Mid-term Review 2018–2019 is a summary of key achievements and results in the first year of the biennium. Results matter, because they hold WHO accountable – to WHO's own goals; to the people WHO serves, in Member States; and to donors and partners, who invest in results.

This report presents areas where WHO had impact and the financial resources that were required to achieve them. In this Executive Summary – to anticipate the start of GPW 13 next year – we organize key results using the triple billion targets.

One billion more people benefiting from universal health coverage

In October 2018, countries agreed to the **Declaration of Astana in Kazakhstan**. Coming 40 years after the historic Alma-Ata Declaration **on primary health care**, it reinvigorated commitment to strengthen primary health care, laying a foundation for universal health coverage.

The **universal health coverage acceleration project** in the Western Pacific Region and the adoption of the global compact towards universal health coverage (UHC2030) in the Eastern Mediterranean Region are evidence of the growing political support for universal health coverage. At the country level, Greece, India and Kenya are moving swiftly on the road to universal health coverage, with WHO support.

Normative work highlighted in the report includes the **prequalification** of health products. In 2018, almost 200 products were prequalified, including vaccines for inactivated polio, rotavirus and typhoid fever. A new drug, moxidectin, was prequalified for river blindness while landmark guidelines were issued on HIV related to new drugs such as dolutegravir and raltegravir.

Other normative work includes the release of the **International Classification of Diseases (ICD-11)**, whose implementation will enable improved tracking of health trends, and the new **Essential Diagnostics List**, which builds on the WHO Essential Medicines List that has long guided countries.

The **elimination of some neglected tropical diseases** – such as lymphatic filariasis, trachoma and malaria in low-burden countries – is a growing reality through WHO's coordination of shipment, distribution and delivery of medicines for mass drug administration in countries.

WHO's global health leadership is also featured in the report. In 2018, WHO led at the highest political level in two United Nations high-level meetings – on noncommunicable diseases and tuberculosis. Bold new targets were set for 2022 at the high-level meeting on tuberculosis. For noncommunicable diseases; world leaders agreed that efforts should include WHO-recommended legislative and regulatory measures on risk factors.

One billion more people better protected from health emergencies

WHO's work in battling epidemics and outbreaks, and responding to health needs in humanitarian crises, remains central; it is the emergencies pillar of the "triple billion" target "to keep the world safe". The response arm of work on emergencies is now much stronger than previously.

WHO investigated and where necessary responded to 481 emergencies and potential emergencies in 141 countries, including two outbreaks of Ebola in the Democratic Republic of the Congo, and the world's worst **cholera** outbreak in Yemen.

WHO helped contain the **Ebola outbreak** in the Equateur province of Democratic Republic of the Congo and is helping to contain the ongoing outbreak in North Kivu, setting up base camps, operations centres, treatment units, mobile laboratories and surveillance, and providing 60 000 doses of a new, experimental vaccine as well as a rapid diagnostic test.

An outbreak of **Middle East Respiratory Syndrome** was prevented in the Republic of Korea because of preparedness efforts of the government with the support of WHO. This outcome was very different from the situation just a few years earlier.

Efforts to eradicate **wild poliovirus** are now focused in Afghanistan and Pakistan, where challenges include a mobile population, and environmental and political obstacles. In parallel, a Strategic Action Plan for Polio Transition was developed in order to sustain a polio-free world.

The International Health Regulations (2005), which govern global health security, account for another important area of WHO's work. In 2018, 187 countries submitted their self-assessment annual reports of the IHR implementation status of 2018 and 24 countries conducted a joint external evaluation – a multisectoral process to assess country capabilities to prevent, detect and respond rapidly to public health risks. Based on these evaluations, 47 countries have developed and are implementing their national action plans for health security as of 2018.

One billion more people enjoying better health and well-being

This report takes a special look at WHO's impact on legislation that promotes healthier populations. Since WHO's **Framework Convention on Tobacco Control** came into force, countries are increasingly using the law for sustainable interventions to reduce tobacco use. Today, almost two-thirds of the world's population is covered by at least one comprehensive tobacco control measure. As well, 59 countries now have laws related to **sugar-sweetened beverages** while several countries in the Americas fought a battle to establish food labelling laws.

WHO also provided support to the United Nations Secretariat at the highest level on antimicrobial resistance, raised awareness on air pollution, called for the elimination of artificial *trans*-fatty acids, and scaled up technical packages of interventions to tackle noncommunicable disease risk factors.

During 2019, WHO will build on these accomplishments as it begins its new general programme of work, which focuses even more on impact at the country level.

HEALTH SYSTEMS



PROGRAMME AREAS

National health policies, strategies and plans

Integrated people-centred health services

Access to medicines and other health technologies and strengthening regulatory capacity

Health systems information and evidence



“ To address the big challenges of the future, we need to support countries to develop health systems which more comprehensively address growing health threats such as noncommunicable disease – especially where populations are ageing. To achieve this, we need progress towards universal health coverage, including stronger primary health care services – that is how we will deliver health for all. ”

Dr Takeshi Kasai
WHO Regional Director for the Western Pacific

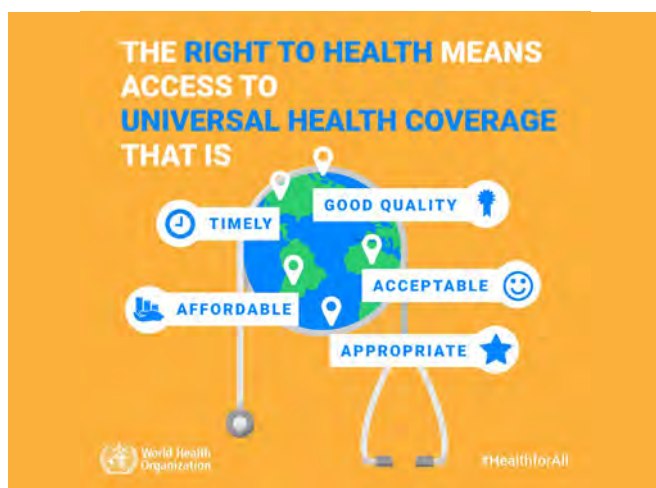
Health systems are fundamental not only to good health but also to overall development. Making health systems more efficient and equitable is a key strategy to fight poverty and foster development. Half of the world’s population cannot obtain the health services they need because they are either inaccessible, unavailable, unaffordable or of poor quality. Widening inequities across the world mean that an estimated 100 million people are pushed into poverty every year when they pay out-of-pocket for health services.

There is no single perfect model of a health system since context is key, but a well-functioning health system is built on having trained and motivated health workers, a well-maintained infrastructure and a reliable supply of medicines and technologies, backed by adequate public funding, a coherent incentive environment, strong health plans and evidence-based policies.

Key achievements

Reaffirming health for all

The year 2018 may prove to be a defining year in WHO’s history. Exactly 70 years after the Organization was founded and 40 years after the **Declaration of Alma-Ata on “Health for All”**, WHO is moving closer to realizing a long-held vision of health as a right and not a privilege. That vision is also being championed by WHO Director-General Dr Tedros Adhanom Ghebreyesus, who has made universal health coverage a top priority.



Outcomes we are aiming to achieve in 2018-2019

- All countries have comprehensive national health policies, strategies and plans aimed at moving towards universal health coverage
- Policies, financing and human resources are in place to increase access to integrated, people centred health services
- Improved access to and rational use of safe, efficacious and affordable quality medicines and other health technologies
- All countries have well-functioning health information, eHealth, research, ethics and knowledge management systems to support national health priorities

Stepping up universal health coverage

In October 2018, countries convened in Astana, Kazakhstan, and renewed their commitment to primary health care as a step to achieving universal health coverage. **The Declaration of Astana** – adopted at the **Global Conference on Primary Health Care** – reaffirms the historic 1978 **Declaration of Alma-Ata**.

The Declaration of Astana comes amid a growing global movement towards greater investment in primary health care as a means to achieve universal health coverage.



Highlights of significant progress towards universal health coverage include:

- In the African Region, the Regional Office helped countries to mobilize domestic resources and transition from being supported by Gavi, the Vaccine Alliance, to being fully self-financing. Angola and the Congo, with WHO technical support, increased their domestic funding for health and are now fully self-financing.
- In the Region of the Americas, 15 countries made significant progress in expanding access to health care and increasing the quality of care.
- In the Eastern Mediterranean Region, universal health coverage has received high-level political support since the adoption of the **global compact for progress towards universal health coverage (UHC2030)** at a ministerial meeting held in Salalah, Oman, in September 2018. Countries were invited to sign the compact as a sign of solidarity and commitment.
- The Regional Office for Europe provided country-specific analyses with actionable evidence for pro-poor policies to Estonia and Lithuania, which acted upon the recommendations. Both countries introduced new policies to provide better protection for vulnerable population groups.
- The South-East Asia Region welcomed the launch by the Government of India of **Ayushman Bharat**. With its twin pillars of health protection and 150 000 health and wellness centres, the system will significantly advance universal health coverage for hundreds of millions of people. Similarly, Indonesia has extended such health coverage to 78% of its population.
- In the Western Pacific Region, the **universal health coverage acceleration project**, funded by Japan, supported Member States in moving towards universal health coverage. In Viet Nam, an innovative approach was adopted that aimed to improve primary care at the local level, thereby offering lessons for a wider, national scaling up.



(L-R) Dr Andrea Xanthos, Greek Minister of Health; Dr Zsuzsanna Jakab, then WHO Regional Director for Europe; Dr Tedros Adhanom Ghebreyesus, WHO Director-General, at the inauguration of the new WHO Country Office in Greece in June 2018.

Rolling out primary health care units in Greece

December 2018 marked the first anniversary of the *Topikes Monades Ygias* (TOMYs) or local health units in Thessaloniki, Greece, which are part of a newly-designed primary health care system.

TOMYs coordinate care in the area. They are staffed with multidisciplinary teams of general practitioners, internists, paediatricians, nurses, health visitors and social workers.

By end-2018, 113 TOMYs are in operation throughout Greece, benefiting 300 000 people, and more units are planned. One in three TOMYs provide extended service hours, from 7:00 to 22:00. They provide continuous health care and their activities include disease prevention, health promotion, diagnosis, treatment, monitoring and care. They also have referral mechanisms in place, which will be further improved in 2019 with WHO assistance.

The Greek health system was deeply affected by the financial crisis, which revealed long-term problems in the provision of care. The TOMYs mark a major step forward from the previously fragmented network of public and private health providers, which were primarily specialists.

The Regional Office for Europe has worked closely with the Ministry of Health of Greece in monitoring the roll-out of TOMYs, ensuring sustainability and improving the quality of services. Technical assistance, funded by the European Union and Japan, helped to:

- develop and maintain a registry of TOMYs, including details on access, staffing, equipment;
- implement a nationwide campaign to promote the new services;
- conduct a user satisfaction survey;
- develop a human resources strategy to ensure the long-term supply of qualified family doctors.

Minister of Health Andreas Xanthos has said that the TOMYs aimed “to shift the focus from treatment to prevention” and that they were a response to “societal demand for the elimination of health inequalities”.

WHO Director-General Dr Tedros Adhanom Ghebreyesus has commended the system for “ensuring that all residents of Greece can access the health services they need, when and where they need them, without facing financial hardship.”

Making it happen in countries

Through the support provided by its Universal Health Coverage Partnership, WHO is now providing in-country policy and planning technical assistance to more than 60 Member States, while at the global level the Organization is bringing together Gavi, the Vaccine Alliance, and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) to align support for the strengthening of health systems and harmonizing of the monitoring of national systems and universal health coverage priorities in countries.

Progress made in the African Region with support from WHO includes:

The West African Economic and Monetary Union adopted the first **sub-regional health workforce investment action plan**, addressing barriers to workforce development.

Burkina Faso deployed optimized strategies to improve retention of health workers in underserved areas.

Guinea developed a rural pipeline programme to accelerate training, recruitment, deployment and retention of health workers in rural areas, and specifically to recruit 3000 community health providers by 2022.



Improving quality of services

A new universal health coverage portal, providing the latest data on health services globally, is helping track progress towards universal health coverage, revealing areas that need attention. Poor quality of health services are a factor impeding improvements in public health. Inaccurate diagnosis, medication errors, unnecessary treatment, inadequate or unsafe clinical facilities or practices, or providers lacking training and expertise were among the

problems. The situation was worst in low- and middle-income countries where 10 % of hospitalized patients contract infections during their stay.

The Regional Office for the Americas has supported work on the development of integrated health networks as part of the implementation of road maps for universal health coverage in several countries. In the Region of the Americas, 15 countries made significant progress in expanding access to health care and the quality of the care. In Bolivia, a new model of care was developed through the *Mi Salud* programme, which articulates the first level of care with specialised care. Guatemala also initiated a pilot project for a new model of care while Panama is developing health networks.

Boosting the health workforce

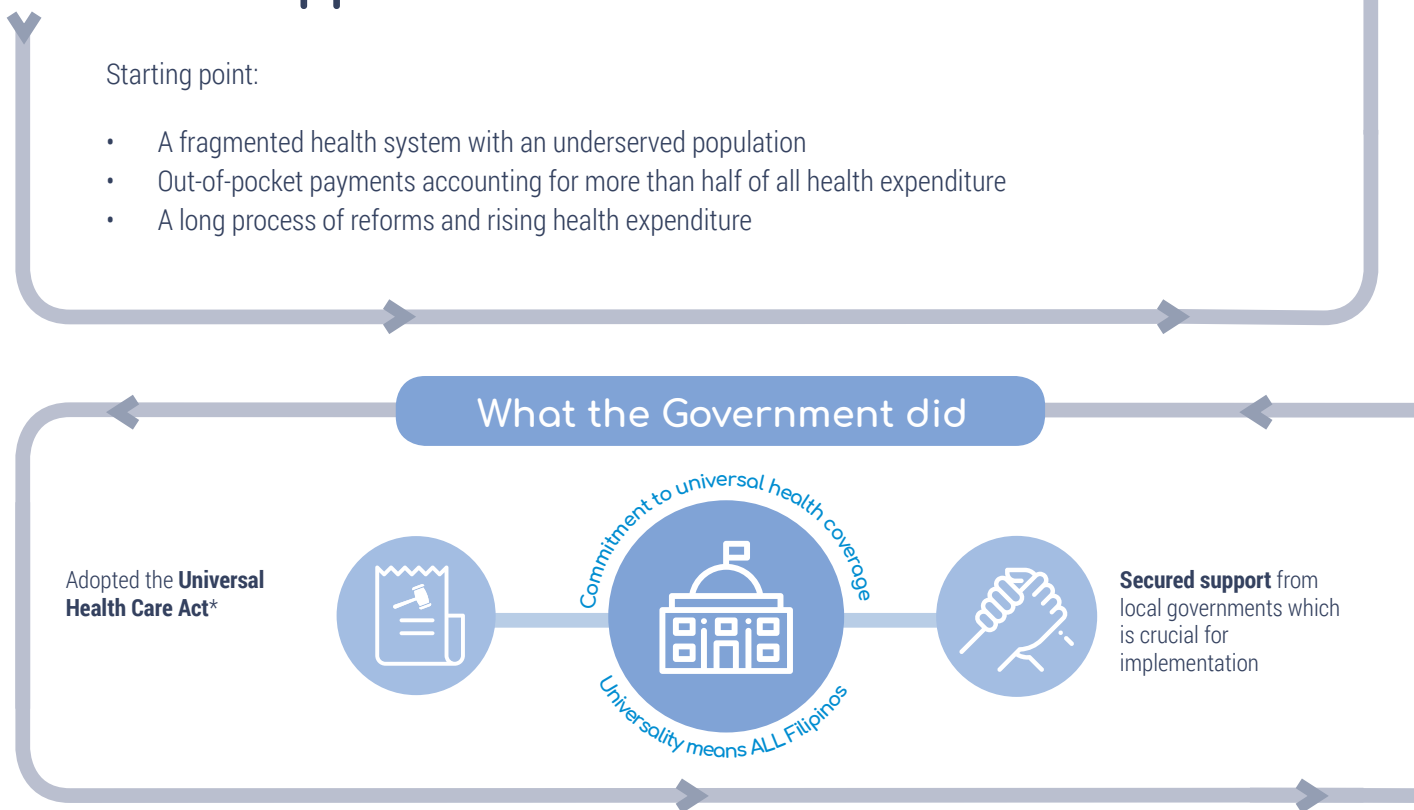
The **Working for Health Multi-Partner Trust Fund (MPTF)** was launched in May 2018, during the Seventy-first World Health Assembly, to pool resources and support countries to invest in the health and social service workforce required to achieve universal health coverage and the Sustainable Development Goals. WHO, and its partners ILO and OECD, plan to raise US\$ 70 million over five years. The funds will be used jointly to deliver innovative partnerships and new knowledge and to finance investment in transformative education, skills and job creation in the global health care workforce.

The WHO competency framework for health workers' education and training on antimicrobial resistance, launched in 2018, provides foundational normative guidance to help ensure that **health workers have the requisite competencies to address antimicrobial resistance**. The framework is being used as a prerequisite for grant requests by Tropical Health Education Trust (THET) Commonwealth Partnerships for Antimicrobial Stewardship projects in four African countries: Ghana, Uganda, United Republic of Tanzania and Zambia. The projects aims to strengthen the capacity of the national health workforce and institutions to address antimicrobial resistance challenges in those countries.

The **National Health Workforce Accounts (NHWA)** data platform is improving the availability, quality and use of data on the health workforce. The platform has received data from over 25 countries. To help implement the platform, WHO initiated capacity-building efforts in 79 countries, of which 52 were low-income and lower-middle-income countries.

The data reported in National Health Workforce Accounts indicate an increase of about 10% in the global stock of health workers since 2013.

Advancing universal health coverage in the Philippines



United Republic of Tanzania achieves milestone in drug regulation

The United Republic of Tanzania is the first confirmed country in Africa to have achieved a well-functioning regulatory system for medical products. The Tanzania Food and Drug Authority (TFDA) has made considerable improvements in recent years to ensure the safety and efficacy of medicines in the health care system.

WHO's assessment of regulatory authorities is based on the Global Benchmarking Tool – an evaluation tool that checks regulatory functions against a set of more than 200 indicators, including product authorization, market surveillance and the detection of potential adverse effects.

The benchmarking of the Tanzanian regulatory authorities was carried out in phases by a WHO-led team of international experts. Earlier in 2018, WHO facilitated self-assessments and conducted a formal evaluation of the Tanzanian Food and Drug Authority as well as its counterpart in Zanzibar, requesting the regulatory authorities to make various adjustments. In the last assessment, the Tanzanian Authority met all indicators that define a maturity level 3 agency, the second highest on WHO's scale.

Less than 30% of the world's medicines regulatory authorities are considered to have the capacity to perform their functions well. For that reason, WHO and African governments have intensified efforts to bolster the capacity of the Region's drug regulatory bodies.

Improving access to medicines

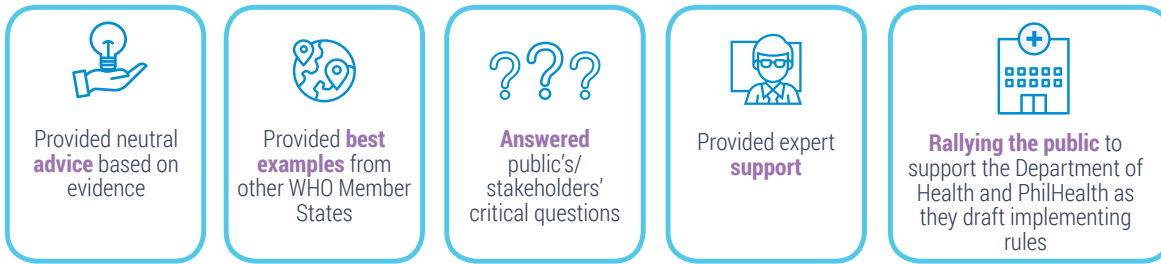
Lack of access to medicines is one of the most complex obstacles to better health. WHO has worked constantly to improve access to medicines throughout its history. The prequalification programme is now firmly established as a mechanism to improve access. Prequalification provides a critical stamp of approval that medicines are safe, effective and of high quality.

Recently prequalified products include the HIV antiretroviral dolutegravir, rectal artesunates for malaria and the first two HIV self-tests. Dolutegravir has many advantages, among them the potential to drive down the cost of antiretroviral therapies significantly. Rectal artesunates can be administered early to patients who are far from health facilities, thereby reducing the risk of death and disability from malaria. The new HIV self-testing kits will greatly increase the number of people who know their HIV status by avoiding the stigma of their having to attend a test centre.

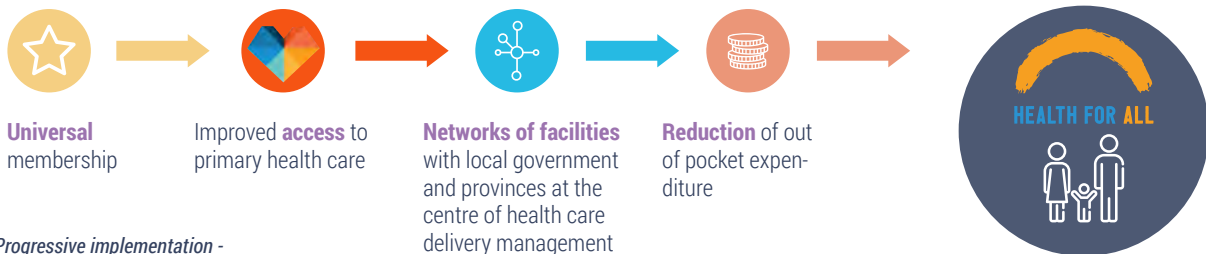
The 10 vaccines that passed prequalification include:

- ShanIPV™ inactivated polio vaccine. This prequalification is important because the current inactivated polio vaccine market is fragile, with insufficient short-term supply for all countries to have access to at least one full dose of vaccine for use in routine immunization programmes.
- Rotasil oral rotavirus vaccine. Rotasil is the first heat-stable Rotavirus vaccine, which makes it suitable for

What WHO did



What the Philippines is moving towards



Progressive implementation - outcomes by 2030

use in low-income countries, where weak infrastructure and frequent lack of electricity make refrigeration difficult. Rotavirus causes about 37% of the deaths from diarrhoea among children younger than 5 years of age worldwide.

- Typhbar-TCV[®] is the first conjugate vaccine to prevent typhoid fever. This vaccine yields long-lasting immunity, requires only one dose and can be given to children as young as 6 months, while other typhoid vaccines are only recommended for children over 2 years. Use of the vaccine should curb the frequent use of antibiotics for presumed typhoid fever, thus slowing antibiotic resistance in *Salmonella typhi*.

In a new pilot initiative, the United States Food and Drug Administration (FDA) will provide the WHO prequalification of medicines programme with reviews of HIV drug applications to expedite assessments, making life-saving drugs more quickly available to patients in developing countries.

Work to improve the affordability of medicines in countries has involved monitoring and sharing information on drug pricing at the regional level.

The South-East Asia Regulatory Network, which includes sharing information on medical product pricing among its activities, launched a live product pricing platform last October.

Data collected from 45 countries in the European Region form the basis of a new WHO report **Medicines reimbursement policies in Europe**, which examines policies that increase access to affordable medicines.

The Region of the Americas launched an initiative, together with 15 institutions from nine countries in the Region, to promote the exchange of information on prices, coverage and regulation. The African Regional Office developed the APRAMED platform to regularly monitor medicine prices. The platform is already being used by the Congo and Nigeria.

To ensure new treatments are safe, beneficial and used responsibly, they must be monitored after they are on the market through pharmacovigilance. To commemorate the fiftieth anniversary of its pharmacovigilance activities, in November 2018, WHO launched a toolkit comprising checklists and guidance to countries on how to set up a drug safety monitoring system.

In 2018, almost 200 products were prequalified, including 55 products for vector control and 48 finished pharmaceutical products.

Achievements in health financing

Robust financing systems are critical for universal health coverage. When people pay most of the cost for health services out of their own pockets and public financing is low, many suffer financial hardship in the event of a severe or long-term illness. The poor may often be unable to obtain services they need.

Addressing fragmentation in financing arrangements has been a priority for WHO's support to Member States, not just to improve financial protection but also to build efficiency and equity in resource use. WHO plays a critical role in supporting health financing policy in countries.

WHO has released the annual update of the **Global Health Expenditure Database (GHED)**. This latest release contains annual data for all Member States from 2000 to 2016.

The data release was accompanied by the publication of the report **Public Spending on Health: A Closer Look at Global Trends**, which synthesizes broad patterns and trends in global health spending, identifying key policy issues. This report is useful in providing further evidence of the importance of the health sector within national economies and in advocating for increased government spending so as to reduce out-of-pocket expenditure.

One example of successful action can be found in Mali. Following an evaluation of the current human resources for health plan, through the joint efforts of the Ministry of Health, WHO and other partners, additional domestic funds were mobilized, making possible the recruitment of several hundred new health sector workers in 2017 and 2018.

Some of the key findings in the report:

- Global health spending is increasing but people are still spending too much out-of-pocket for health care.
- Public health spending is generally increasing, but not in low-income countries.
- More than half of health spending is on primary health care in low- and middle-income countries, but less than 40% of that spending is from domestic public resources.

Scaling up sustainable universal health coverage in Kenya

In 2017, President Uhuru Kenyatta prioritized achievement of universal health coverage by 2022 as one of Kenya's top four development agenda items. WHO has provided extensive support to the country in this regard, including reviewing policy on sustainable health financing.

In March 2018, following a meeting between President Kenyatta and WHO Director-General, Dr Tedros, WHO organized a high-level mission on health financing for universal health coverage, with the Minister of Health, the International Monetary Fund (IMF) fiscal affairs director, senior government officials and key stakeholders.

WHO recommended an initial modest health benefit package addressing the population's critical needs, with clear pathways for future expansion and citizen engagement. Other recommendations included strong incentives for sub-national governments to invest in basic services and health enablers (better nutrition as well as safe water and sanitation services), including primary health care.

The most viable income source was general tax revenues for an essential service package with non-contributory entitlement. The high-level mission recommended restructuring the National Health Insurance Fund (NHIF) to improve its efficiency and considering other financing modalities such as taxes on tobacco, added sugar and petroleum.

Following the WHO high-level mission, the Government has created a Health Benefits Advisory Panel to review the benefits package. Reforms are also under way to turn the NHIF into a key strategic purchaser for universal health coverage.

WHO has also supported development of a universal health coverage road map, with key milestones for health financing to meet the President's health development agenda.

President Kenyatta has said the path to universal health coverage (UHC) is ongoing. "We view UHC not as a destination but as a continuous process which will involve constant widening of the social safety nets to ensure that no one is left behind."

Dr Tedros has described Kenya as a "trailblazer" for its drive towards universal health coverage, which could leave behind a "ripple effect" across the Region.

Improving health information systems in countries

- In the African Region, the Health Information Systems (HIS) status was assessed in all 47 countries, with the information on 45 countries validated in November 2018. Information system gaps were mapped in the 10 flagship countries for universal health coverage and specific support provided in Namibia for review of the system for Civil Registration and Vital Statistics. HIS strategy assessment and development were performed in Burundi and the Congo, including alignment of partners around priorities for health information systems.
- In the European Region, country missions were conducted to enhance national health information, eHealth and research systems, establish country teams for WHO's Evidence-Informed Policy Network EVIPNet, support indicator development at the country level, develop country profiles with MOH, commence roll-out for ICD-11 and train staff in countries.
- In the South-East Asia Region, the SCORE (Survey, Count, Optimize, Review, Enable) for reviews of health information systems' performance in respect of health goals were completed in 10 countries.
- In the Western Pacific Region, after the Sustainable Development Goals/Universal health coverage baseline report in 2017, "SDG/UHC" country profiles were developed for all countries in the region. A few countries started to apply similar approaches to develop country SDG/UHC and health system development monitoring tools.



Enhancing data

In June 2018, the **International Statistical Classification of Diseases and Related Health Problems – Eleventh Revision (ICD-11)** was released. The 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, 70 countries from all six WHO regions have been trained in hands-on use and implementation of this global standard for diagnostic health information.

The **Global Reference List of 100 Core Health Indicators** is also an important tool. It comprises a standard set of core indicators prioritized by the global community to provide information on the health situation and trends. The 2018 list of indicators contains modifications to reflect the Sustainable Development Goals, including universal health coverage.

World health statistics 2018, WHO's annual snapshot of the state of the world's health, highlights the remarkable progress made towards the Sustainable Development Goals in some areas and shines light on other areas where progress has stalled.

Move for more transparency in research

In December 2018, WHO released the **International Standards for Clinical Trial Registries**, version 3.0, for the **International Clinical Trials Registry Platform** to ensure that a complete overview of research is accessible to all those involved in health care decision-making. This will strengthen the transparency, validity and value of the scientific evidence base.

Previously, WHO had coordinated a consensus among some of the world's largest funders of medical research and funding international non-governmental organizations, requiring that all clinical trials they funded or supported should be registered and the results disclosed publicly.

Currently, about 50% of clinical trials go unreported, often because the results are negative. These unreported trial results leave an incomplete and potentially misleading picture of the risks and benefits of vaccines, drugs and medical devices and can lead to the use of suboptimal or even harmful products.

In the Western Pacific Region, technical support was provided to Fiji, Papua New Guinea, Samoa, Tonga and Vanuatu on health research ethics and the regional health ethics review committee reviewed 13 health research proposals during 2018.

Key figures for 2018–2019

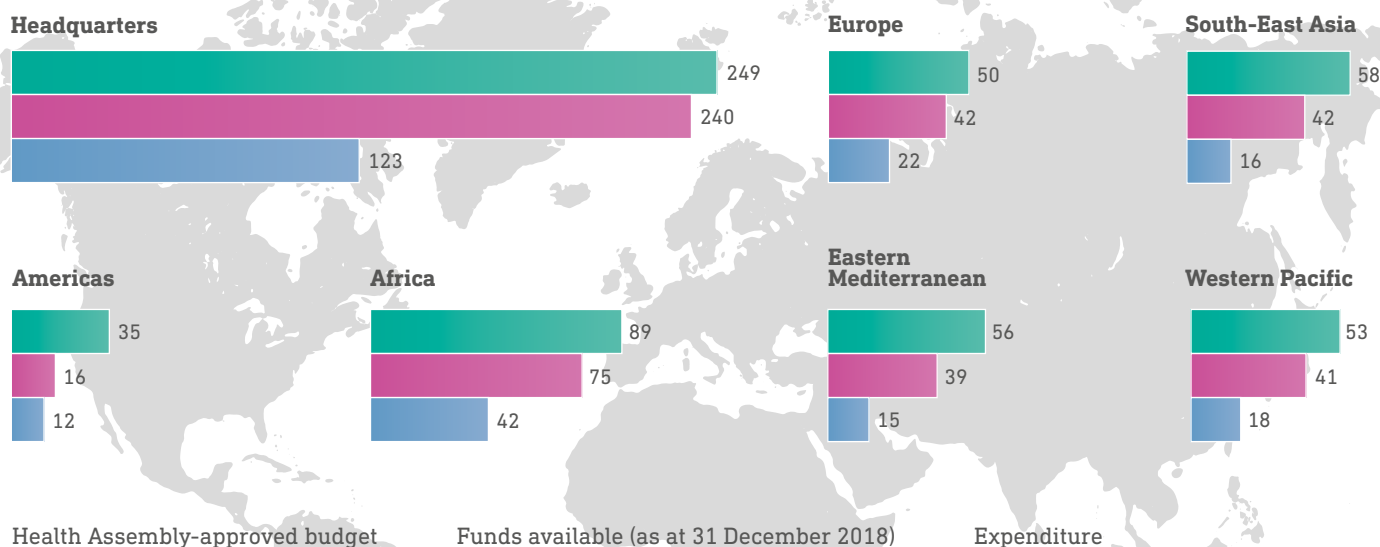
Approved Programme budget: US\$ 590 million

Funds available: US\$ 495 million (84% of Programme budget)

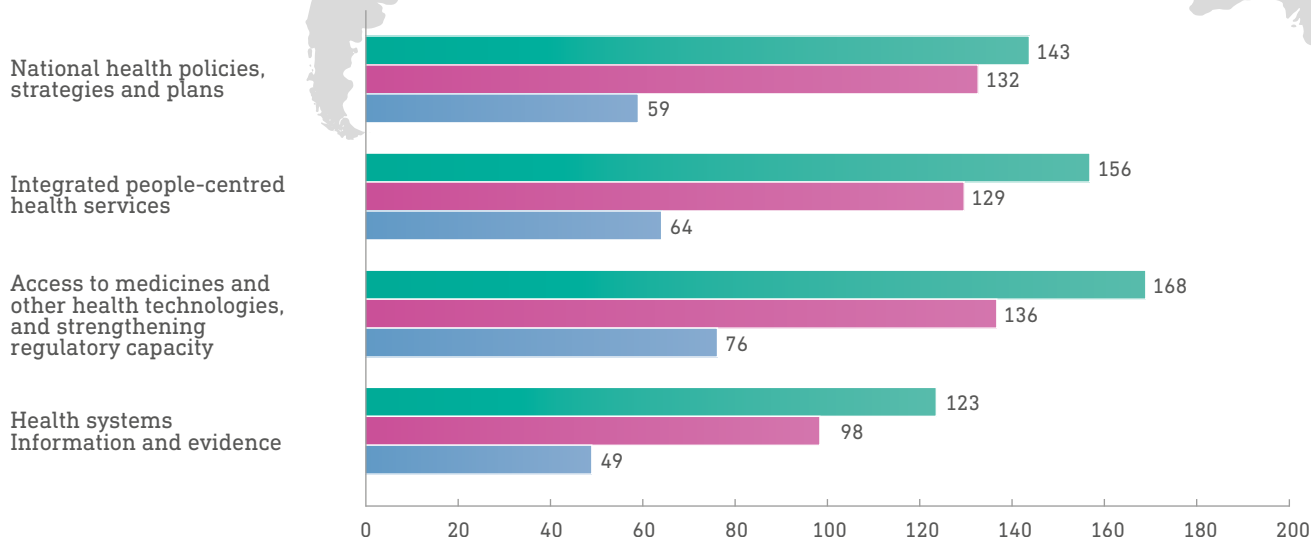
Expenditure: US\$ 248 million (42% of Programme budget, 50% of available resources)



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



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



Budget and implementation

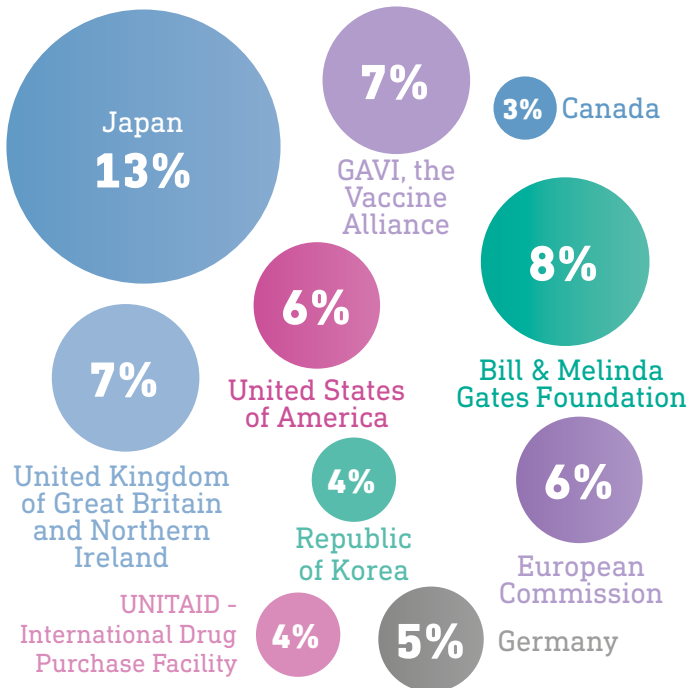
The Health systems category was well resourced in 2018, with a level of 84% of the approved budget funded, 30% of that from flexible funding. With staff expenditures making up 58% of the total expenditure level, this could potentially

present a concern regarding sustainability if the flexibility of specified funding is not maintained.

Almost half of all available resources and expenditure (48% and 50%, respectively) was at the headquarters level.



Top 10 voluntary contributors (specified)



Funding source:

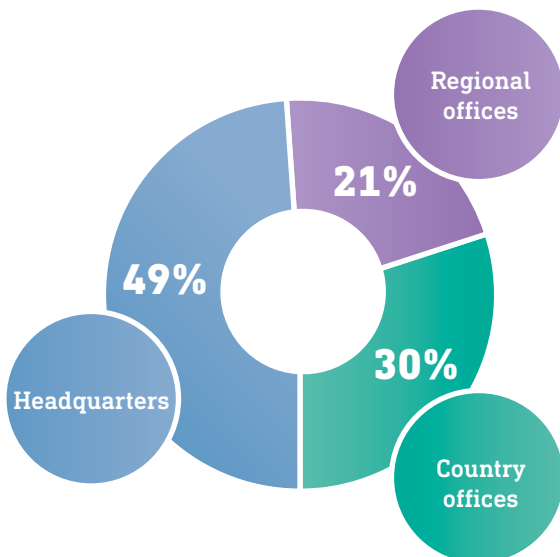
Flexible funding: 30%

Voluntary contributions – specified: 70%

Of the total voluntary contributions specified, 63% were from 10 contributors (shown beside)



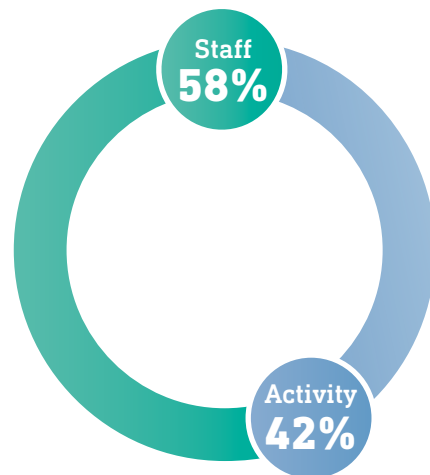
Expenditure by level



This is partly due to the significant extent of normative work and specialized expertise needed. Available resource levels and expenditure levels, relative to the approved budget levels, remain a concern in both the Region of the Americas (46% and 34%, respectively) and the Eastern Mediterranean Region (70% and 27%, respectively). Significant support was provided from headquarters to strengthen health systems at the country level in different areas, including building resilient systems, access to medicines and other health technologies and health



Expenditure: staff vs. activity



financing, especially in the context of reaching universal health coverage.

Both funding and expenditure rates were consistent across programme areas.

For further details on the Programme Budget funding and implementation for this category, please refer to the WHO Programme Budget Portal (<http://open.who.int/2018-19/our-work/category/04/about/key-figures> and <http://open.who.int/2018-19>).

WHO HEALTH EMERGENCIES PROGRAMME



**World Health
Organization**

Regional Office for South-East Asia

PROGRAMME AREAS

Infectious hazard
management

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

Health emergency
information and
risk assessment

Emergency
core services

Emergency
operations



“

It is absolutely vital that we are prepared for any potential case of Ebola spreading beyond the Democratic Republic of the Congo. WHO is investing a huge amount of resources into preventing Ebola from spreading outside the Democratic Republic of the Congo and helping governments ramp up their readiness to respond should any country have a positive case of Ebola.”

Dr Matshidiso Moeti
WHO Regional Director for Africa

Every day, emergencies of all kinds occur – conflicts, natural disasters, disease outbreaks – which can cause lasting damage to health systems and communities and even have global impact. Significant gaps remain in the capacity of many countries to manage these emergencies because of health systems that are ill-prepared and inadequately resourced. It is in these settings that the highest rates of maternal and child mortality occur, and where malnutrition, mental disorders and disease outbreaks are common.

The WHO Health Emergencies Programme works with countries and partners to prepare for, prevent, respond to, and manage recovery from all hazards that create health emergencies. WHO has a critical leadership role in ensuring a swift international response, and in recent years has also assumed an operational role.

The need for WHO's work is evident. Today, a record number of people worldwide, nearly 70 million, have been forcibly displaced and lack access to basic services. Climate change and expanding populations present new crises, such as changing patterns of disease transmission and weather-related disasters. Despite the growing challenges, significant progress has been made such that WHO is in a better place than ever to serve the most vulnerable and promote health.

Key achievements

WHO continued to help Member States to better **prepare, prevent, detect and respond** to the multitude of health risks. This entailed bringing together partners, providing guidance, support and expertise, and conducting operational and logistical missions.

Mounting a successful response

WHO supports countries – particularly those with minimal health capacities – so that they are ready to respond to high priority risks. Strengthening operational readiness helps health systems handle the initial impact of emergencies, as well as subsequent recovery. When a disaster occurs, the more rapid the response, the better the outcome.

Outcomes we are aiming to achieve in 2018-2019

- All countries are equipped to mitigate risks from high-threat infectious hazards
- All countries assess and address critical gaps in preparedness for health emergencies, including in core capacities under the International Health Regulations (2005) and in capacities for all-hazard health emergency risk management
- Health events are detected and risks are assessed and communicated for appropriate action
- Populations affected by health emergencies have access to essential life-saving health services and public health interventions
- National emergency programmes are supported by a well-resourced and efficient WHO Health Emergencies Programme



In 2018, WHO implemented activities for operational readiness in over 60 countries across all six WHO regions, including in respect of training packages, public health risk profiles, and early warning and high-risk hazards planning. WHO coordinated and provided technical support for operational readiness functions for outbreaks of Ebola virus disease in the Democratic Republic of the Congo and for the cholera outbreak in Zimbabwe.

For the Ebola outbreak, WHO helped neighbouring countries to: improve border surveillance and contact tracing; train vaccination teams; and implement infection prevention and control. Another example of readiness work is the WHO Emergency Medical Teams initiative, which helps countries to build stronger health systems by enhancing national emergency medical teams and operations centres. It is supporting 35 countries in this area, with WHO-trained expert mentors helping them to create and strengthen national emergency medical teams.

WHO launched **national rapid response team** training in 2014 in response to an Ebola virus disease epidemic. It has since become an integral part of health security learning. In 2018, training for rapid response teams in support of the Ebola virus disease response was organized in six African countries.

Strengthening a global network for rapid response to health emergencies

WHO relies on its global network of more than 1644 technical and operational partners when responding to health emergencies. Key networks of partners include:

- **Global Outbreak Alert and Response Network (GOARN)** – a technical network of over 200 multidisciplinary experts ready for deployment anywhere in the world when an outbreak strikes.
- **Global Health Cluster** – involves over 700 partners in 27 countries working to meet the health needs of 75 million people worldwide, with WHO as its Secretariat.
- **Emergency Medical Teams Initiative** – helps organizations and countries build capacity and strengthen health systems by coordinating the deployment of medical teams in emergencies.
- **Standby Partnerships programme** – links WHO with quasi-governmental organizations involved in emergency and relief work and maintains a roster of trained experts ready to be deployed.

Responding to the Ebola outbreak

When an outbreak of Ebola virus disease was declared in the Democratic Republic of the Congo in May 2018, a multidisciplinary team comprising experts from WHO, Médecins Sans Frontières and provincial health officials immediately travelled to the hotspot, Bikoro – a town with limited health facilities. WHO promptly set up an incident management system with dedicated staff and resources.

Since May 2018, WHO has provided operational support to the Ebola virus disease response in the Democratic Republic of the Congo. It has set up base camps for over 160 frontline responders, who have also received training; built office infrastructure for more than 400 staff; established an emergency operations centre; and deployed personal protective equipment.

Treatment centres were set up equipped with mobile laboratories and new rapid diagnostic tools. Clinicians were deployed through the WHO Emerging Diseases Clinical Assessment and Response Network (EDCARN), a WHO-coordinated network of experts in emerging diseases.

By the end of 2018, almost 60 000 people had been vaccinated with a new experimental vaccine. The logistics of delivering the vaccine were especially complicated because it requires specialized logistics to maintain it at minus 80 degrees. Community engagement teams helped address concerns and control outbreaks by raising awareness of risk factors and protective measures, such as vaccination and safe burial.

This was a far cry from the response to the 2014 outbreak in West Africa. Then, there was no vaccine, limited diagnostic services and few trained responders. Health workers were in short supply, while both surveillance and rapid response systems were inadequate. Laboratories were mostly located in cities and community engagement was limited. The epidemic exploded into the most severe Ebola virus disease outbreak ever, with repeated flare-ups and new transmission chains, resulting in 29 000 confirmed or probable cases and 11 000 deaths over two years. The epidemic was a wake-up call, providing key lessons in outbreak response.

Instead of the terror and chaos of 2014, in 2018 the response was coordinated, planned and financed. The initial outbreak in Equateur province was contained within three months. A subsequent outbreak in Kivu province is ongoing, with operations hampered by challenging conditions and security issues. Nevertheless, the number of cases – more than 900, with 600 deaths – is far smaller than in 2014. Hundreds, possibly thousands, of cases have been averted.

Responding to the Ebola outbreak

In the midst of conflict, and in some of the most challenging conditions, Ebola responders are working round the clock to ensure that people can get the information, care and treatment that they need. This is a snapshot of the operations in Democratic Republic of the Congo:



6

treatment centres supported by WHO and partners



254

staff trained on security



57 634
vaccinations administered*



24 448 717
people screened at points of entry*



48hrs to set up a laboratory
2hrs to get a test result



13 500
samples tested

More than
1000
experts deployed by WHO and partners

*data as reported by 1 January 2019

Stopping diseases from crossing borders

Since May 2018, WHO has supported the Democratic Republic of the Congo in preventing the spread of Ebola virus disease to neighbouring countries by setting up exit screening for travellers at international airports, seaports and major land crossings. The activities included risk mapping at porous borders, screening for signs and symptoms of Ebola virus disease, mapping the history of exposure, and reviewing exit screening procedures.



New Ebola virus disease test enables faster outbreak response

Previously, testing for Ebola virus disease could take days or even a week. A lack of local laboratory capacity meant that samples had to be sent to highly secure laboratories far from the outbreak location. This wasted precious time for the patient and allowed the undetected virus to spread.

The arrival of a rapid genetic test for the Zaire strain of Ebola, the **Xpert Ebola test**, changed that. Developed during the 2014–2016 Ebola virus disease outbreak, the test uses the GeneXpert machine to produce results in under two hours instead of several days, allowing the rapid initiation of patient care and containment measures. The test can be safely implemented in provisional laboratories near patient care settings; it is simpler to use than a conventional polymerase chain reaction, and can be operated by locally-trained staff. During the Ebola virus disease outbreak, new laboratories could be set up in 48 hours to move with the outbreak, and **13 500 GeneXpert samples were tested**.

Staying safe by sharing expertise

Emerging epidemic diseases threaten global health security. While WHO has specific strategies for combating known diseases, such as yellow fever, there are no medical counter-measures for some high-threat pathogens. To address this, WHO fosters research and information sharing for high-threat pathogens through expert technical networks and advisory groups, bringing together the latest expertise and institutional knowledge. These networks may offer innovative solutions for tackling pandemics and “infodemics” (damaging “epidemics” of rumours during outbreaks).

Some flagship networks include:

- **Global Influenza Surveillance and Response System** – a 66-year-old network comprising 150 institutions in 114 countries, it generates data for vaccine composition and offers guidance on influenza pandemic preparedness.
- **Emerging Diseases Clinical Assessment and Response Network** – defines standards of care, such as clinical standards and standard operating procedures, and, in emergencies, deploys clinical experts to the front line.
- **Emerging and Dangerous Pathogens Laboratory Network** – focuses on human and veterinary infections by following an integrated approach to laboratory response.

An important element in WHO’s work with global expert networks is the research and development blueprint (R&D Blueprint). It triggers research during outbreaks entailing fast-track development of effective diagnostic tests, vaccines and medicines, such as the vaccines against Ebola virus disease. In May 2018, a vaccine previously tested in Guinea was deployed in outbreak areas.

Proven strategies implemented at scale

The number of high-threat infectious hazards continues to rise. WHO develops global strategies with partners from technical, scientific and social fields to counter high-threat infectious hazards and help manage scarce resources. The **International Coordinating Group on Vaccine Provision** monitors global stock levels of vaccines against cholera, meningitis and yellow fever to ensure adequate supplies in an outbreak.

Some flagship global strategies include:

- **Eliminate Yellow Fever Epidemics (EYE) global strategy** – to tackle the increased risk of yellow fever epidemics in a coordinated manner and to eliminate the disease by 2026, targeting the most vulnerable countries. In 2018, 61 million people were vaccinated in Africa.

Stronger health system in the Republic of Korea contains outbreak

In September 2018, a 61-year-old Korean man was confirmed as having Middle East respiratory syndrome (MERS-CoV) a day after returning home to Seoul from a business trip to Kuwait. Middle East respiratory syndrome is a viral respiratory disease that kills more than one out of three people it infects.

The case brought back nightmares of the 2015 outbreak in the Republic of Korea in which 186 people were infected and 39 died; 70 health care facilities were also affected. The cost was an estimated US\$ 8 billion.

This time was different. The Republic of Korea had made significant improvements in its health system, so that outbreaks of diseases like Middle East respiratory syndrome could be quickly identified and contained. Following WHO recommendations on priority areas for systems strengthening – based on technical missions during the 2015 outbreak and a 2017 Joint External Evaluation (JEE) – the country had improved its health worker training, disease surveillance, infection prevention and control procedures, laboratory systems and interagency communications.

When the new case arrived in 2018, the Republic of Korea was able to respond promptly and keep the disease from spreading. There were no further infections. The system was changed to address the gaps which were identified during the evaluation. Early recognition, prompt isolation and good infection, prevention and control measures in health care facilities make a huge difference in how an event will unfold.



Restoring health-care services in the Syrian Arab Republic

Years of conflict in the Syrian Arab Republic have taken a toll on the health system – once one of the region's best – and have created one of the world's biggest and most complex humanitarian emergencies. Only half of all health facilities are fully functional due to attacks on facilities, while conflict in the north has severely disrupted services.

In 2018, there were outbreaks of typhoid fever and acute diarrhoea caused by unclean water and sanitation. There were also outbreaks of measles owing to low vaccination coverage, while rates of cutaneous leishmaniasis rose sharply.

- WHO, with partners, is helping to restore disrupted services. It also supports more than 1700 health-care facilities reporting to a disease early warning system, which helps rapidly detect and curtail such outbreaks. An outbreak of vaccine-derived poliovirus was stopped with a mass vaccination campaign reaching 2.6 million children.
- In 2018, WHO also delivered 1900 tonnes of health supplies and equipment, donated mobile clinics to bring health care to underserved areas, and trained 30 000 people in a wide range of health issues.



- **Global Task Force on Cholera Control** – much progress has been made on the global roadmap for ending cholera, which aims to reduce cholera mortality by 90% globally and eliminate it in 20 high-risk countries by 2030, with 10 countries taking active measures to control cholera.
- **Global Influenza Strategy for 2019–2030** – monitors influenza virus evolution, updates vaccine compositions and outlines global priorities for pandemic preparedness.
 - More than 500 million people were vaccinated for seasonal influenza around the world in 2018.
 - 400 million doses of pandemic vaccine were secured through the Pandemic Influenza Preparedness Framework.

Mitigating high-threat infectious hazards

We do not know which high-threat disease will emerge next, or where, only that novel pathogens are a certainty. New diseases often emerge in vulnerable countries that may not have the capability to prevent, detect and respond to outbreaks. WHO worked with its network of partners to reduce the risks of re-emergence of high-threat pathogens and the emergence of new and unknown high-threat pathogens, such as viral haemorrhagic fevers, vector-borne diseases, respiratory pathogens, biosecurity threats and antimicrobial resistance. Areas where action was taken include those set out below.

- **Laboratory biosafety and biosecurity** – In 2018, WHO worked to improve specimen collection and safe transport, and access to quality-assured laboratory diagnostic capacity. Global consultations were organized to gather expert views and develop guidance and share best practices in the safe shipping of infectious substances, laboratory biosafety and biosecurity, and community-based surveillance.
- **Coordination of animal and health sectors** – Nearly 75% of emerging pathogens are zoonotic. Implementing the International Health Regulations (2005) requires the joint contribution of different disciplines and sectors through a One Health approach. WHO has been working in close collaboration with the Food and Agriculture Organization of the United Nations (FAO), and, in particular, the World Organisation for Animal Health (OIE), to align the veterinary sector's work with implementation of the International Health Regulations (2005). Together OIE and WHO have developed **national bridging workshops** to review gaps in coordination between the health and veterinary sectors.



Controlling cholera in Yemen

The number of suspected cholera cases in the war-torn nation of Yemen dropped from a peak of 50 000 a week in 2017 to a low of about 10 000 a week in 2018, following a range of interventions, including a mass vaccination campaign. More than 306 000 people were vaccinated against cholera as part of a joint WHO-UNICEF campaign that concluded in October 2018. Yemen has experienced a surge in cholera cases since April 2017 due to ongoing conflict, destroyed health, water and sanitation infrastructure, and malnutrition, which increases the vulnerability of the population. The cholera epidemic in Yemen was the largest in the world in 2018.

Technology helps track diphtheria in the Rohingya Humanitarian Crisis

When diphtheria broke out in November 2017, the outbreak quickly spiralled to 150 cases a day. WHO's new Early Warning, Alert and Response System (EWARS) enabled quick collection of field data allowing response teams to act promptly. Rather than leafing through dozens of paper reports, health workers kept close track of the outbreak on their laptops. Contact tracing and diphtheria treatment centres also helped contain the outbreak.

Getting countries to monitor and report preparedness capacities

In 2018, WHO worked closely with countries to monitor and report on their emergency preparedness capacities for all hazards. The work is mostly founded on the **International Health Regulations** (2005), the legal framework which sets out procedures for preparing and responding to public health threats. WHO has developed four tools to help countries assess and report capacities for emergency preparedness. These include **simulation exercises** and **Joint External Evaluations** (a voluntary process to assess a country's capacity to prevent, detect and respond to risks, and to identify critical gaps and opportunities for better preparedness).

- In 2018, 187 countries reported on their national capacities to respond to emergencies.
- 24 Joint External Evaluations and 31 simulation exercises were conducted in 2018.

A **simulation exercise** for a global pandemic response involving some 40 countries took place in December 2018, coordinated by WHO and the EOC Network, a global network of emergency operations centres. Taking as its theme, a virtual influenza outbreak on a fictional island, staff from emergency operations centres around the world were able to test their pandemic plans in order to identify areas for improvement.

Strengthening national emergency preparedness

Through health strengthening efforts, WHO worked to improve functional capacities, such as laboratories, national emergency plans, multisectoral cooperation and surveillance systems capable of verifying acute public health risks. WHO also supported countries in **national action planning for health security** in order to accelerate implementation of the International Health Regulations (2005).

WHO helps countries strengthen laboratory and surveillance capacity by supplying technical guidance, materials and tools. The **Safe Hospitals Initiative** helps keep hospitals safe and operational during a disaster. An assessment tool provides a snapshot of the hospital's safety and preparedness.

Rapidly detecting health emergencies

WHO has a system for carrying out continuous event-based surveillance of public health events and verification and assessment of detected events. It currently picks up 7000 public health threat signals every month, of which 0.5% result in formal field investigations and risk assessments.

During outbreaks, WHO provides support to countries for continuously monitoring events and conducting risk assessments, including implementation of the **Public Health Information System**.

WHO's **Disease Outbreak News (DONs)** provides updates containing epidemiological summaries, responses, risk assessments and advice. DONs are among the most visited WHO webpages, receiving nearly three million visits a year. In 2018, WHO published 91 DONs.

The **Early Warning, Alert and Response System (EWARS)** is a new computer programme developed by WHO for outbreak detection in emergency settings. It allows for quick collection of field data to enable a prompt response.

In 2018, WHO monitored and assessed nearly **180 health events each week**, producing weekly and daily updates.

As at the end of 2018,

28 countries had completed their national action plans for health security.

850 laboratory personnel in 62 countries received training.

400 professionals at ports and airports were trained in surveillance.

2800 health professionals in 141 countries were trained in health security.

Key figures for 2018–19 WHO Health Emergencies

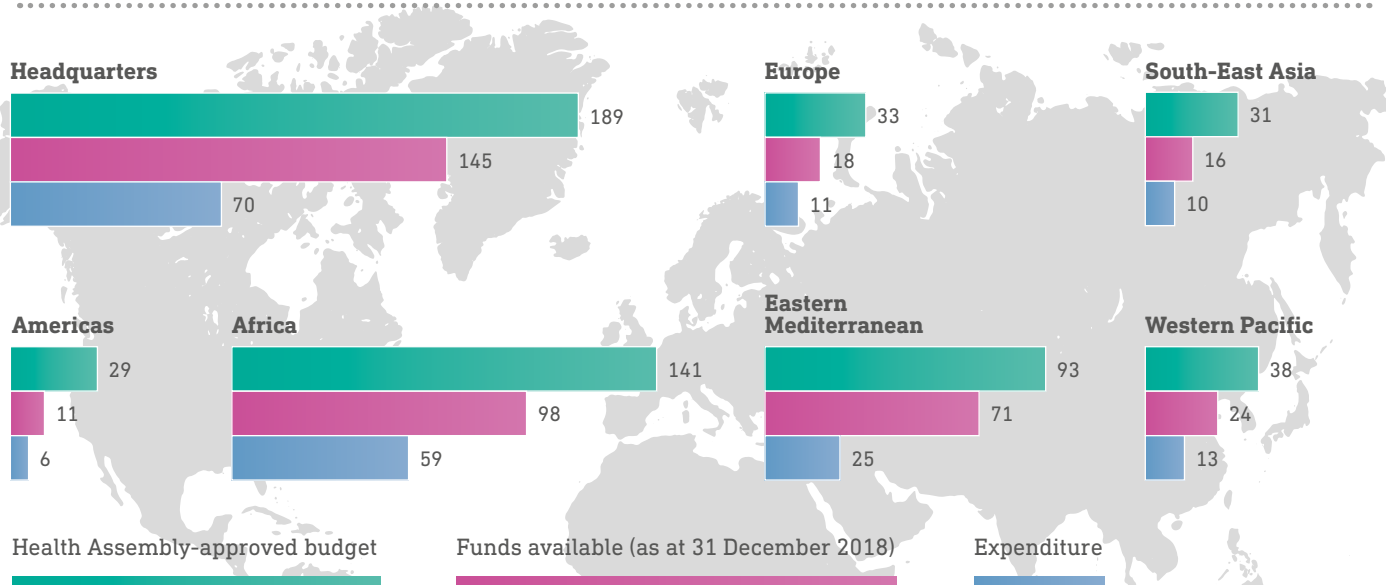
Approved Programme budget: US\$ 554 million

Funds available: US\$ 383 million (69% of Programme budget)

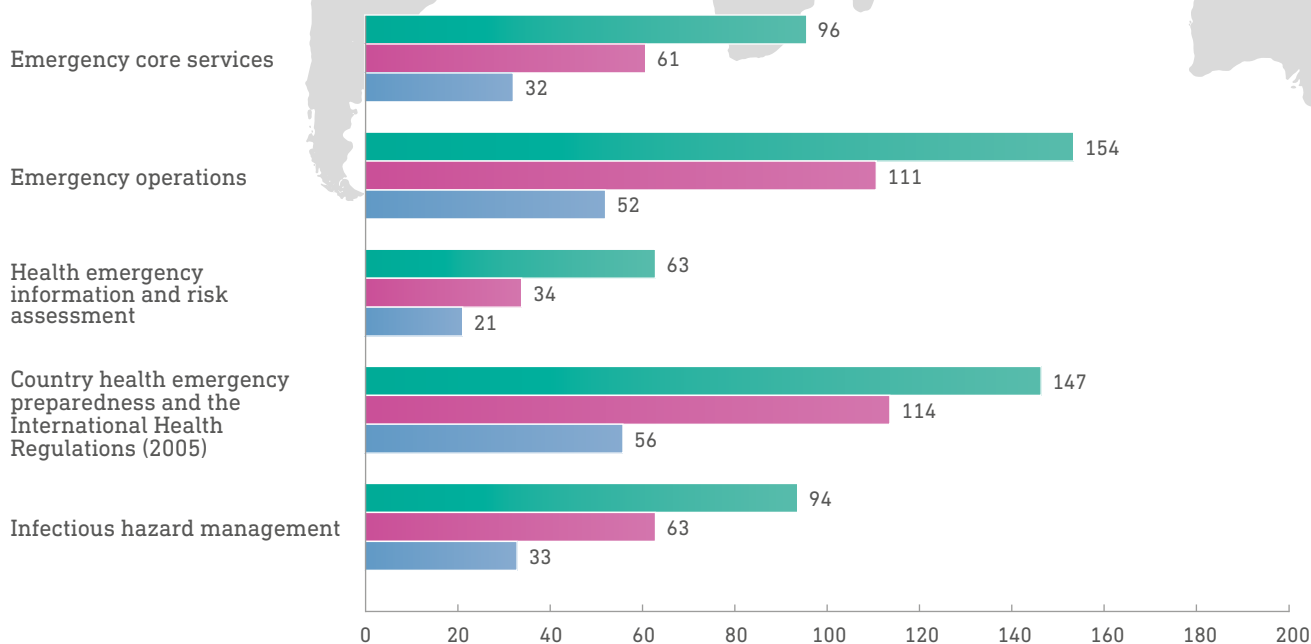
Expenditure: US\$ 194 million (35% of Programme budget, 50% of available resources)



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



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



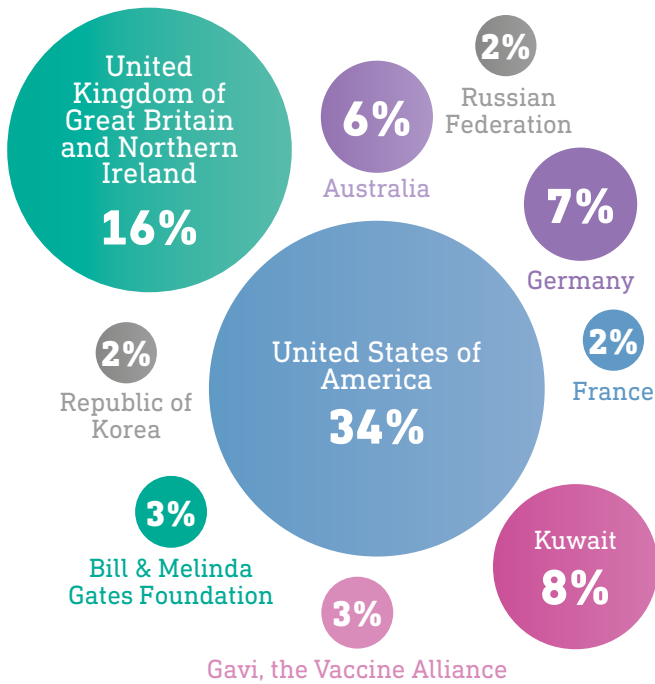
Budget and implementation

The WHO Health Emergencies Programme was financed to 69% of its approved level. However, this was uneven across major offices with, for example, 77% in headquarters and 76% in the Eastern Mediterranean Region, but only

38% in the Region of the Americas. Although the scale of demand for the Programmes' core work was much higher in the African and Eastern Mediterranean Regions (owing to the high level of emergency work in the two regions),



Top 10 voluntary contributors (specified)



Funding source:

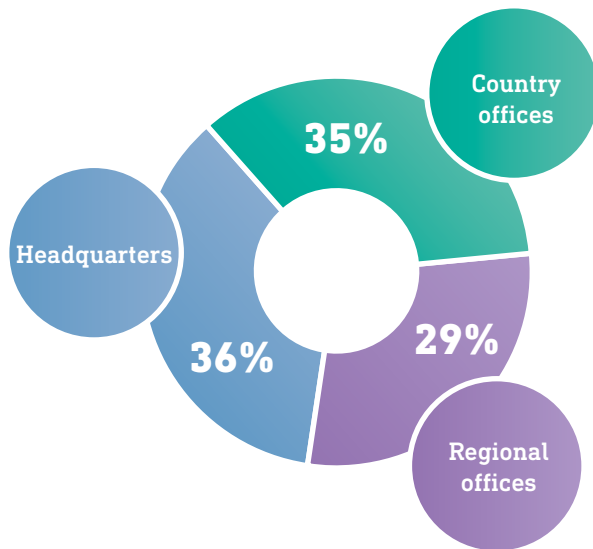
Flexible funding: 29%

Voluntary contributions – specified: 71%

Of the total voluntary contributions specified, 83% were from 10 contributors (shown beside)



Expenditure by level

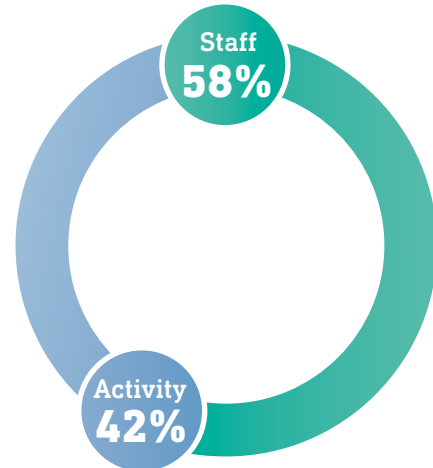


expenditure as a percentage of the approved level was lower in the latter, at only 27%. The African Region, by comparison, achieved 42% of the approved level. The low expenditure rate reflects the challenge of operating in conflict, fragile and vulnerable situations. Closer support for implementation is needed.

The extent of available resources remained relatively consistent across programme areas with the exception of health emergency information and risk assessment which had only 54% of the approved level. However, expenditure levels were all close to the average of 35% of the approved level for the WHO Health Emergencies programme area.



Expenditure: staff vs. activity



Given the relatively large size of the approved budget for the WHO Health Emergencies Programme, the flexibility of funding remains a key to full financing of this programme.

For further details on the Programme budget funding and implementation for this category, please refer to the WHO Programme Budget Portal (<http://open.who.int/2018-19/our-work/category/12/about/key-figures> and <http://open.who.int/2018-19>).

Key figures for 2018–2019 Humanitarian response plans and other appeals

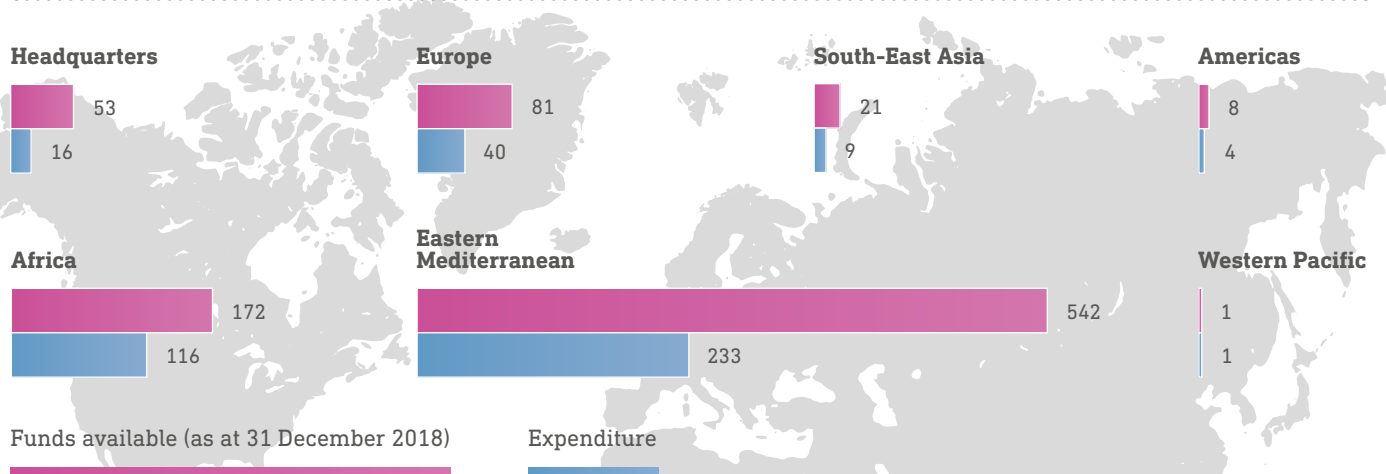
Approved Programme budget: US\$0 million

Funds available: US\$ 878 million

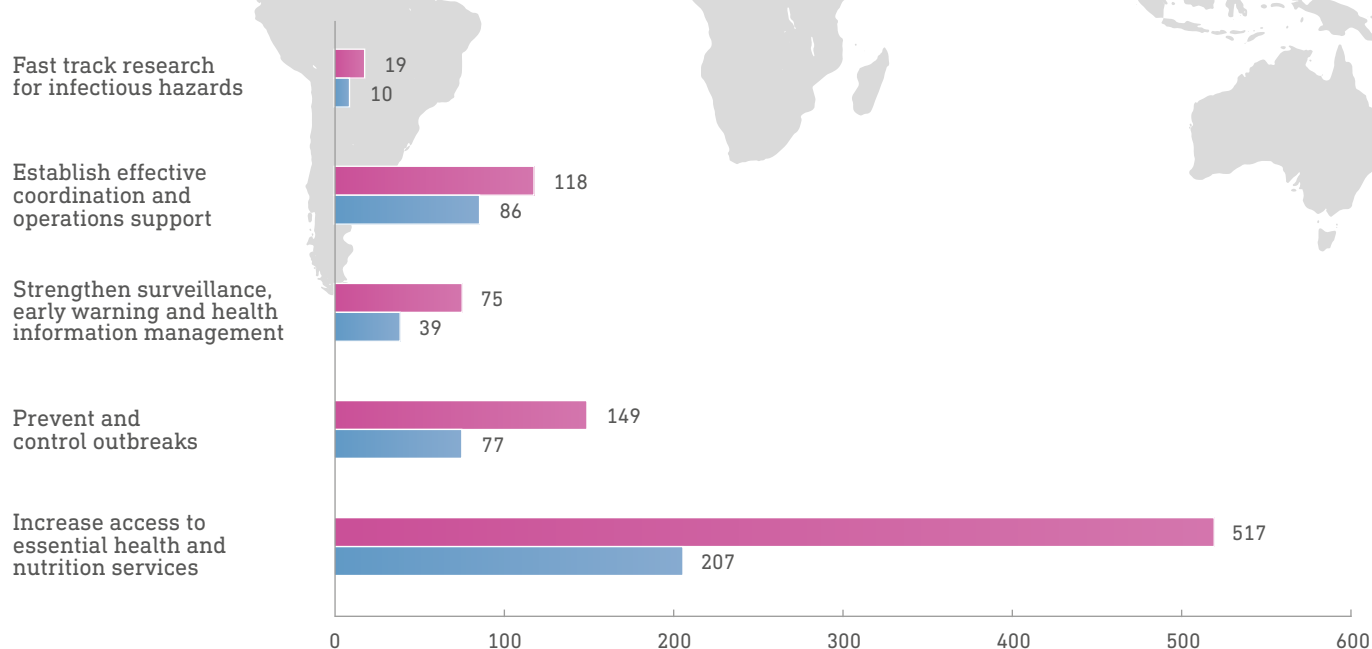
Expenditure: US\$ 419 million (48% of available resources)



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



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



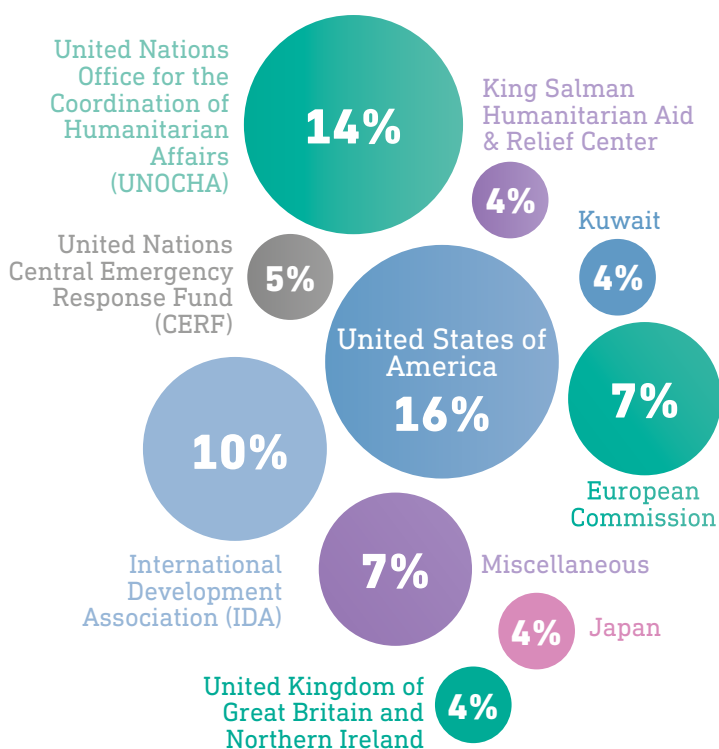
Budget and implementation

Being entirely event-driven, the programme area of Outbreak and crisis response had no approved budget level for 2018–2019. It also received only 1% of its available resources from flexible funding sources, given the reliance on donor support of such work.

Overall expenditure was 48% of the available resources with headquarters the lowest at 30%. The African Region reached 67% and the Western Pacific Region almost 100% (although the latter received the smallest amount of any major office in absolute terms). Ninety-five per cent of expenditure was at the country level. Only 7% of expenditure was for staff.



Top 10 voluntary contributors (specified)



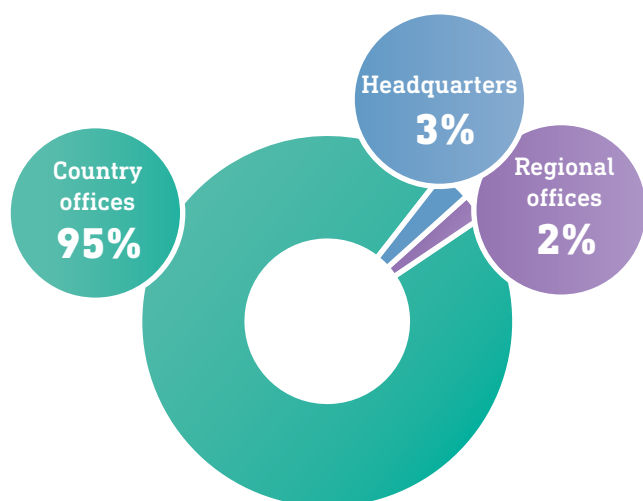
Funding source:

Flexible funding: 1%
 Voluntary contributions – specified: 99%

Of the total voluntary contributions specified, 75% were from 10 contributors (shown beside)



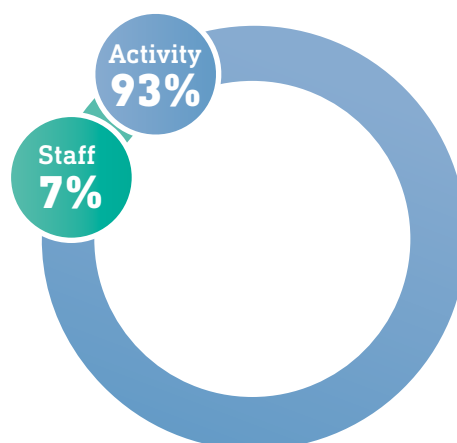
Expenditure by level



The data show that the rate of expenditure is low for the areas with substantially more financing. This is particularly evident for the increasing access to essential health and nutrition services. The rate of expenditure is at 40% of a significantly larger funding of US\$ 517 million. The reasons for this low rate are being assessed in order to determine whether there is a need for investing resources in implementation, including collaboration with relevant



Expenditure: staff vs. activity



technical programmes in WHO which are also key for responding to emergencies.

For further details on the Programme budget funding and implementation for this Category, please refer to the WHO Programme Budget Portal (<http://open.who.int/2018-19/our-work/category/13/about/key-figures> and <http://open.who.int/2018-19>).

PROMOTING HEALTH THROUGH THE LIFE COURSE

PROGRAMME AREAS

Reproductive,
maternal, newborn,
child and adolescent
health

Ageing and health

Health and the
environment

Equity, social
determinants,
gender equality
and human rights



“ Promoting health over the life course demands a whole-of-society movement to create nurturing conditions in which people of all ages can thrive. It requires peoples' participation, the voices of all, and that those voices be heard, particularly the voices of those left behind. ”

Dr Carissa F Etienne
WHO Regional Director for the Americas

The life course approach recognizes the specific health concerns of different stages of life and ages: safe pregnancy, delivery and childbirth; early childhood development; healthy transition to adulthood during adolescence; women's health, including during reproduction; and healthy ageing, which is now the fastest-growing life stage.

An unacceptably high number of women and young children, mostly in low-resource settings, die every day of causes that can easily be prevented. Social, economic and environmental factors play a part. The life course approach aims to identify the factors that lead to inequitable health outcomes. It also considers how previous and future generations are interconnected. The overall goal is to promote health equity by protecting human rights and reducing gender inequalities.

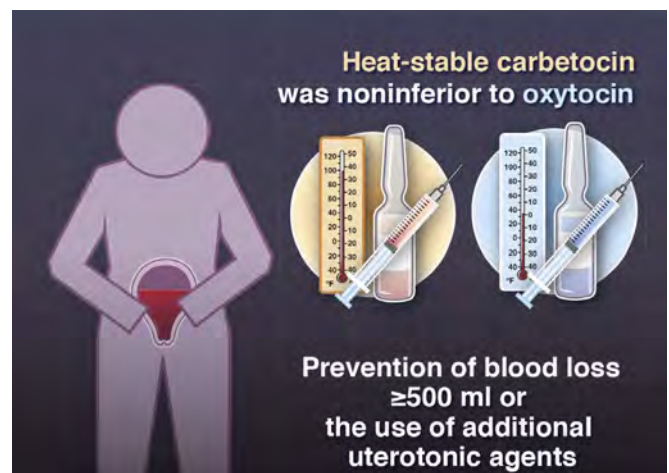
Key achievements

Bringing innovations to make childbirth safer and better

The tragedy of maternal mortality still takes 830 lives a day. The largest direct cause of these deaths is severe bleeding after birth. Almost 99% of these deaths occur in developing countries. Now, a new formulation of a drug offers fresh hope, according to a study led by the special Human Reproduction Programme¹ and published in the *New England Journal of Medicine* in 2018. The study shows that **heat-stable carbetocin** is as effective as the standard therapy, oxytocin, which requires refrigeration. Eliminating the need for refrigeration could save thousands of women who live in settings where it is difficult to store drugs in the right conditions. The study included close to 30 000 women in 10 countries.

Outcomes we are aiming to achieve in 2018-2019

- Increased access to interventions for improving health of women, newborns, children and adolescents
- Increased proportion of people who are able to live a long and healthy life
- Reduced environmental threats to health
- Improved capacities in WHO, the health sector and across all government departments and agencies (whole-of-government) for addressing social determinants, gender inequalities and human rights in health and producing equitable outcomes across the Sustainable Development Goals



¹ The UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction.

Evidence from the special Human Reproduction Programme's research on labour and delivery has helped WHO to produce the guideline on **intrapartum care for a positive childbirth experience**. The 56 evidence-based recommendations include enabling women to decide on their pain management, labour and birth positions. Some recommendations are being incorporated in national plans. The special Human Reproduction Programme research also led to the development of WHO recommendations on non-clinical interventions to reduce unnecessary caesarean sections. The increasing medicalization of birth has led to needless and potentially harmful interventions being performed, including interventions previously used only to treat complications or avoid risks, such as caesarean sections. Unnecessary interventions may strain scarce resources.

Global monitoring of **Maternal Death Surveillance and Response** aims to notify, quantify and review deaths, and also to inform work to improve the quality of care around birth and ultimately reduce maternal mortality. Of the 148 countries that responded to the 2018 survey or the 2015 baseline survey, more than 80% of countries reported a policy for notification of maternal death within 24 hours and a national policy for review of deaths.

Reducing newborn death

Globally, the number of neonatal deaths declined by half, from 5 million in 1990 to 2.5 million in 2017 (most recent data). However, the decline in neonatal mortality was slower than that for under-5 mortality. It is crucial that appropriate care and feeding be provided in the child's first 28 days for premature or low-birth weight newborns to increase their chances of survival. WHO has promoted kangaroo mother care to this end. Significant progress is being made in the reduction of maternal, newborn and child mortality.



Saving the lives of mothers in Paraguay

In 2014, Paraguay embarked on a four-year programme to reduce the relatively high number of women who die in childbirth, under the slogan #CeroMuertesEvitables.

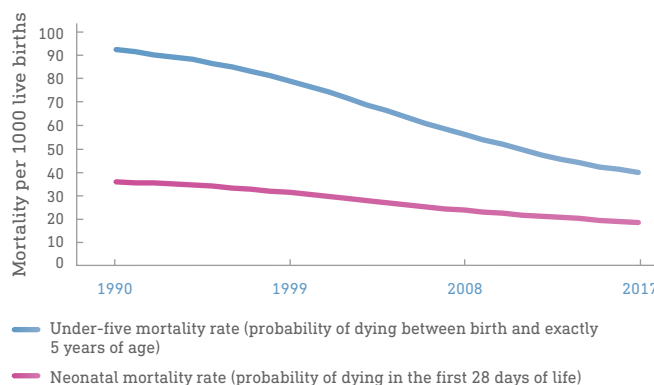
WHO in the Region of the Americas/PAHO provided technical cooperation with a focus on strengthening four areas: integrated health services network; maternal and neonatal health surveillance; human resources development in the mother-child area at three levels of care; and strategic information system.

The impact of the programme is clear, with a 10% drop in the number of maternal deaths during the last 3 years. Family Health Units have been strengthened with improved basic equipment, supplies and materials in order to enable better prevention and monitoring of malnutrition in pregnant women and children under five. Rural and indigenous women now also have better access to financial education and economic empowerment through socio-productive initiatives.

Another impact was the strengthened capacity of human resources for comprehensive health care, with an emphasis on obstetric and neonatal emergency management through "Code Red" training sessions, which made technical and financial cooperation possible in health facilities in hard-to-reach communities. More than 6600 health professionals and technicians were trained.

Additionally, the mortality information system was improved, with reinforced analysis capabilities concerning maternal deaths and clarification of discrepancies between registered and estimated maternal mortality.

Neonatal and under-5 mortality rates



Improving care for maternal and newborn health in Malawi

Malawi's National Quality Management policy, 2017- 2022, sets the framework for improving the quality of health services and achieving national development goals. WHO and partners have helped to develop new service delivery standards for quality of care, based on WHO's latest guidelines.

A total of 24 health facilities (districts or community hospitals and health centres) were identified as learning sites in six districts with high maternal mortality levels, high catchment populations and available funding. Improvements are being made in the proper and effective use of partographs, supervision and infection prevention in maternal health areas, documentation of care and data management and use.

Malawi is one of ten pathfinder countries supported by WHO as part of the Network to improve the quality of care for maternal, newborn and child health (the QoC Network).

Malawi's national goals for 2030

- Reduce maternal mortality rate from 439 to 140 per 100 000 live births
- Reduce neonatal mortality rate from 27 to 12 per 1000 live births
- Reduce under-five mortality rate from 63 to 25 deaths per 1000 births

Kangaroo mother care: saving newborns

WHO recommends kangaroo mother care for newborns of low birth weight as an effective alternative to conventional neonatal care, which is expensive and requires skilled personnel. Kangaroo mother care involves prolonged skin-to-skin contact, exclusive breastfeeding and close monitoring for illness.

WHO has been coordinating clinical trials to generate new evidence on kangaroo mother care. A study on home-initiated kangaroo mother care showed that it substantially reduced neonatal and infant mortality for low birth weight infants. A second study in four African countries and one Asian country is ongoing.

WHO coordinated the scale up of kangaroo mother care in four regions of Ethiopia and three states in India, reaching a total population of six million. Barriers were systematically identified and addressed by district health teams, including by enabling mothers to stay in hospitals for kangaroo mother care, addressing the false beliefs of health workers that incubators were a better alternative to kangaroo mother care and counselling family members to support kangaroo mother care at home. Population-based coverage of more than 80% initiation of kangaroo mother care and 60% effective kangaroo mother care (defined as more than 8 hours a day of skin-to-skin contact and exclusive breastfeeding) has been achieved – a significant rise from the baseline coverage of less than 5%. The scale up has been expanded across the provinces and states involved in the two countries.

In the Western Pacific Region, the eight priority countries with the highest burden of newborn deaths were supported to scale up **Early Essential Newborn Care**. WHO's clinical coaching for routine Early Essential Newborn Care, which reached 30 000 health workers in more than 3600 hospitals in the priority countries, was well received. Upon request from countries, a teaching module was developed on kangaroo mother care. Subsequent assessments showed significant practice change in delivery and postnatal room occupancy, with kangaroo mother care rising to 35% of preterm babies, a fivefold rise from 7% in two years. The scale up was most pronounced in the Philippines and Viet Nam. Significantly, the practice of health workers greatly improved. The results from one hospital in Da Nang, Viet Nam, showed a decrease in sepsis, admission to intensive care units for newborns and hypothermia on admission and a rise in exclusive breastfeeding, as published in *EClinicalMedicine*, a Lancet journal.



Eliminating congenital syphilis

Sexually transmitted infections (STIs) still represent a massive global burden of disease, with 1 million people acquiring a curable STI every day and 500 million people living with the incurable Herpes Simplex Virus. Syphilis is one of the most common STIs, with 6 million new cases each year. Mother-to-child transmission of syphilis has serious consequences – it is the second leading cause of stillbirth. WHO is working to address this situation on a number of fronts through the special Human Reproduction Programme and both are actively monitoring STIs, including congenital syphilis. WHO published a report on syphilis global estimates in 2018.

WHO and the Special Programme are supporting countries to scale up the use of dual testing for both HIV and syphilis. Coverage of syphilis screening is low in many high-prevalence countries, often lagging behind HIV screening. Since WHO prequalification of the first rapid test for the two diseases in 2017, screening has expanded.

WHO has supported efforts to expand syphilis screening through rapid dual tests for pregnant women in more than 10 countries in 2018, with the aim of reducing mother-to-child transmission of syphilis through testing and treatment with benzathine penicillin. Many countries are being supported to eliminate congenital syphilis. In 2018, Malaysia was the twelfth country to be validated for elimination of mother-to-child transmission of syphilis.

Syphilis screening with rapid dual tests for pregnant women was expanded in more than 10 countries in 2018 with support from WHO

WHO is also working on point-of-care tests for gonorrhoea, chlamydia and trichomoniasis, as well as tests for HPV to prevent cervical cancer. Vaccines against herpes, gonorrhoea and chlamydia are being developed

Eliminating cervical cancer

In May 2018, the WHO Director-General, Dr Tedros Adhanom Ghebreyesus, made a global call to action towards the elimination of cervical cancer, which is caused by sexual transmission of the human papillomavirus. Despite being one of the most preventable and treatable forms of cancer, with a vaccine and effective screening and treatment available, human papillomavirus kills a woman every two minutes and 90% of these deaths occur in low- and middle- income countries – there are both gross inequities and a public health threat.

Vaccination against human papillomavirus, screening and treatment of precancer, early detection and prompt treatment of invasive cancers and palliative care have proven to be effective strategies for addressing cervical cancer across the care continuum and represent the WHO life course approach to cervical cancer control. The development of a global strategy to specify 2030 targets for eliminating cervical cancer is under way at the request of the Member States during the 144th session of the Executive Board, held in January 2019.

WHO, the special Human Reproduction Programme, IARC and other partners are collaborating to accelerate response. Strong research programmes have been developed to:

- validate new technologies for the screening of cervical cancer and the treatment of cervical pre-cancer lesions;
- define and validate the most cost-effective algorithms to ensure screening and treatment of all targeted women;
- ensure that any new technology supporting the elimination of cervical cancer agenda can be rapidly validated and made available to countries.

By October 2018, 85 countries had introduced vaccination against human papillomavirus. Bolivia (Plurinational State of), Myanmar, Mongolia, Morocco, the United Republic of Tanzania and Uzbekistan are implementing pilot projects to scale up, over the next three years, the introduction of human papillomavirus testing for screening, and cryotherapy or thermal ablation for the treatment of pre cancer lesions, with support from WHO and six other United Nations partners (IAEA, IARC, UNAIDS, UNFPA, UNICEF and UN Women).

Thailand, a pathfinder in strengthening gonorrhoea surveillance for antimicrobial resistance

To prevent the spread of gonorrhoea, including the drug-resistant type, it is vital that people get diagnosed and receive appropriate care promptly. Thailand has been a pathfinder in strengthening the surveillance programme for gonorrhoea antimicrobial resistance, as recommended by WHO to guide revisions of gonorrhoea treatment. Based on antimicrobial resistance patterns, gonorrhoea treatment guidelines in the Ministry of Health of Thailand have been revised and disseminated widely in both the public and private sectors. To date, through enhanced surveillance by the WHO Global Gonococcal Antimicrobial Surveillance Programme, gonorrhoea remains susceptible to ceftriaxone and cefixime in Thailand.

Accelerating child-centred coverage in the United Republic of Tanzania

In 2013, WHO supported the Ministry of Health in the United Republic of Tanzania to pilot a blended learning course on implementing an integrated approach to child health that focuses on the well-being of the child (distance learning Integrated Management of Childhood Illness or d-IMCI). Following a systematic assessment of the pilot, which showed that scale-up of the training was feasible and effective, a total of 7820 health workers were trained in 72 districts between 2015 and 2018. The d-IMCI provides a solution to low coverage of IMCI, poor adherence to IMCI guidelines, high turnover of IMCI-trained providers and high costs of training. It has minimized disruption of services and reduced costs by 70%. The course takes 10 weeks to complete and includes three face-to-face classroom encounters that last 1 day each, one onsite coaching session and two sessions of distance learning. Facility coverage of up to 90% has been achieved by scheduling several cohorts of training in parallel, allowing them to train on alternate days at the same site in a district.

Turning the tide against gonococcal antimicrobial resistance

Gonorrhoea is on a growing list of infections that are running out of treatment options. *Gonococci* – the bacteria which cause the infection – are becoming increasingly resistant to the antibiotics that formerly killed them. In 2012–2014, data generated from Gonorrhoea Surveillance Programme showed that 70 of 72 countries reported resistance to quinolone, yet the majority of countries in resource-constrained settings still have quinolone in their national STI treatment guidelines.

In 2016, WHO released a new guideline on the treatment of gonorrhoea based on the latest evidence, including antimicrobial resistance patterns. WHO recommended that countries update their gonorrhoea treatment guidelines based on country antimicrobial resistance patterns and remove quinolones as a treatment option.

By 2018, the majority of countries (58 countries) had adapted the new WHO-recommended treatment guidelines. Quinolone has been deleted as a recommendation for treating gonorrhoea. The majority of countries now recommend the use of ceftriaxone or cefixime to treat gonorrhoea. There has also been an increase of countries monitoring antimicrobial resistance in gonorrhoea; there are currently 67 countries monitoring gonorrhoea antimicrobial resistance.

Youth health no longer overlooked

At a time when there are more adolescents in history than at any period before, adolescent health is finally attracting the attention it deserves. The need for a youth focus in planning health care is increasingly recognized. For example, half of all mental health disorders appear by 14 years but mostly go untreated; also, suicide is the third leading cause of death in 15 to 19-year-olds. In view of this, the Accelerated Action for the Health of Adolescents (AA-HA!) was launched by WHO and UN partners. In the African Region, 36 countries are now using the AA-HA guidance for national coordination, planning and setting priorities. In the Eastern Mediterranean Region, a guide has been developed for programmatic action for adolescent health in humanitarian settings.

WHO has, with partners, set up an advisory group, **Global Action for Measurement of Adolescent Health**, to address data gaps and harmonize and prioritize indicators. Normative tools published include a handbook on adolescent health services barriers assessment and guidelines on adolescent nutrition and on HIV prophylaxis.

Innov8 to reach vulnerable adolescents in the Dominican Republic

In the Dominican Republic, pregnancy in adolescents is a problem, particularly for young girls in vulnerable communities. In late 2017, the national programme to prevent pregnancy was reviewed by the Ministry of Health, the Region of the Americas/PAHO and other partners.

The review group used the WHO tool **Innov8** for analysis; its equity-based methodology allows the evaluation and redesign of national health strategies and programmes to close coverage gaps. Specifically, Innov8 was used to identify groups not reached by health programmes, recognize barriers and facilitating factors and find structural mechanisms that impact inequities and facilitate intersectoral action. Innov8 was also used to measure and monitor progress.

In 2018, the intersectoral team managed to complete the first seven steps of Innov8, fulfilling fundamental recommendations for the preparation of the new Prevention Plan for Adolescent Pregnancies 2019–2023. The updated Plan ensures the inclusion of the most vulnerable adolescent groups, reduces inequities and achieves lower pregnancy rates in this population.



Actions on mainstreaming gender equality and human rights to achieve health equity

Work to mainstream gender equality and human rights into programme areas has continued, including various initiatives taken up at the regional level.

In the African Region, 21 countries have been supported to mainstream gender equality, health equity and human rights into their health policies. Six countries now have national plans to accelerate the abandonment of female genital mutilation and 12 countries are set to use WHO tools to strengthen the health system response to gender-based violence and sexual assault. A pilot of the adolescent health services barriers assessment tool in Kenya and Nigeria revealed powerful details about the existing barriers. The research was done to support implementation of the AA-HA! Framework.

The **WHO European Health Equity Dataset** was developed by the Regional Office to capture trends on health equity. The Region also endorsed the first ever Men's Health Strategy, which takes a comprehensive approach to men's health, backed by a report on the subject.

In the Western Pacific Region, awareness on gender equality and health equity was raised at a number of *Talanoa* Dialogues – traditional gatherings in Fiji and the Pacific for inclusive, participatory and transparent discussion. Training of health workers was also provided in Kiribati, Solomon Islands and Vanuatu, while the health sector response was assessed in Viet Nam and Micronesia (Federated States of).

Building a climate resilient health system in Ethiopia

Climate change is threatening countries' rapid development progress through changes in average temperature and precipitation. This raises the challenge of providing reliable, sustainable water and sanitation services to a large and growing population across diverse climatic regions.

WHO has supported Bangladesh, Ethiopia, Nepal and United Republic of Tanzania to address climate change, water and health, with funding from the Government of the United Kingdom of Great Britain and Northern Ireland.

In Ethiopia, evidence of the interlinkages between these areas was developed and policy coherence strengthened. Climate resilient water safety plans were implemented in 31 water supply systems, covering more than 1 million people.

The success of this project has led to a further grant of US\$ 10 million for WHO to scale up work in Bangladesh, Ethiopia, Malawi, Mozambique and Nepal to strengthen surveillance systems and develop early warning systems for cholera and other climate-sensitive diseases, as well as to implement climate-resilient water and sanitation safety plans.

This work is based on WHO's climate-resilient water safety plans, which explain how to take into consideration the broader issues of climate change, regional climate vulnerability assessments, disaster risk reduction and integrated water resources management in a way that is aligned with the systematic framework for managing risk presented in the **Water safety plan manual**.



A growing commitment to healthy ageing

Increasing attention to healthy ageing is evident in the remarkable progress made since WHO released the **Global Strategy and Action Plan on Ageing and Health** in 2016. In the two years since, the number of countries with a national focal point in health ministries has increased to 112 and the number of those with national strategies on ageing has doubled to 88. Regional meetings involving 80 countries have increased policy coherence. In China, a newly established department of ageing was set up. National workshops on implementing national strategies are picking up pace across all regions including in Chile, Maldives, Nepal, Qatar, Tajikistan, Thailand and Senegal.

The **WHO Global Network for Age-friendly Cities and Communities** has now expanded to 800 cities and communities in 40 countries, covering more than 200 million people. Leaders in these cities work to improve housing, transport, health and long-term care for older adults.

Guidance on aligning long-term and health care systems with older people's needs has advanced with the **WHO Guidelines on Integrated Care for Older People**. One tool to support implementation is the WHO Mobile Health for Ageing (mAgeing) programme. Technical advice has been provided to 43 countries across regions on adapting the WHO Guidelines on Integrated Care for Older People.

To improve data collection and reporting and ensure older adults are counted and visible, WHO and partners has launched the **Titchfield City Group on Ageing and Age Disaggregated Data**, with 60 national statistical offices. WHO also provides support for national case studies. The WHO Study on Global AGEing and Adult Health is helping to monitor healthy ageing over time in six countries – China, Ghana, India, Mexico, the Russian Federation and South Africa.



Building the momentum on combating air pollution

A quarter of all annual deaths are related to preventable environmental causes. With healthier environments, 13 million deaths could be prevented annually. Environmental risk factors – above all air pollution – are driving up health care costs.

The first **WHO Global Conference on Air Pollution and Health** was held in late 2018, in collaboration with United Nations partner organizations. Participants, including government ministers, called for bold and prompt action and recognized that actions to tackle air pollution and mitigate climate change can achieve combined and therefore substantially greater benefits.

WHO's BreatheLife campaign raises awareness around air pollution, its health impacts and effective interventions. There are now 53 locations (mostly cities) and 146 million people involved in the network, which aims to inspire the public to action, share data and solutions and trigger alerts.

The number of cities in the Eastern Mediterranean Region reporting their air quality monitoring data through the WHO database has risen by 25%.

Building climate resilient health systems

A special initiative, **Climate change and health in small island developing States**, was launched by WHO at the 23rd Conference of the Parties to the United Nations Framework Convention on Climate Change in November 2017.

The initiative's vision is that by 2030, all health systems in small island developing States will be resilient to climate variability and change, in parallel with countries reducing

their carbon emissions. In 2018, WHO worked with the small island developing States to develop a Global Action Plan to build evidence of the impact of climate change, empower the health sector to adapt, implement actions to address the impacts of climate change on health and increase funding.

WHO guidelines influencing country actions

People living in cities – nearly half the global population – are also exposed to a range of environmental threats such as poor water, sanitation and waste management. Two global guidelines – on sanitation and on housing – were issued in 2018. WHO's first global guidelines on sanitation called for countries to make comprehensive policy shifts to enable everyone to have access to toilets that safely contain waste by 2030. For every US\$1 invested in sanitation, WHO estimates a nearly sixfold return as measured by lower health costs and increased productivity. Some 830 000 annual diarrhoeal deaths are due to unsafe water, sanitation and hygiene.

A WHO-commissioned review of mercury biomarkers established a global benchmark for human exposure to mercury. Vulnerable populations were identified, such as communities dependent upon fish for their diet and communities where mercury is used in artisanal or small-scale gold mining (such as Ghana, Mozambique and Nigeria).

In the European Region, the release of the Environmental Noise Guidelines was a key achievement. The **WHO Asia-Pacific Centre for Environment and Health** was launched in the Western Pacific Region.

Cross-cutting work on determinants to get health into all policies

By addressing both social and environmental determinants as a pillar of primary health care, WHO highlighted the importance of multisectoral action and **health in all policies** (HiAP) at the Global Conference on Primary Health Care held in Astana in October 2018. WHO's support includes establishing a unit on HiAP in Saudi Arabia, developing a strategic plan in Burundi and implementing a HiAP strategy in Kenya. With UNESCO, WHO prepared a portfolio of promising practices in education and training for HiAP.

Further to the Commission on Equity and Health Inequalities in the Americas (2016), the WHO Regional Office for the Americas worked in consultation with ministries of health, indigenous peoples, Afrodescendants and other groups to develop a Regional Strategy and Plan of Action on Ethnicity and Health, which provides recommendations to inequities and inequalities in the Americas.

The WHO European Health Equity Online Dataset captures within-country trends and current status on health equity, the essential conditions needed to enable people to live a healthy life and the policies known to increase health equity. Also in Europe, the WHO Action Plan for Refugee and Migrant Health Technical Assistance has been developed in response to the current crisis. Other cross-cutting work includes the first WHO guidelines on housing and health, which provide recommendations on overcrowding, indoor temperatures, injury hazards and other matters.

SOLUTIONS

**INVEST IN
ENERGY-EFFICIENT
POWER GENERATION.**

**IMPROVE DOMESTIC,
INDUSTRY AND
MUNICIPAL WASTE
MANAGEMENT.**

**REDUCE AGRICULTURAL
WASTE INCINERATION,
FOREST FIRES AND
CERTAIN AGRO-FORESTRY
ACTIVITIES.**

**MAKE GREENER AND
MORE COMPACT
CITIES WITH
ENERGY-EFFICIENT
BUILDINGS.**

**PROVIDE UNIVERSAL ACCESS TO
CLEAN, AFFORDABLE FUELS
AND TECHNOLOGIES FOR
COOKING, HEATING AND
LIGHTING.**

**BUILD SAFE AND AFFORDABLE PUBLIC
TRANSPORT SYSTEMS AND PEDESTRIAN-
AND CYCLE-FRIENDLY NETWORKS.**

CLEAN AIR FOR HEALTH

#AirPollution



Key figures for 2018–2019

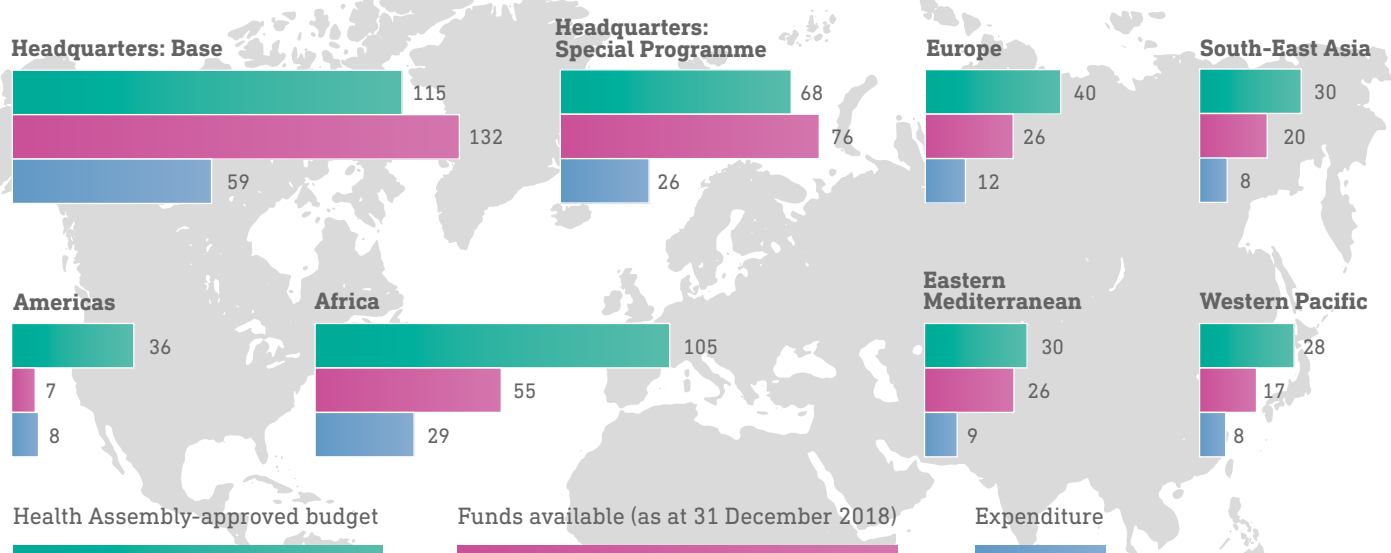
Approved Programme budget: US\$ 384 million

Fund available: US\$ 283 million (73% of Programme budget)

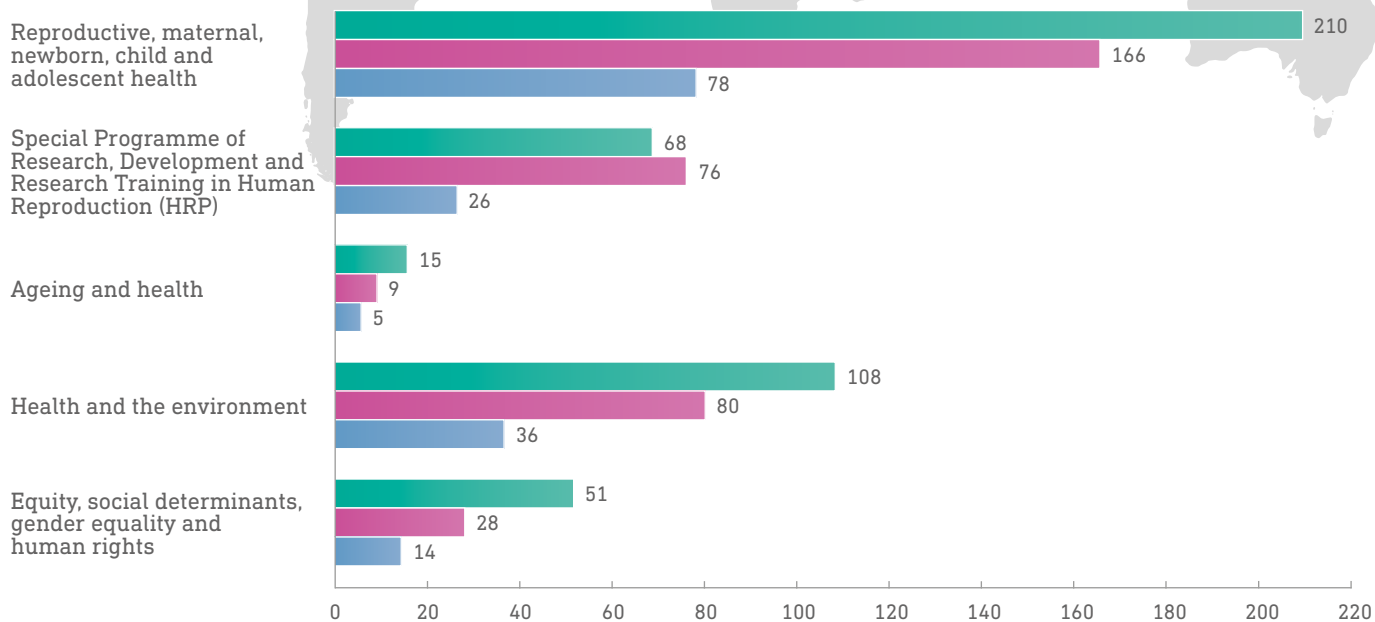
Expenditure: US\$ 133 million (35% of Programme budget, 47% of available resources)



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



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



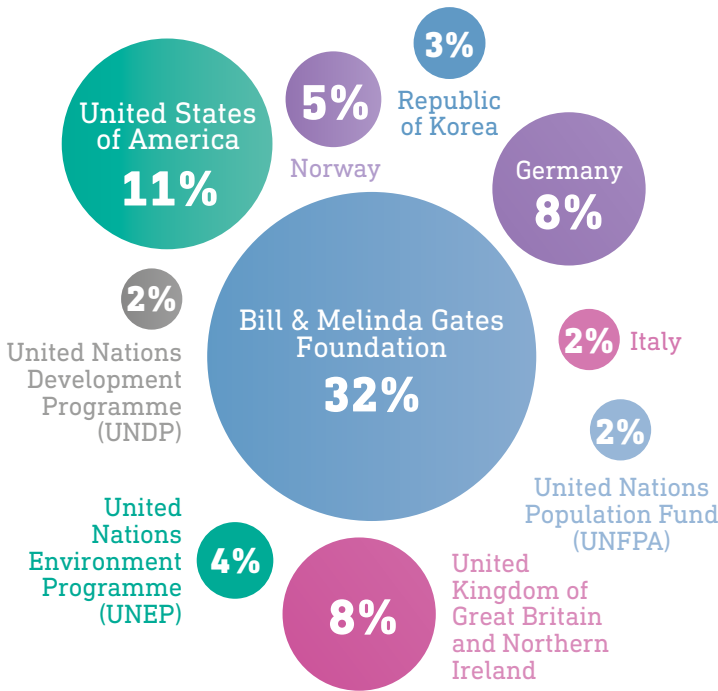
Budget and implementation

Resource levels in the Health Through the Life Course category amounted to 73% of the approved budget. However, this was somewhat unevenly spread across major offices. Headquarters has significantly more resources as

compared with its budget. Specified resources were at more than twice the level of flexible resources (68% versus 32%). Levels of expenditure are much higher at headquarters compared with the regional and country levels.



Top 10 voluntary contributors (specified, base)



Funding source:

Flexible funding: 32%

Voluntary contributions – specified: 68%

Of the total voluntary contributions specified, 77% were from 10 contributors (shown beside)

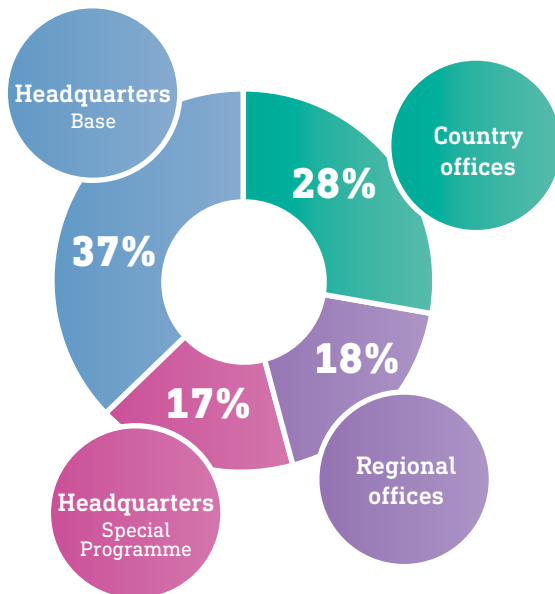
Special Programme of Research, Development and Research Training in Human Reproduction (HRP):

Flexible funding: 1%

Voluntary contributions – specified: 99%



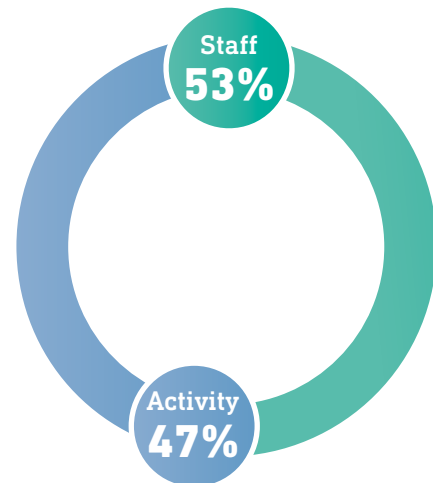
Expenditure by level



Programme areas also show an uneven pattern in terms of funding and implementation. The reproductive, maternal, newborn, child and adolescent health programme area shows higher levels of both funding and implementation, especially at headquarters, while the equity, social determinants, gender equality and human rights programme areas show particularly low levels. Political commitment and sustainable corporate funding in the programme areas that are not attractive to donors continue to pose funding challenges. As a result, human resources in these programme areas continue to be lower than what is required to delivery optimally.



Expenditure: staff vs. activity



Given the cross-cutting nature of Health Through the Life Course category of work in many instances, it has been able to make progress at regional and country levels through coordinated investment from other programme areas across all three levels. For example, in the reproductive, maternal, newborn, child and adolescent health programme areas, results have also been achieved in countries through engagement with emergency response work.

For further details on the Programme budget funding and implementation for this category, please refer to the WHO Programme Budget Portal (<http://open.who.int/2018-19/our-work/category/03/about/key-figures> and <http://open.who.int/2018-19>).

NONCOMMUNICABLE DISEASES

The background of the entire page is a photograph of three young men in athletic wear performing a handstand in a park. They are silhouetted against a bright sunset sky. The man on the left is in a full handstand with arms and legs spread wide. The man in the middle is also in a handstand, slightly behind the first. The man on the right is partially visible, also in a handstand. The ground is grassy and there are trees and buildings in the distance.

PROGRAMME AREAS

Non-communicable diseases

Mental health and substance abuse

Violence and injuries

Disabilities and rehabilitation

Nutrition

Food safety



“ It is not acceptable that people die earlier when we know that policies regulating tobacco and alcohol consumption, as well as effective control of high blood pressure, can do a lot to avoid these early deaths. ”

Dr Zsuzsanna Jakab
WHO Regional Director for Europe

Noncommunicable diseases, injuries and mental health disorders are among the biggest threats to health and development in the twenty-first century. Noncommunicable diseases – primarily cardiovascular and respiratory diseases, cancers and diabetes – currently account for seven out of every 10 deaths worldwide (41 million), including 15 million “premature” deaths among people aged between 30 and 69 years, mostly from developing countries. Cardiovascular diseases account for most deaths from noncommunicable diseases, at 18 million annually, while depression affects 300 million people.

Noncommunicable diseases are the leading cause of death globally and a key cause of spiralling health costs.

Many premature deaths from noncommunicable diseases can be prevented or delayed through interventions in the four main risk areas: tobacco use, lack of physical activity, unhealthy diets, and harmful use of alcohol.

Early diagnosis, better access to affordable treatment, multisectoral actions and a whole-of-government approach can reduce risk factors and save lives. Without such interventions, there will be enormous health, economic and social consequences.

The toll from substance abuse, disability, violence and injuries, oral health and eye and ear health is considerable. Deaths from injuries are the tip of the iceberg, as numbers of non-fatal injuries are far higher. Road traffic accidents cause 1.35 million deaths but between 20 and 50 million injuries a year.

Key achievements

Using the law to address health issues

An increasing number of countries are using legislation as a cost-effective measure in the implementation of interventions at population level that address tobacco use and unhealthy diets. Today, almost two thirds of the world’s population is covered by at least one comprehensive tobacco control measure – a figure that has quadrupled from 15% in 2007.

WHO has played a key role in enabling such legislation, notably since the landmark WHO Framework Convention on Tobacco Control came into force in 2005. Currently, many of WHO’s cost-effective “best buy” measures to address

Outcomes we are aiming to achieve in 2018–2019

- Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors
- Increased access to services for mental health and substance use disorders
- Reduced risk factors and improved coverage with interventions to prevent and manage unintentional injuries and violence
- Increased access to comprehensive eye care, hearing care and rehabilitation services
- Reduced nutritional risk for improved health and well-being
- All countries are adequately prepared to prevent and mitigate risks to food safety

noncommunicable diseases rely on legal and regulatory reforms; some involve fiscal measures that help raise revenue.

The focus is still on implementing the WHO Framework Convention on Tobacco Control through **MPOWER**. The Framework Convention has been a powerful tool in global tobacco control, resulting in legislation that has reduced tobacco product sales to minors and led to restrictions on tobacco advertising, promotion and sponsorship. The Secretariat is helping Member States to develop and enforce legislation, prevent tobacco industry interference, introduce higher taxes and plain packaging and monitor tobacco use.

Legislating for tobacco control

- Technical assistance with tobacco taxation in 50 Member States – in 2017 and 2018, WHO has supported successful initiatives in Bangladesh, the Gambia, Pakistan and the Philippines. Technical assistance and high-level advocacy have supported the formulation of legislation in several countries.
- **Georgia** has endorsed a modern tobacco control law, with all three levels of WHO providing support. WHO led a powerful communications campaign that contributed to strong public support for tobacco control measures. Compliance with the smoke-free policy has reached over 98% in the hospitality sector.

Momentum is building for a **tax on sugar-sweetened beverages**. To date, 59 Member States have reported implementing such a tax. The countries are in all six WHO regions and cover all income levels, but the type and level of taxation, as well as the products covered, vary.

- **Maldives, Nepal and Viet Nam** – WHO has provided specialized technical support to countries in economic modelling for the taxation of sugar-sweetened beverages to enable policy development, as well as for high-level advocacy.

Translating political commitment to action in countries

The political momentum generated over several years reached a high point in September 2018, when world leaders took a landmark step to combat the problem at the **United Nations General Assembly high-level meeting on the prevention and control of noncommunicable diseases (NCDs)**. Heads of State and Government agreed to 16 commitments to tackle noncommunicable diseases, including awareness campaigns to promote healthier lifestyles, human papillomavirus vaccination to protect against cervical cancer, and treating hypertension and diabetes.

World leaders agreed that their efforts should include policies recommended by WHO and legislative and regulatory measures against the risk factors, such as tobacco taxes and restricting alcohol advertising. Other commitments include halting the rise in childhood obesity, promoting regular physical activity, reducing air pollution, and improving mental health and well-being, as well as strengthening health systems.



The WHO Independent High-level Commission on NCDs – set up to propose bold and innovative solutions – includes as Co-Chairs the former Federal Minister of Pakistan, Dr Sania Nishtar (left) and the President of Uruguay, Dr Tabaré Vázquez (centre).

The Commission is being convened by WHO Director-General, Dr Tedros Adhanom Ghebreyesus (right).

Controlling hypertension in India

Hypertension kills more people in India than anything else. Nearly one third of adults (200 million people) have hypertension but only about 11% have regular blood pressure checks .

To meet the government target of a 25% reduction in the prevalence of raised blood pressure, about 45 million more people need to control their blood pressure. In November 2017, the India Hypertension Management Initiative was launched to partner the government in achieving the target.

All three levels of WHO, led by the country office, have directly provided guidance and training, as well as human and financial resources, through collaboration with the Resolve to Save Lives Initiative.

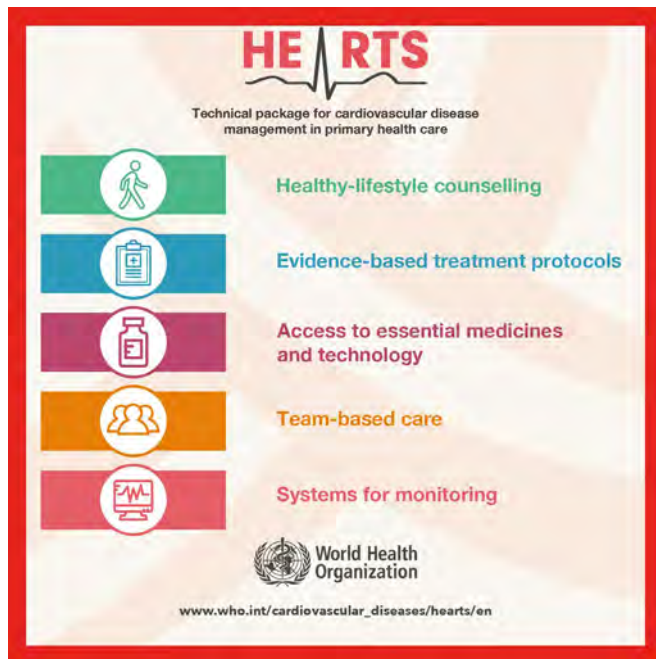
In the first phase being carried out in India's five states, the India Hypertension Management Initiative has been successful in coordinating multiple partners; selecting state-specific hypertension treatment protocols; recognizing the value of digital blood pressure devices; providing effective training; distributing medication to patients; and establishing a robust information system.

More than 200 000 patients have been registered since the launch. The programme has facilitated the strengthening of the primary care system to equip it to address noncommunicable diseases. After nine months of implementation, blood pressure is being controlled in between 26% and 40% of adults in three states – a significant change from the original 11%. The government plans to expand the initiative to all states.



Scaling up HEARTS

One of the global public health goods produced by WHO, the **Global Hearts Initiative** technical package, offers a set of high impact, evidence-based interventions. WHO is supporting countries to scale up protocol-based management, improve access to medicines and technologies and measure outcomes more accurately. More than 10 countries have started implementing HEARTS. Since implementation began in 2018 in India, more than 100 000 people with hypertension are being treated under a standard protocol.



New efforts in tackling cancer

Cancer is a leading cause of death among children. The likelihood of dying from cancer is four times higher for a child in developing countries than in high-income countries because of a failure to diagnose the disease, high treatment costs and a lack of trained health professionals.

The **WHO Global Initiative for Childhood Cancer**, launched in September 2018, aims to double the number of children cured of cancer – to achieve a survival rate of at least 60% by 2030 – thus saving an additional one million lives. The Initiative will help raise awareness and encourage countries to prioritize tackling childhood cancer and deliver best practices in childhood cancer care. WHO will support governments in assessing their current capacities in cancer diagnosis and treatment. The **WHO guide to cancer early diagnosis** helps address barriers to, and delays in, cancer care.

WHO is supporting the **scale up** of some of the newer technical packages:

LIVE LIFE – to prevent suicide

INSPIRE – to end violence against children

HEARTS – to prevent and control cardiovascular diseases

SAFER – to reduce harmful use of alcohol and related consequences

REPLACE – to eliminate industrially produced trans fats from the food supply

ACTIVE – to increase physical activity



Also at the United Nations High-level meeting on NCDs, Mr Michael R. Bloomberg (left) agreed to continue as WHO's Global Ambassador for Noncommunicable Diseases and Injuries. He will take forward important initiatives, such as building the Partnership for Healthy Cities and promoting investment in noncommunicable diseases and injuries prevention.

Increasing physical activity

The new **WHO Global action plan on physical activity 2018–2030** shows how countries can reduce physical inactivity in adults and adolescents by 15% by 2030. It recommends a set of 20 policy areas for creating a more active society by improving the environments in which people live, work and play and increasing the opportunities and programmes suitable for people of all ages and abilities to walk, cycle, play sport, engage in active recreation, dance and play. Worldwide, one in four adults (28%) and four in five adolescents do not engage in enough physical activity to gain health benefits.

Focus on injury prevention

In 2018, WHO continued supporting countries to roll out the WHO technical package, **INSPIRE: seven strategies for ending violence against children**. Policy dialogues to initiate implementation of INSPIRE were held in 23 pathfinding countries. Capacity-building work took place in all regions.

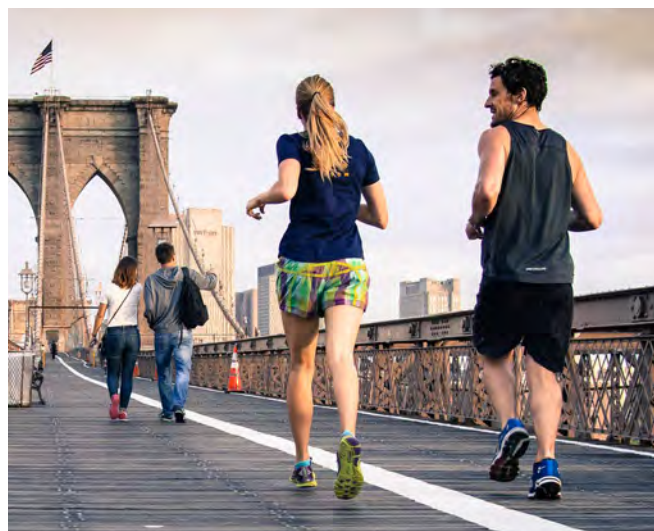
Taking action to address mental health

WHO's **Mental Health Atlas 2017** revealed a shortage of health workers trained in mental health and a lack of investment in community-based mental health approaches in many countries. Based on 2017 data, the atlas shows that while some countries have improved mental health policy-making and planning, the scale up of resources is too slow to meet targets.

More than 150 country profiles have been published. The profiles provide national snapshots of policies, plans and laws governing mental health facilities providing care and the resources available.

The harmful use of alcohol, drugs and tobacco can also be an issue, leading to risky behaviours, such as suicide, which is the second leading cause of death among those aged between 15 and 29 years.

Specific efforts to tackle suicide – the most extreme symptom of the wider unaddressed mental health emergency – included a toolkit for suicide prevention activities in the community and an editorial written by the Director-General, Dr Tedros Ghebreyesus, and pop singer Lady Gaga.



“ We can all help to build communities that understand, respect and prioritize mental wellness. We can all learn how to offer support to loved ones going through a difficult time. And we can all be a part of a new movement – including people who have faced mental illness themselves – to call on governments and industry to put mental health at the top of their agendas. ”

Director-General, Dr Tedros Adhanom Ghebreyesus and singer Lady Gaga co-founder of *Born This Way Foundation* (writing in an op-ed article on mental health in October 2018)

Uganda hospitals improve emergency units with WHO tools

A simple set of clinical trainings and process changes in hospital emergency units, with no new input of material resources, has had a dramatic impact on mortality. The pilot implementation of four WHO basic emergency care tools has reduced deaths from injuries and acute conditions by 50% in two district hospitals in Uganda. The intervention, which improves the way in which care is delivered in front-line emergency units by maximizing existing resources, is effective, simple and low-cost. It will be scaled up nationally as part of an overall reform of the health sector.

Parenting programmes prevent violence in South Africa

In South Africa, a low-cost parenting programme reduced the abuse of teenagers by their parents and caregivers. The programme, Parenting for lifelong health (PLH), was led by WHO and partners. It is now being scaled up in at least eight countries in Africa. This is the first ever parenting programme which is non-commercial, low-cost, targeted to families with teenagers, and has been adapted and tested in low- and middle-income settings.

Parenting programmes are effective in reducing child maltreatment, but until recently evidence was restricted to high-income countries. Existing parenting programmes are expensive – they are generally licenced commercial products and expensive to implement.

Several years ago, WHO and partners started PLH to create free, low resource parenting programmes to prevent and reduce child maltreatment. The programme is based on manuals and delivered by trained community members. The approach was piloted and tested in a cluster randomized control trial involving 552 families in 40 villages in the Eastern Cape Province, South Africa, where studies show high rates of family conflict and violence against adolescents.

PLH proved effective: families who had received the parenting programme had fewer cases of abuse and physical punishment; enhanced parenting and parental supervision; improved economic welfare and financial management; and better family planning. Currently, PLH has manuals for teens and young children. The programme is being rolled out as part of the INSPIRE technical package, which offers seven strategies for ending violence against children.

Increased action to meet growing nutrition challenges

Jointly with FAO and other United Nations agencies, WHO is leading global action to improve nutrition under the United Nations Decade of Action on Nutrition (2016–2025). A first progress report was discussed at the United Nations General Assembly in 2018 and 12 countries have made SMART commitments on food and health system changes. Global and regional action networks have been established to control the marketing of foods to children and improve the nutritional labelling of food, food security and the food environment.

WHO is supporting the mainstreaming of essential nutrition interventions in primary health care. Nutrient profiling systems and guiding principles for front-of-pack labelling have been devised to facilitate the development of marketing and labelling policies. WHO has also provided technical support to 20 countries for the management of complicated cases of acute malnutrition.

Making the food supply safer

The **WHO/FAO International Food Safety Authorities Network (INFOSAN)** was integral to

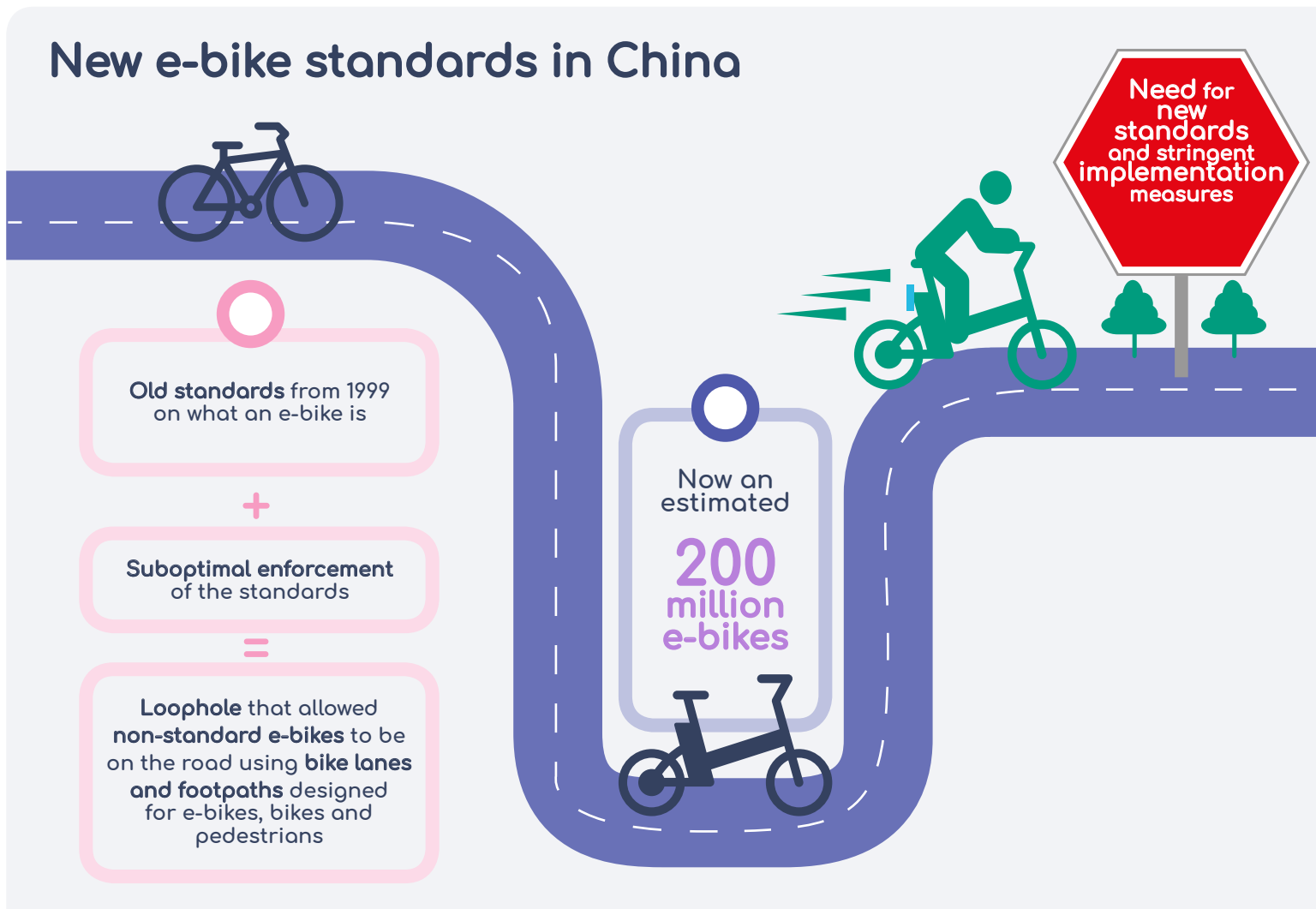
the response to several large-scale food safety events in 2017/2018. They included the largest ever outbreak of listeriosis in South Africa linked to contaminated ready-to-eat meat, which caused more than 1000 cases of the disease and 200 deaths. Detailed information on ready-to-eat meat product batches that had been exported to 15 countries was communicated through the network. This enabled the importing countries to take swift action to recall them, thereby avoiding exposing consumers to potentially unsafe food.

The Network encourages greater international cooperation by supporting Member States with the management of food safety risks.

WHO developed and published **Strengthening surveillance of, and response to, foodborne diseases: a practical manual** to assist countries to integrate foodborne disease surveillance and response activities into existing national surveillance and response systems, as required by the International Health Regulations (2005).

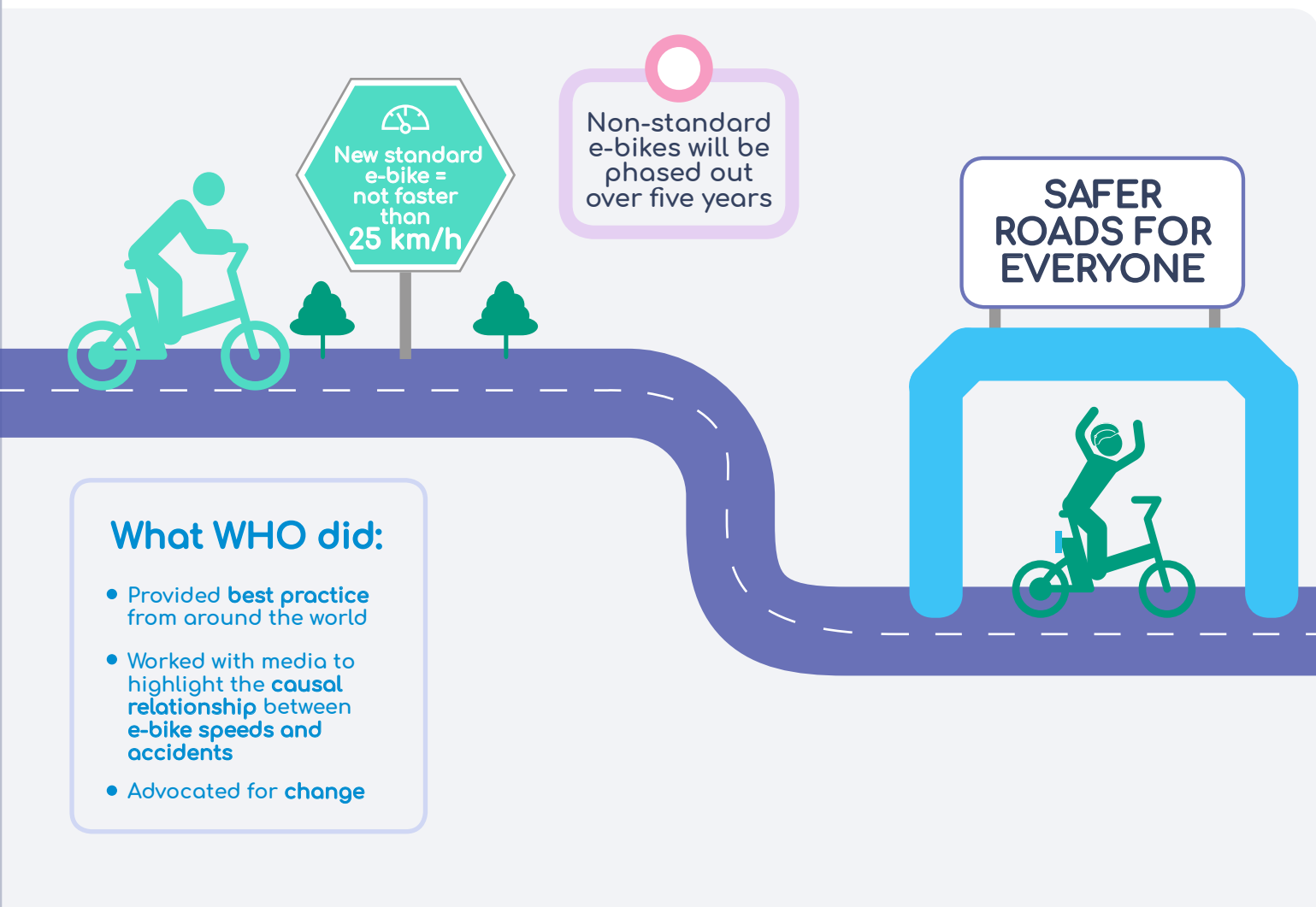


New e-bike standards in China



Global public health goods produced by WHO in 2018, which provide useful guidance, information and evidence in the area of noncommunicable diseases and conditions, include:

- the launch of a new WHO web portal that provides country-specific data on investment opportunities for scaling up interventions to address noncommunicable diseases. The tool shows a set of policies that provide the greatest cost benefit for tackling noncommunicable diseases;
- the launch of the new **WHO global status report on alcohol and health**. WHO's SAFER initiative helps governments take practical steps to reduce the harmful use of alcohol and its consequences;
- the launch in 2018 of **WHO's Global Burn Registry**, the first ever global platform for collecting standardized data on burn victims. Burns account for an estimated 180 000 deaths a year and many other injuries;
- the **Global status report on road safety 2018** – funded by Bloomberg Philanthropies – provides further evidence on a growing problem, as well as a tool for advocating solutions and concrete actions to tackle the situation and save lives;
- the release of a web-based open-access training course on trauma care for front-line health-care providers, dealing with acute illness and injury with limited resources. WHO launched the **Global Emergency and Trauma Care Initiative** to scale up emergency care;



- support provided to countries in implementing the **Model Disability Survey**, which provides comprehensive information about the distribution of disability in a country or region and identifies unmet needs; and
- the issue jointly by WHO and ITU of a new **international standard for devices such as smartphones** to make them safer for listening. More than 1 billion young people (nearly 50% of people aged 12–35 years) are at risk of hearing loss due to prolonged and excessive exposure to loud sounds.

Key figures for 2018–2019

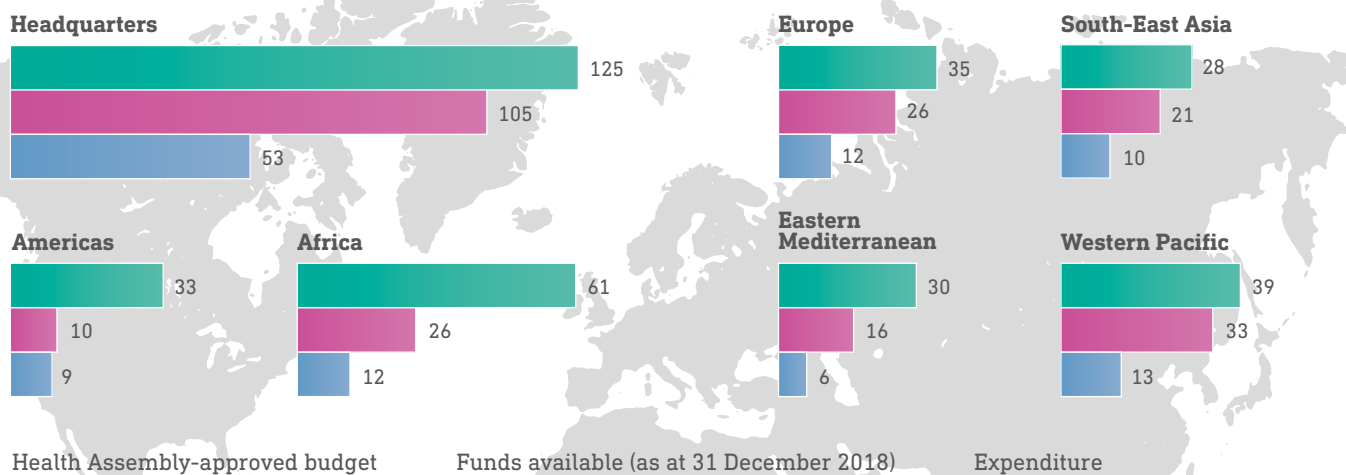
Approved Programme budget: US\$ 351 million

Fund available: US\$ 237 million (68% of Programme budget)

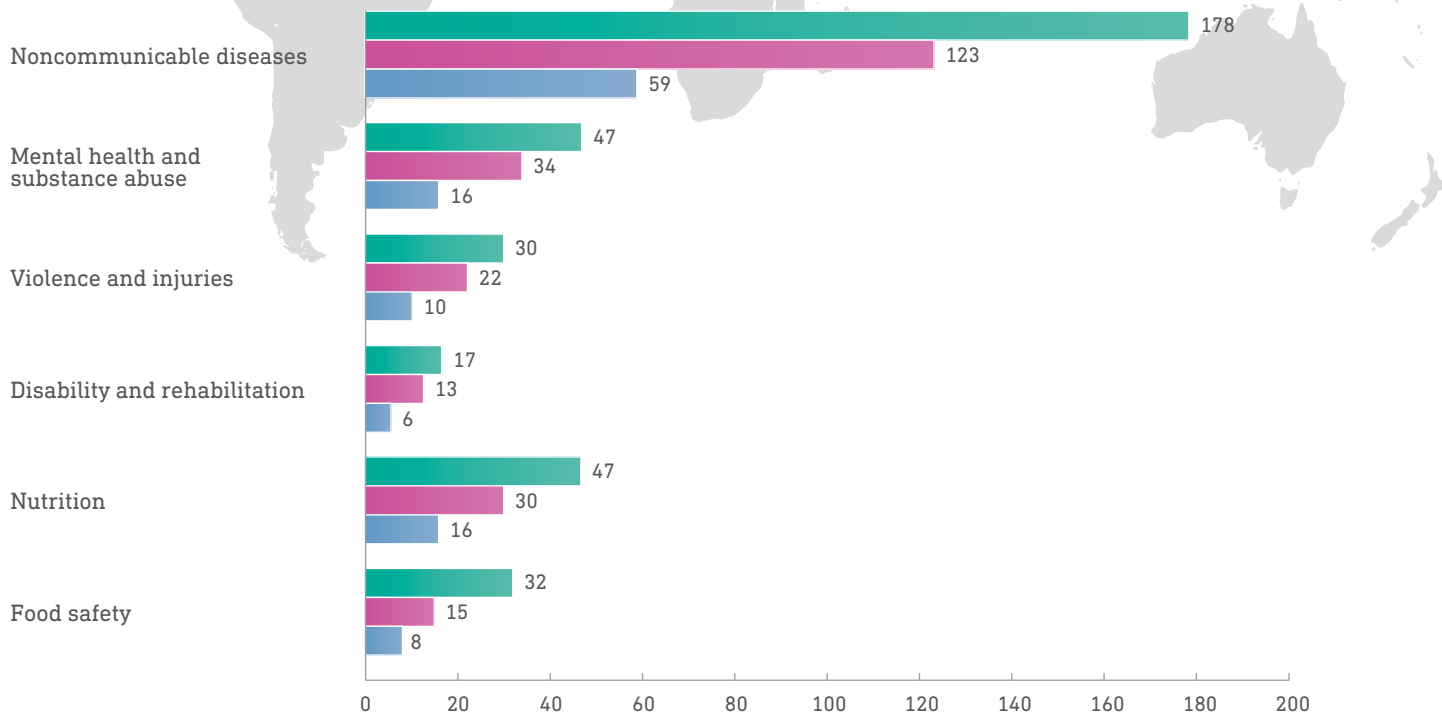
Expenditure: US\$ 115 million (33% of Programme budget, 49% of available resources)



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



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



Budget and implementation

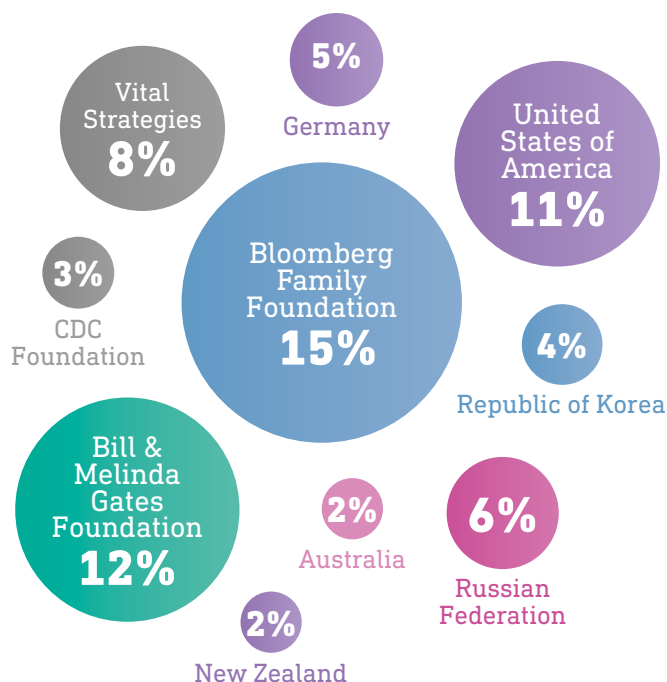
Available funding is 68% of the approved budget, which is the lowest among all categories. Future funding remains a critical concern, especially in programme areas such as Food safety (47% of the approved level) and Nutrition (64% of the approved level). Global expenditure in

Noncommunicable diseases was US\$ 115 million or only 33% of the approved budget level, which is also the lowest among all categories. This could be a reflection of low level of financing.

The proportion of flexible funding of the total funding in noncommunicable diseases is relatively high, compared



Top 10 voluntary contributors (specified)



Funding source:

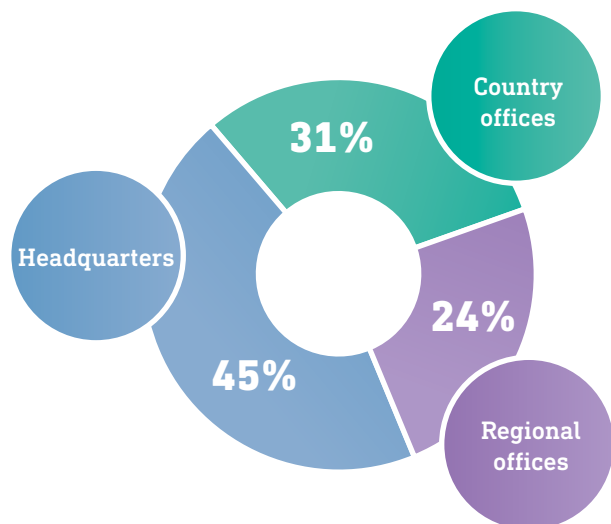
Flexible funds: 42%

Voluntary contributions – specified: 58%

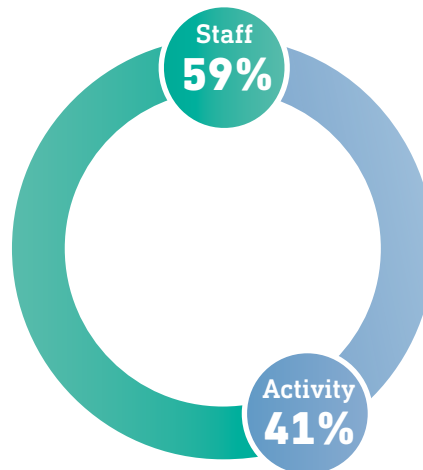
Of the total voluntary contributions specified, 68% were from 10 contributors (shown beside)



Expenditure by level



Expenditure: staff vs. activity



with specified funding (42% versus 58%, respectively). This reflects the efforts of the Organization to align resources to the priorities of Member States despite being less attractive to donors. In some cases, the late arrival of major voluntary contributions has delayed implementation in 2018. Despite these challenges, significant progress has been made in some areas, especially in addressing risk factors for noncommunicable diseases. Implementation is a challenge in both the African and Eastern Mediterranean Regions. In country offices that have chronic resource limitations, implementation had been augmented through different sources and measures, such as engagement with

national governments, WHO collaborating centres and other partners, and building synergies between programmes, especially at the country level. This explains why even in those areas facing implementation challenges, good progress has been achieved to deliver the work in some areas in noncommunicable diseases.

For further details on the Programme budget funding and implementation for this category, please refer to the WHO Programme Budget Portal (<http://open.who.int/2018-19/our-work/category/02/about/key-figures> and <http://open.who.int/2018-19>).

COMMUNICABLE DISEASES



PROGRAMME AREAS

HIV and hepatitis

Tuberculosis

Malaria

Neglected tropical diseases

Vaccine-preventable diseases

Antimicrobial resistance



“ To end the scourge of infectious diseases, prevention, early detection and treatment must be available to everyone, everywhere. ”

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

Historic progress has been made to reduce the global burden from communicable diseases, but they still remain a major challenge. Despite being preventable or treatable, these “diseases of poverty” kill more than 4 million people a year and impede social and economic development.

Recent reports indicate that the current pace of progress is insufficient to achieve the set targets. There needs to be focused action on:

- high-impact communicable diseases, including efforts to reach vulnerable and marginalized populations;
- high-quality immunization services, as part of an integrated, people-centred platform for disease prevention; and
- antimicrobial resistance, working on raising awareness, global surveillance, optimal use of medicines and research and development.

By focusing on those most affected and most at risk, zeroing into overlooked areas and scaling up innovation, we go far beyond controlling these diseases: we will also address long-standing issues such as health systems strengthening, while also delivering on the goals of equity, human rights and the expansion of universal health coverage.

Key achievements

Growing success in disease elimination

The world is at a unique point in the history of communicable diseases where elimination and eradication have become feasible targets. We are poised to put crippling diseases such as dracunculiasis (guinea-worm disease) behind us. In 2018, only 28 cases of dracunculiasis were reported. The final hurdle to elimination may lie in the infestation with guinea worm of dogs in Chad. Yaws, a disfiguring, painful and debilitating childhood disease that infected 50 million children in the 1950s, is also set for eradication, with some countries on track to interrupt transmission by 2020. India's triumph over yaws offers lessons for others.

Outcomes we are aiming to achieve in 2018–2019

- Increased access to key interventions for people living with HIV and viral hepatitis
- Universal access to quality tuberculosis care in line with the End TB Strategy
- Increased access of populations at risk to preventive interventions, diagnostic confirmation of malaria and first-line antimalarial treatment
- Increased and sustained access to neglected tropical disease control interventions
- Increased vaccination coverage for hard-to-reach populations and communities
- All countries have essential capacity to respond to antimicrobial resistance

While complete eradication is a rare achievement, elimination – the reduction to zero of new cases of disease or infection in a defined geographical area – is a relatively feasible target for many diseases now. In 2012, a WHO road map set ambitious targets to eliminate 17 neglected tropical diseases. Progress picked up following WHO-negotiated drug donations by pharmaceutical companies. In 2018, as in the previous three years, about 1 billion people were treated. WHO coordinates the shipment, distribution and delivery of the drugs. WHO's role in delivering free, quality-assured drugs – which may otherwise not be available – to some of the world's poorest people cannot be overstated.

The road ahead to ending the epidemics of AIDS and tuberculosis by 2030 (United Nations Sustainable Development Goal (SDG) target 3.3), is more challenging. For malaria, although progress in high-burden countries has levelled off, some low burden countries are moving quickly towards elimination.

Elimination – now a growing reality in many countries:

- **Lymphatic filariasis** – eliminated as a public health problem in 14 countries, with seven other countries working towards elimination;
- **Trachoma** – eight countries have achieved elimination as a public health problem, while the disease is still a public health problem in 36 countries;
- **Onchocerciasis** – WHO has verified elimination of transmission in four countries in the Americas, and transmission has been eliminated in subnational foci in three additional countries. Transmission is ongoing in sub-Saharan Africa, Yemen and one focus in the Americas; and
- **Human African trypanosomiasis (sleeping sickness)** – with historically low case numbers reported (1446 in 2017), the 2020 target of elimination as a public health problem is achievable.

On track for elimination of lymphatic filariasis

In 2018, Egypt, Palau, Viet Nam and the Wallis and Futuna Islands were validated for eliminating lymphatic filariasis, a painful and profoundly disfiguring disease. Some 36 million people still have chronic disease manifestations.

More than 800 million people require mass drug administration to stop the spread of the infection. Samoa became the first country to implement the new WHO-recommended triple drug regimen for treatment of lymphatic filariasis. Annual mass treatment of the entire eligible population began in 2018, with school and house visits. WHO provided technical and financial support.

Preliminary results show a high coverage of more than 90% of the eligible population of Savaii Island. Following the success of this year's mass drug treatment, the country will be declared free of lymphatic filariasis.

The end of the road for yaws

Yaws is a chronic and debilitating bacterial infection.



Treponema pertenue bacteria

Endemic in
15
countries

66 000
cases in 2018

Strategy

90% coverage
Treat all endemic communities

Treat all active clinical cases and their contacts

It is found primarily in **poor communities** in warm, humid and tropical forest areas of Africa, Asia, Latin America and the Pacific where the majority of **affected populations, mostly children**, live at the “end of the road”, far from health services.

Advancing towards trachoma elimination

Trachoma puts more than 150 million people at risk of blindness in 41 countries. International efforts to eliminate trachoma as a blinding disease are based on the strategy developed by WHO – a combination of interventions known by the acronym SAFE, which stands for surgery for trichiasis (inturned eyelashes), antibiotics, facial cleanliness and environmental improvement. These interventions will be community-targeted and will seek community involvement through the primary health care approach.

Results are being demonstrated in countries. In May, Nepal was validated for having eliminated trachoma as a public health problem. Nepal stepped up efforts to eliminate the disease in 2002. By 2005, the prevalence of active trachoma had fallen by 40%. Eye hospitals and dozens of eye clinics with trained staff were set up. About 30 000 eyelid operations were performed and 15 million doses of antibiotics distributed, with help from partners. Ghana and Iran (the Islamic Republic of) also eliminated trachoma in 2018, while Mexico eliminated trachoma in 2017.

Decades of work on new drug for river blindness pay off

In June 2018, moxidectin was approved by the United States Food and Drug Administration (FDA) as the first new treatment for onchocerciasis (river blindness) in 20 years. The **Special Programme for Research and Training in Tropical Diseases** (TDR) conducted nearly two decades of research in collaboration with partners on moxidectin, which studies show to be superior to the current drug ivermectin. This is a critical milestone for onchocerciasis control and elimination. The FDA also awarded a priority review voucher, a mechanism to support drug development for neglected diseases. Observers say this was a model use of the mechanism, which speeds up approval and enables funds to be raised by selling the voucher, which can then be used in the review of a different product.

Role and achievements of WHO

- Developed eradication strategy
- Support health ministries to implement strategy
- Support operational research to improve eradication efforts
- Support pre-certification efforts
- Secure donations of azithromycin
- Advocacy and partnership
- Develop health and hygiene education material

Eradication



Zero transmission

Between 2013-2018
WHO provided more than

85 000
rapid diagnostic tests

In 2018

EMS-WHO agreement

153 million

tablets of azithromycin
to be donated over 5 years to treat
51 million people

Integrated surveillance and testing

Screening also targets other skin diseases -
Buruli ulcer, leprosy and scabies.

Gaining momentum in the fight against tuberculosis

Participants in the first **United Nations High-level meeting on the fight to end tuberculosis**, held in New York in September 2018, endorsed an ambitious and powerful declaration to accelerate progress towards End TB and adopt bold new targets for 2022.

WHO high-level missions with partners to high-burden countries including India, Mongolia, Pakistan, the Philippines and Viet Nam have helped to sustain the momentum. In many countries, national accountability bodies have been established, in keeping with the declaration of the High-level meeting. Work on the multisectoral accountability framework was continued alongside its implementation in countries, as requested by Member States.

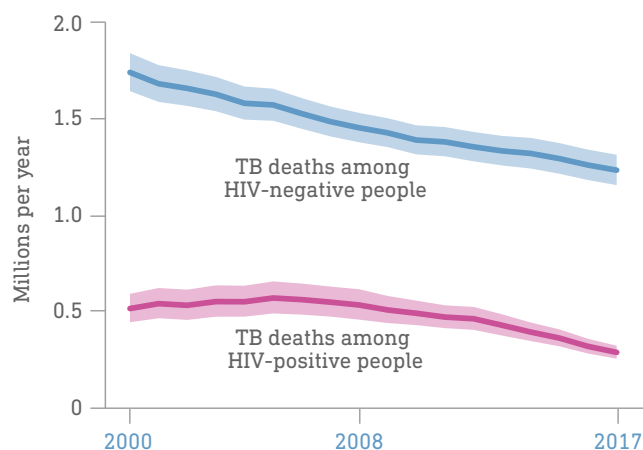
Greater progress is possible even in resource-constrained low- and middle-income countries, as exemplified by the significant progress seen in reducing the burden of tuberculosis in the Western Pacific Region, where 23 million people were successfully treated. Several African countries also recorded impressive declines in incidences of tuberculosis.

**Between 2000 and 2017,
54 million lives
saved from tuberculosis**

Drug-resistant tuberculosis continues to constitute a public health crisis. In 2017, over half a million people developed tuberculosis that was resistant to rifampicin, the most effective first-line drug, and of these, 82% had multidrug-resistant tuberculosis (MDR-TB). Only one in four affected people with MDR-TB are currently being detected and even fewer are treated successfully.

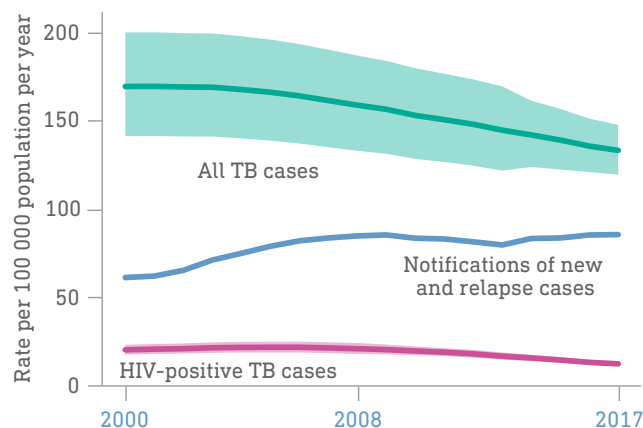
In 2018, to address this challenge and improve treatment outcomes for MDR-TB patients, WHO released new consolidated treatment guidelines for MDR-TB, recommending a shift to fully oral regimens. This new treatment course is more effective and less likely to provoke adverse side effects. WHO recommends backing up treatment with active monitoring of drug safety and counselling support to help patients complete their course of treatment.

Global trends in the number of deaths from tuberculosis, 2000–2017



Shaded areas represent uncertainty intervals.

Global trends in estimated tuberculosis incidence rate, 2000–2017



Shaded areas represent uncertainty intervals.

WHO is also contributing to shaping the tuberculosis research agenda. In 2018, WHO initiated the development of a global strategy for research and innovation on tuberculosis, as requested by Member States. A road map for the development of this strategy is in line with the research commitments of the political declaration of the High-level meeting.

India partners private sector to fight tuberculosis

India accounts for about one quarter of the world's burden of tuberculosis. In 2017, 2.7 million people fell ill with the disease; of these, a staggering number – almost 1 million – missed out on access to high-quality care. It is thought that many of those concerned accessed care in the private sector, which is often the first point of care for people with tuberculosis. To address this issue, India has prioritized greater engagement with the private sector over the last three years, in line with the WHO End TB strategy. This has brought substantive gains in closing gaps in notifications.

A key contributor to this effort has been an innovative private sector engagement project that was successfully piloted in three cities – Mehsana, Mumbai and Patna – with technical assistance from WHO. Lessons from this approach are now being scaled up through the Joint Efforts for Elimination of Tuberculosis (JEET) initiative, with the support of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

WHO is closely engaged in the implementation of the initiative, providing high-level political and administrative support as well as coordination, supervision and monitoring. Technical assistance was provided by WHO for developing and deploying tools, policy options and guidelines, as well as a digital platform for notification.

In 2018, through the JEET initiative:

- an additional 57 949 health facilities have been mapped, of which 13 504 have been engaged
- a total of 819 “coordination “hubs” (health facilities with doctors, pharmacists and X-ray services) were created
- a total of 114 continuing medical education sessions have been held to bolster notifications.

This has prompted 165 739 notifications from the private sector.

The JEET target is to notify an additional 1.6 million patients over three years.

E-2020: supporting countries in getting to zero malaria incidence by 2020

A special WHO initiative, E-2020, is supporting 21 malaria-eliminating countries in getting to zero malaria incidence by 2020. In 2018, Paraguay and Uzbekistan achieved malaria-free certification. Uzbekistan's certification brings to 19 the number of countries in the European Region that have received this WHO certification. The Region as a whole has been declared as having interrupted indigenous malaria transmission.

Costa Rica, one of 21 countries identified by WHO as having the potential to eliminate malaria by 2020, reduced cases of indigenous malaria – transmission of the malaria parasite within a country's own borders – by so much that it has received an award from the Pan American Health Organization (PAHO) in recognition of the strides it has made. Notably, no one has died from malaria in Costa Rica since 2009.

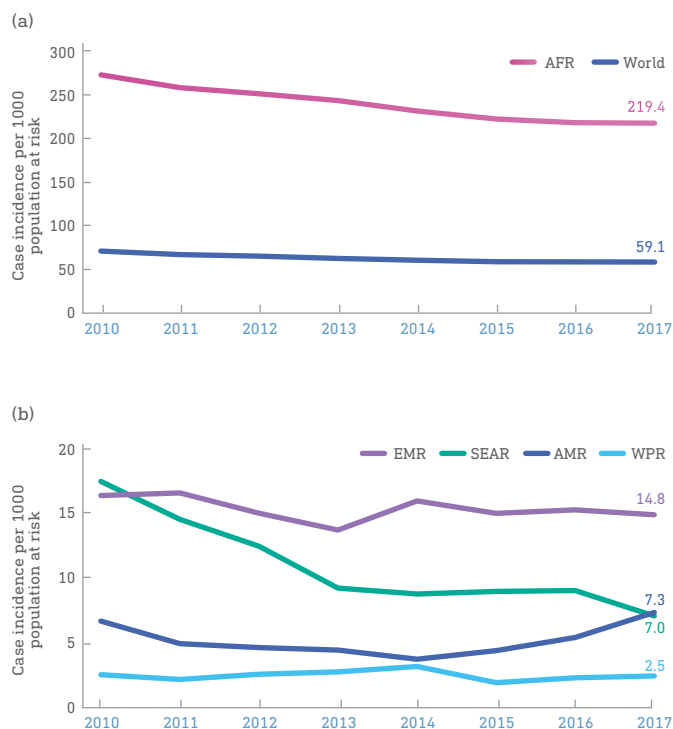
As part of the **WHO framework for malaria elimination**, WHO supports ministries of health in developing a technically sound national malaria strategy. Through regular country visits, WHO has assisted governments in their efforts to strengthen national capacities to combat the disease and monitor disease trends. Globally, a total of 36 countries and territories have received the WHO certification. Ten more countries are on track to eliminate malaria by 2020.

Getting back on track to reduce the malaria burden

As the **World malaria report 2018** notes, progress is insufficient to meet two critical targets of the Global Technical Strategy for Malaria 2016–2030: reductions of at least 40% in global malaria cases and deaths compared with 2015 levels. Without making headway in the highest-burden countries, where 70% of global malaria cases occur, the global community will begin to miss key milestones.

In response, the Director-General called for an aggressive new approach to accelerate progress. Health ministries have been working with WHO and partners on the high burden to high impact approach. Launched in November 2018, this is a country-driven response in which appropriate mixes of interventions are scaled up using accessible and affordable front-line services. WHO will support countries in establishing evidence-based strategic plans.

Trends in malaria case incidence rate, globally and by WHO region, 2010–2017



AFR: WHO African Region; AMR: WHO Region of the Americas; EMR: WHO Eastern Mediterranean Region; SEAR: WHO South-East Asia Region; WHO: World Health Organization; WPR: WHO Western Pacific Region.

The European Region has reported zero indigenous cases since 2015.

Jumpstarting progress against malaria in 11 high-burden countries

WHO, in collaboration with the RBM Partnership to End Malaria, has catalysed a new approach to jumpstart progress against malaria in the countries that carry the highest burden of the disease. This approach – called **high burden to high impact** – rests on four pillars:

- galvanizing political attention to reduce malaria deaths
- driving impact through the strategic use of data
- improving global guidance, policies and strategies
- implementing a coordinated country response.

“High burden to high impact” (previously referred to as the “10+1” initiative) builds on the principle that no one should die from a disease that is preventable and treatable. It is led, initially, by 11 countries – 10 in sub-Saharan Africa (Burkina Faso, Cameroon, Democratic Republic of the Congo, Ghana, Mali, Mozambique, Niger, Nigeria, Uganda and United Republic of Tanzania) plus India. These high-burden countries are home to an estimated 151 million cases of malaria and 275 000 deaths, which together account for 70% of the global disease burden. Lessons learned in this first group of countries will be applied, over time, to all countries with high rates of transmission of the disease.

Improving child health in remote Nigerian communities

Integrated community case management (iCCM) is a cost-effective strategy that engages community health workers living in hard-to-reach areas to diagnose and treat three deadly but curable illnesses: malaria, pneumonia and diarrhoea. WHO, with Government of Canada funding support, has brought iCCM to remote communities in sub-Saharan Africa with a high disease burden.

With medicines supplied through the **WHO Rapid Access Expansion (RACe)** programme, community health workers diagnose and treat children under the age of 5 years for the three killer diseases – malaria, pneumonia and diarrhoea – that cause 54% of child deaths in Nigeria.

“The programme is unique because it involves both the community and the health system”, says Dr Abosede R. Adeniran, director of family health at the Nigerian Federal Ministry of Health. “In Niger and Abia States, we now have local evidence that this is the way to go, as it relates to addressing the unacceptably high under-5 mortality rate in Nigeria.”

Addressing malaria among miners in Suriname

Suriname is moving closer to eliminating malaria. With support from WHO and other partners, the country has reduced the number of indigenous cases of malaria by 98% since 2010; 40 cases were reported in 2017. In 2017 and 2018, the Regional Office for the Americas/PAHO assisted with an external review of the surveillance system and strategic plan as well as helping to develop a new elimination plan until 2022. In the new plan, integrated health services will be provided for the migrant population in mining areas. Often undocumented and involved in illegal gold mining, they frequently reside in areas difficult to access, and therefore have limited access to health services.

HIV “treat all” policy success in Brazil

In 2018, the Government of Brazil announced the largest reduction ever in AIDS-related deaths in the country, as a result of Brazil’s policy for greater access to HIV prevention, testing, treatment and care.

A report by the Brazilian Ministry of Health shows that, between 2014 and 2017, HIV-related deaths fell by 16.5% thanks to the implementation of the country’s “treat all” policy, expanded HIV testing and faster linkages between testing and treatment services. These programmes also led to a reduction in AIDS cases – from 21.7 cases per 100 000 population in 2012 to 18.3 cases in 2017.

Brazil is one of the leading countries in the implementation of WHO’s “treat all” recommendations, which were launched globally in 2016. As of mid-2018, the policy had been adopted in 84% of all low- and middle-income countries, including 100% of the “fast-track” countries Brazil, as a trailblazer in the HIV response, had initiated the policy in 2013, and has since achieved considerable impact in improving the health and well-being of people living with HIV.

In addition to the drop in AIDS deaths, the implementation of the “treat all” policy in Brazil has improved HIV diagnosis rates and reduced the mean time-lapse between diagnosis and treatment initiation. Brazil has also implemented a national HIV self-testing programme targeted at key populations and people using pre-exposure prophylaxis (PrEP) for prevention, as part of a combination prevention strategy.

Implementing HIV catch-up plans in Africa

WHO is providing financial and human resources to help countries develop and implement their catch-up plans for the response to HIV, based on the WHO guidelines for preventing and treating HIV and other evidence-informed strategies.

Several countries were supported in 2018 in various areas, including decentralization of services to districts strengthening the supply management system and developing a strategic plan for treatment and development of a one-year roadmap for treatment programmes.

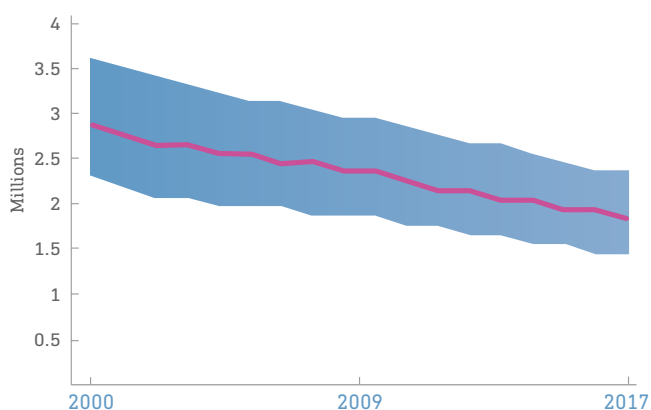
WHO continues to closely monitor the implementation of the catch-up plans, meeting regularly with countries and technical partners and ensuring that data collection and analysis provide high-quality information for decision-making.

WHO leading the health sector response in HIV and hepatitis

During 2018, WHO released several new landmark policies and guidelines, developed with partners:

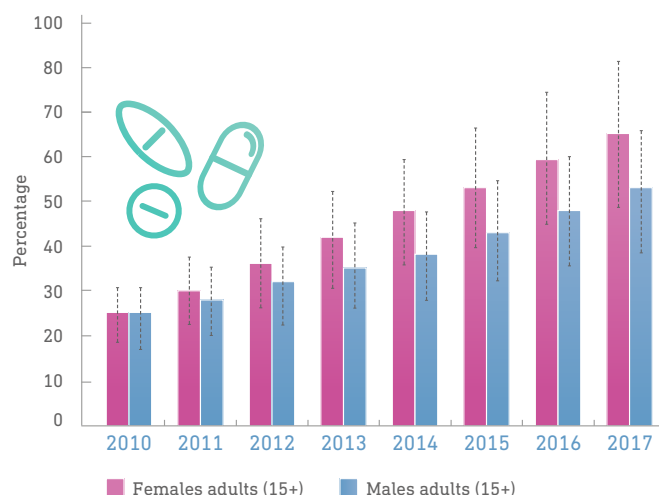
- improved HIV and hepatitis treatments, with guidance on the use of dolutegravir and raltegravir, as well as changes to first-line and second-line antiretroviral therapy (ART);
- innovative testing and diagnosis, including HIV self-testing;
- paediatric testing and treatment and accelerated prevention, including pre-exposure prophylaxis for HIV.

Number of new HIV infections



Shading represents upper and lower estimates

Coverage with antiretroviral therapy



Vertical dotted lines represent lower and upper estimates

Considerable progress has been made with the WHO **treat all** policy to offer ART to any person with HIV regardless of CD4 count. Most countries are now following this policy guidance, and monitoring of implementation is routine. All Member States have adapted the policy in the Western Pacific Region, and almost 1 million people now receive ART in the Region; in the Region of the Americas, 22 Member States are following the policy; in the African Region, the focus is now on implementation at the district level.

Thanks to ART, the number of AIDS-related deaths is the lowest this century, with fewer than 1 million people dying each year from AIDS-related illnesses.

In the African Region, more than three in five people are accessing life-saving ART and 93% of pregnant women living with HIV received ART.

More children than ever immunized



Immunization is a core building block of strong primary health care and universal health coverage, providing a point of contact for health care at the beginning of life and throughout the life-course. It is the intervention with the widest and broadest reach, with an immunization programme in every country of the world.

Worldwide, about 123 million infants – nine in 10 infants – were immunized with at least one dose of diphtheria-tetanus-pertussis (DTP) vaccine in 2017, according to estimates by WHO and the United Nations Children's Fund (UNICEF). An additional 4.6 million infants were vaccinated globally in 2017, compared with 2010 but, because of population growth, global coverage with three doses of DTP (DTP3) has remained at 85% since 2015.

WHO is supporting countries by strengthening immunization systems and access through policy, strategy and tools, as well as building trust, confidence and community demand for vaccination. Success stories include the elimination of measles in the Democratic People's Republic of Korea, Singapore and Timor-Leste. Today, only 13 countries still have to eliminate neonatal tetanus. There has also been an increase in coverage of the second-dose of measles vaccine, with global coverage now at 67% compared with 39% in 2010.

Reducing the hepatitis burden in Mongolia and Pakistan

Mongolia has one of the highest rates in the world of liver cancer, a leading cause of death related to chronic hepatitis. In 2017, Mongolia launched the **Healthy Liver Programme** to reduce deaths from liver cancer and cirrhosis through early detection and treatment of viral hepatitis and to eliminate hepatitis C (HCV) as a public health threat by 2020.

WHO worked closely with the Government of Mongolia, providing technical support for implementation, including guidelines and assessments of the 21 public and private laboratories that conduct HCV viral load tests. As of June 2018, about 300 000 people had been screened for HCV and hepatitis B (HCB); 23 000 people had received HBV treatment and 20 000 had received HCV treatment. The aim is to screen 1.8 million people. Riding on this success, Mongolia hosted the global event for World Hepatitis Day 2018.

Another country with a huge burden of hepatitis is Pakistan, where almost 12 million people live with hepatitis B or C, a number that grows by 150 000 each year. Timely and reliable data on prevalence are lacking, as are essential hepatitis services. Also, health workers have a low capacity for engaging in safe injection practices. Screening is inadequate and harm reduction services for people injecting drugs are limited. WHO helped to develop the country's National Hepatitis Strategic Framework. Better use of strategic information is driving progress.



Battling measles outbreaks in Europe

Vaccination gains can be easily lost. In 2018, measles cases hit a record 83 000 in Europe, with 72 deaths. Although more children are being vaccinated in Europe than ever before, there were gaps in subnational coverage in some countries and insufficient coverage for “herd immunity” in 34 countries in the European Region.

WHO has provided guidance to ensure that all populations are covered, to identify missed children, to improve outbreak detection and response and to strengthen trust in vaccines. WHO supported Ukraine – where 23 000 people were affected in 2018 – in planning and budgeting for vaccines and supplies. A series of workshops was held to review challenges and provide recommendations for target group planning and vaccine and supply forecasting. In Serbia, which reported 14 measles deaths, a WHO tailored immunization programme involved country-specific training for health-care professionals.



In contrast to the overall global progress, backsliding now threatens the hard-won gains made in vaccine coverage. Since 2000, the incidence of measles has been reduced by 80%, but 2018 saw an increase in measles-related cases and deaths. There were also several large outbreaks of measles in all regions of the world, these are costly in health and financial terms, but they do serve as the “canary in the coal mine”, revealing where immunization coverage is low for all vaccines.

The additional immunization efforts needed to accelerate progress were described in the 2018 **Assessment Report of the Global Vaccine Action Plan**, issued by the Strategic Advisory Group of Experts (SAGE). This was widely disseminated and promoted to immunization- and health-related stakeholders to guide efforts for accelerated impact at the country level. SAGE warned that many targets set out in the Global Vaccine Action Plan are unlikely to be achieved by the end of the decade, now just one year away.

Elimination of neonatal tetanus in remaining 13 countries

The leadership and normative roles of WHO are critical in immunization. Some examples of deliverables in 2018 are shown below.

- WHO published a resource guide to summarize current knowledge and provide guidance on the integration of immunization with other health interventions, policies or activities to strengthen health systems. The work to integrate the essential immunization programme and surveillance with efforts to eradicate poliomyelitis (polio) is accelerating rapidly in order to harness the successes of the polio programme.
- A WHO position paper highlights the importance of using typhoid vaccines to control endemic and epidemic typhoid, and recommends that priority be given to introducing the new typhoid conjugate vaccine in countries with the highest burden of disease or a growing burden of drug-resistant typhoid. The disease is responsible for nearly 12 million infections and between 128 000 and 161 000 deaths a year.
- In support of the call to action to eliminate cervical cancer, WHO is working with manufacturers to expedite increases in human papillomavirus (HPV) vaccine supply and support an equitable distribution of available HPV vaccine doses, with priority being given to girls aged between nine and 14 years, the most critical target group.

Increased action against antimicrobial resistance

Antimicrobial resistance is a global threat to health. Antibiotics, antivirals and antifungals are now increasingly ineffective because of resistance resulting from excessive or inappropriate use.

Since the adoption of the Global action plan on antimicrobial resistance in 2015 by WHO, FAO and OIE, strong progress has been made in global efforts to achieve the plan's five strategic objectives:

Global action plan on antimicrobial resistance: strategic objectives

- Raising awareness and promoting education and training
- Surveillance, research and evidence for action
- Reducing infection through infection prevention and control measures, including water, sanitation and hygiene (WASH)
- Optimizing the use of antimicrobial medicines in human and animal health
- Increasing investment in research and development for new medicines, diagnostic tools and vaccines

Tracking the situation and progress

Surveillance data monitor the scale of the threat and trends. Progress in this area in 2018 includes the following.

- A total of 67 countries have now enrolled in **GLASS**, the **Global Antimicrobial Resistance Surveillance System** established by WHO, with 48 countries (double the number in 2017) providing resistance data and more than 6000 surveillance sites generating data, an eightfold increase since 2017.
- WHO launched **GLASS-EAR (GLASS Emerging AMR Reporting)** to support detection, early-warning and risk assessment capacities.
- WHO published the first-ever **Report on Surveillance of Antibiotic Consumption** with data from 65 countries.
- A global integrated surveillance protocol for antimicrobial resistance in humans, the food chain and the environment (the ESBL Ec Tricycle project) is being piloted.

The number of low-income countries that developed a **national action plan** doubled in 2018 compared with the previous year.

Reducing the need for antimicrobials

Infection prevention and control (IPC) reduces the need for antimicrobials. WHO has produced a range of practical tools and resources on IPC, including updated guidelines on surgical site infection. WHO supported over 40 countries in implementing IPC measures. It is supporting the implementation of recommendations in the first global guidelines to prevent carbapenem-resistant bacteria in health-care facilities and the monitoring and strengthening of basic WASH services in health-care facilities, waste-water treatment and surveillance.

In **Sierra Leone**, WHO provided soap, protective equipment, bin liners, waste bins, sanitizers and veronica buckets to support IPC in health facilities nationwide. Dedicated health-care workers are important for preventing infection, while community engagement is crucial to increase understanding of IPC practices such as basic hygiene and sanitation.

In **Nigeria**, WHO and partners supported campaigns in schools in Lagos on handwashing, personal hygiene, knowledge of antibiotics and antimicrobial resistance, food safety and environmental sanitation.



A total of 122 countries have now established national action plans based on templates and support provided by WHO while 57 countries are finalizing plans.

Enhancing One Health coordination and political commitment

The economic and financial impact of drug resistance impact economies in terms of health-care costs, decreases in labour supply, productivity, food production, animal welfare, household incomes, national revenues, etc. Antimicrobial resistance is also a risk to achieving global goals on poverty alleviation, food security, water and sanitation, and economic production. To address these challenges, a One Health approach is essential at the national and global level.

The **tripartite collaboration (FAO, OIE and WHO)** worked on:

- a monitoring and evaluation framework (for use at national and global levels) which will guide countries in establishing systems to develop, monitor and report relevant data;
- the annual self-assessment survey that closely monitors progress in the implementation of activities in countries, in which 154 countries, representing 91% of the world population, participated.

The United Nations Interagency Coordination Group on Antimicrobial Resistance (IACG)

WHO coordinated the secretariat of the Coordination Group on behalf of the tripartite agencies (FAO, OIE and WHO) and provided practical guidance for effective global action, with the following contributions in 2018:

- enhanced creating stronger political momentum, fostering cooperation, mobilizing stakeholders and increasing advocacy efforts;
- providing recommendations, to be submitted to the Secretary-General of the United Nations in 2019, to help reduce the health impact and economic damage caused by antimicrobial resistance by facilitating a global One Health antimicrobial resistance movement.

Raising awareness

World Antibiotics Awareness Week involved 130 countries participating in over 500 events using WHO awareness and advocacy toolkits.

To promote “smart” use of antimicrobials, WHO is finalizing a toolkit on antimicrobial stewardship for hospitals in developing countries. WHO also helped to revise relevant Codex Alimentarius standards on antimicrobial resistance in the food chain.

Tackling misuse

WHO is tackling misuse and overuse of antimicrobial medicines by continuing to support countries in:

- adopting the new “AWaRe” framework which will guide them towards increasing use of the Access antibiotics while restricting use of “Watch” and “Reserve” groups, to maintain the effectiveness and prolong the availability of last-line treatment options;
- establishing and strengthening antimicrobial stewardship programmes to reduce misuse of antimicrobials, thereby reducing resistance and enhancing treatment options;
- strengthening national regulatory mechanisms that monitor substandard and falsified antimicrobial products.

AWaRe has successfully met many challenges over the first two years. Immediately after its launch, it was adopted by several high- and low-income countries. Few new antimicrobials have been developed in recent decades, so 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 clinical phase 3);
- to monitor the clinical antibacterial and antituberculosis pipeline and review the global priority list of resistant bacteria posing the greatest threat in order to guide research into new drugs;
- on a landscape analysis of diagnostic tools and products for addressing antimicrobial resistance in developing countries.

Key figures for 2018-2019

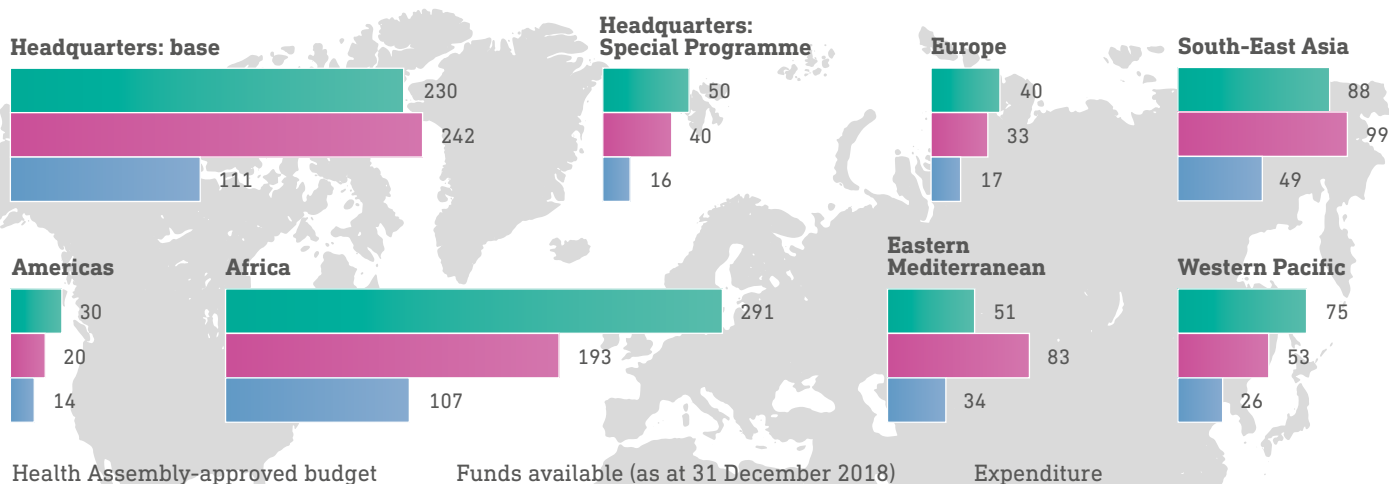
Approved Programme budget: US\$ 805 million

Funds available: US\$ 723 million (90% of Programme budget)

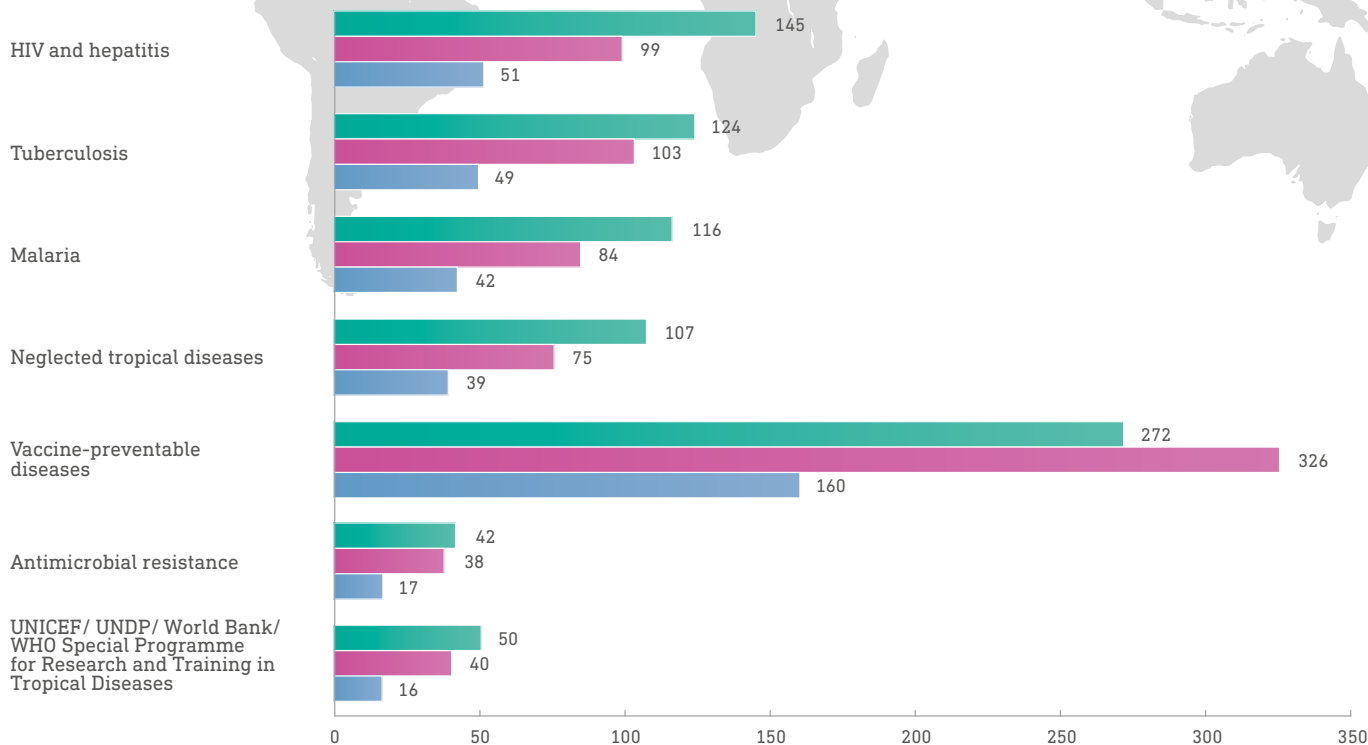
Expenditure: US\$ 358 million (44% of Programme budget, 50% of available resources)



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



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



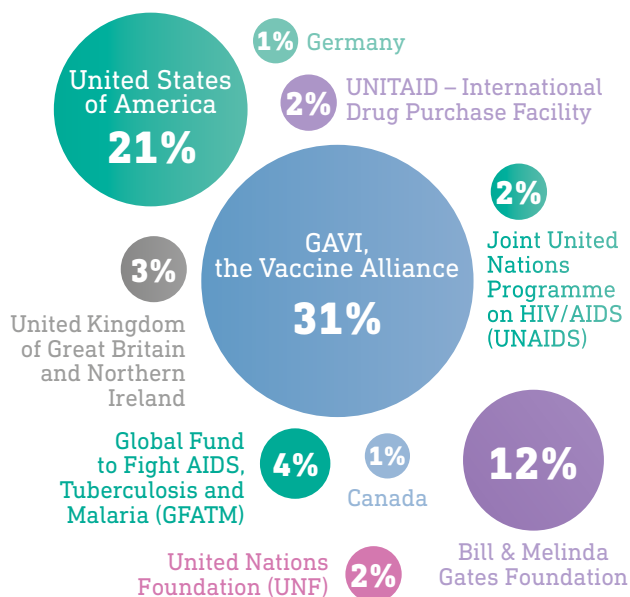
Budget and implementation

The Communicable disease category has some of the highest financing and expenditure rates of all categories of work at the country level, along with Polio. The level of financing across programme areas at the country level varies depending on the maturity of the programme

and operational needs. For example, for the Vaccine-preventable diseases programme area, the country level represents 59% of the total funding for the programme area, compared with 29% for Neglected tropical diseases. With a portfolio of 20 different diseases with very different



Top 10 voluntary contributors (specified, base)



Funding source:

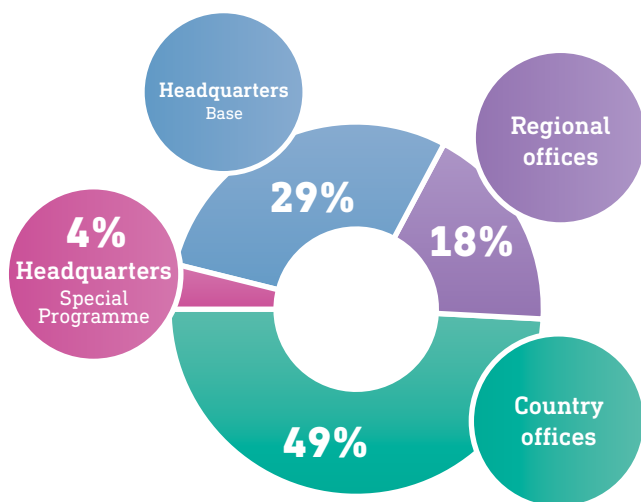
Flexible funding: 13%

Voluntary contributions – specified: 87%

Of the total voluntary contributions specified, 79% were from 10 contributors (shown beside)



Expenditure by level

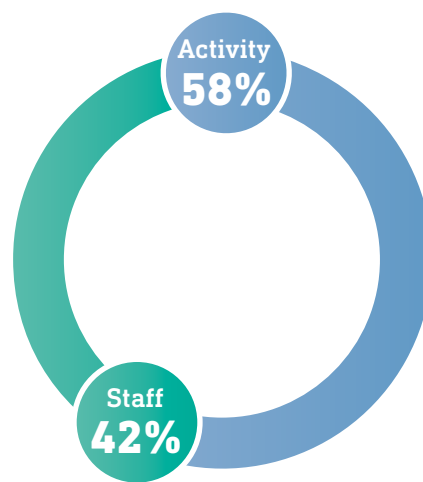


epidemiological characteristics, the technical support and guidance demands for neglected tropical diseases require consolidation of the skill set, rather than the diffusion of rare resources among multiple offices and levels. Similarly, the drugs donation programme for neglected tropical diseases is also integrated and accounted at headquarters but, in practice, is directly delivered at country level.

Communicable diseases attract considerable levels of voluntary financing, but this is highly specified, as in many other programme areas. This restricts the ability to move funding easily to where it will be most needed and makes funding uneven between programme areas, major offices and levels of the Organization. It is noteworthy that the Vaccine-preventable diseases area is currently funded to 120% of its budget, as approved by the Health Assembly. This is the result of a lower-than-required budget set at the time of approval of the Programme budget, when the substantial budget requirements of the pilot malaria



Expenditure: staff vs. activity



vaccine implementation programme in three African countries in late 2018 could not be included. The required change in budget allocation was made during the course of the biennium. Across all major offices, the Communicable diseases category overall was financed to at least 66% of the approved budget. It is a relatively well financed area. Available funding even exceeded the budget approved by the Health Assembly in the South-East Asia and Eastern Mediterranean Regions and at headquarters. Increased fundraising needs to be undertaken for the African Region in particular, where the funding gap remains at US\$ 98 million, with most programme areas being the most poorly funded of all the major offices.

For further details on Programme budget funding and implementation for communicable diseases, refer to the WHO Programme Budget Portal (<http://open.who.int/2018-19/our-work/category/01/about/key-figures> and <http://open.who.int/2018-19>).

THE GLOBAL POLIO ERADICATION INITIATIVE





“ In Afghanistan and Pakistan, the National Emergency Action Plans for Polio Eradication are being implemented with tremendous energy. We remain determined to make our Region, and the world, free of polio in the very near future. ”

Dr Ahmed Al-Mandhari
WHO Regional Director for the Eastern Mediterranean

In most countries, the effective surveillance and immunization systems built for polio eradication have also helped to broaden capacities to tackle other infectious diseases.

Polio is a highly infectious viral disease affecting young children, which can cause irreversible paralysis and possible death. Although there is no cure for it, an effective vaccine and a dedicated drive to eradicate polio mean that most of the world is now polio-free.

As long as a single child remains infected, however, all children everywhere are at risk. Failure to eradicate polio from the last remaining strongholds could lead, within 10 years, to as many as 200 000 new cases arising worldwide every year.

Key achievements

Renewed political commitment

Political leaders from around the world have voiced their support for the efforts of the Global Polio Eradication Initiative and advocated for a polio-free world at various global events, including meetings of the G7, G20, the Meeting of Commonwealth Heads of Government and the Rotary Convention.

In polio-affected countries, political commitment to eradication continues. The Government of the Democratic Republic of the Congo has signed the Kinshasa Declaration for the Eradication of Poliomyelitis and the Promotion of Vaccination, committing to improve vaccination coverage rates in 16 provinces, and the Government of Nigeria has secured a US\$ 150 million World Bank loan to scale up immunization services.

Cornering wild poliovirus

Attention on circulating wild poliovirus is now focused on Afghanistan and Pakistan. In both countries, the public sector, civil society, and community and religious leaders are all mobilized in the fight against polio. In 2018, the governments of both countries strove to improve the quality of their vaccination campaigns using national emergency action plans that focus on closing immunity gaps. A visit to both countries in early 2019 by the WHO Director-General,

Outcomes we are aiming to achieve in 2018–2019

- No case of paralysis due to wild or type-2 vaccine-related poliovirus globally

In 2018, there were 33 reported cases of wild poliovirus worldwide. This represents a 99% decrease since 1988, meaning that more than 17.5 million cases of paralysis have been averted.

the WHO Regional Director for the Eastern Mediterranean and the President of the Global Development Programme of the Bill & Melinda Gates Foundation was testament to the high priority afforded to polio eradication. During their four-day visit, they met with the heads of State and witnessed local eradication efforts first-hand.



Dr Tedros Adhanom Ghebreyesus, WHO Director-General and Chair of the Polio Oversight Board, administering oral polio vaccine to a young child in Pakistan.

Given that immunization gaps among highly mobile population groups constitute a major challenge in both Afghanistan and Pakistan, joint, coordinated efforts are being made to expand vaccination coverage using special nomadic teams to help to reach children on the move.

August 2018 marked two years since the last detection of wild poliovirus in Nigeria. As a result of continuous improvements in access to the north-east of the country, coupled with efforts to strengthen surveillance and enhance routine immunization, the African Region as a whole could be eligible for certification as free of wild poliovirus by late 2019. Furthermore, no cases of type 3 wild poliovirus have been detected anywhere in the world since 2012, and the strain may therefore be certified as eradicated before the end of the year.

Programme innovation

The polio eradication programme is constantly developing new ways to track the virus more effectively, vaccinate a greater number of children, and harness new tools to help to end the disease for good.

Significant progress has also been made in developing new tools, including novel oral polio vaccine, a potentially safer type of oral vaccine for use as an outbreak response tool in the post-polio era, but which would not replace the inactivated poliovirus vaccine altogether.

Battling circulating vaccine-derived poliovirus

In 2018, outbreaks of circulating vaccine-derived polio occurred in the Democratic Republic of the Congo, Indonesia, Kenya, Mozambique, Niger, Nigeria, Papua New Guinea and Somalia. Such outbreaks arise primarily in places where immunity is low. The Global Polio Eradication Initiative thus has two urgent tasks before it: to eradicate wild poliovirus as quickly as possible; and to stop the use of oral polio vaccine globally, thereby eliminating the long-term risk of the emergence of new strains of circulating vaccine-derived poliovirus.

The same proven strategies that are being used to stop wild poliovirus transmission are also being used to respond to circulating vaccine-derived polio. In December 2018, an international group of public health experts determined that the 2017 outbreak of type 2 circulating vaccine-derived polio, which had occurred in the Syrian Arab Republic, had been brought to a halt. That news followed 18 months of intensive vaccination and surveillance efforts in conflict-affected, previously inaccessible, areas.

In Papua New Guinea, the polio eradication programme conducted 100 days of emergency response from June to September 2018.

Bringing an end to ongoing circulating vaccine-derived polio outbreaks will remain a key priority throughout 2019.

New policy decisions

In May 2018, the Seventy-first World Health Assembly adopted resolution WHA71.16 on poliovirus containment to accelerate progress and ensure poliovirus materials are appropriately contained under strict biosafety and biosecurity handling and storage conditions. A comprehensive Post-Certification Strategy has also been finalized, which specifies global technical standards for containment, vaccination and surveillance activities, essential for maintaining a polio-free world.

Recognizing the ongoing challenge posed by circulating vaccine-derived polioviruses, the Global Commission for the Certification of Poliomyelitis Eradication met in November 2018 and recommended an updated process for declaring the world polio-free, beginning with certification of the eradication of type 3 wild poliovirus, followed by certification of the eradication of type 1 wild poliovirus. "We have achieved eradication of a disease once before, with smallpox [...]. The world is a much better place without smallpox. It's now more urgent than ever that we redouble our efforts and finish this job once and for all as well." Professor Helen Rees, Chairperson of the 19th meeting of the International Health Regulations (2005) Emergency Committee – concerning ongoing events and context involving transmission and international spread of poliovirus. The Committee was unanimous that polio continues to be a global emergency.

Smartphone app helps to track polio in Nigeria

In Nigeria and surrounding areas, health workers are using a smartphone application, e-Surve, to enable quick, accurate, up-to-date disease surveillance. The app guides programme officers through conversations with local health officials, offering prompts on how to identify and report suspected cases of disease. With the touch of a button, responses are submitted to a central database where health officials can analyse and track outbreaks across multiple districts in real time.

Dr Namadi Lawal, a surveillance officer with the National Primary Health Care Development Agency, describes e-Surve as "a wonderful innovation". Since its introduction, he has been able to receive significantly more accurate information in real time. This is particularly important because without the accurate and timely reporting of cases of disease, an outbreak can be fully under way before authorities realize there is a problem. The app also helps to identify trends and track data.

Bringing vaccination to remote communities

As well as conducting surveillance, health workers have worked tirelessly to bring polio vaccines to the remote communities of Lake Chad. Dotted with hundreds of small islands, the lake is one of the most challenging places in the world to deliver health services. Vaccinators must travel by boat for several days to deliver polio vaccines to isolated island villages, using solar-powered refrigerators to keep the vaccines at the correct temperature. In 2018, vaccination campaigns on the lake enabled thousands of children, who would otherwise have gone unprotected, to be accessed for the first time.



Female polio workers break taboos in Afghanistan

Front-line polio workers are possibly the largest female workforce in Afghanistan. As more women than ever work to eradicate polio, they are also unintentionally leading a social revolution, breaking a strong taboo against women who work. Women make up a third of polio workers in urban areas in the country, although the proportion is lower in rural areas. Hiring female health workers in traditional contexts is critical, as, unlike their male counterparts, women have access to households and are able to build trusting relationships with other women, and thus convince mothers to vaccinate their children.

This approach in Afghanistan shows that by considering gender issues, the polio eradication programme is able to maximize its reach. For example, a district polio worker in Kandahar, Habibur Rahman, explains: "Before we had female polio workers, we were missing [vaccination among some] children. Females can enter the house, but males cannot."

She adds that recruiting female workers can be difficult. "Many think women should not work," she says. Now, with more female workers, vaccination coverage has improved in this area, where polio cases have arisen in recent years.

Spotlight on gender

WHO is committed to advancing gender equality and the empowerment of women, including in its efforts to eradicate polio. WHO works collectively with Global Polio Eradication Initiative partners to identify and remove gender-related barriers to immunization, recognizing and taking into account the diversity of people's specific needs, challenges and priorities. This ensures that the Organization's eradication work has equal benefits for girls, boys, women and men and people with diverse gender identities.

New gender-sensitive indicators have been introduced to ensure that polio vaccines reach girls and boys equally, to track the timeliness of disease surveillance for girls and boys, and to monitor the rate of women's participation as front-line workers in countries in which polio is endemic. WHO continues to collect and analyse sex-disaggregated data and conduct gender analysis on a regular basis, to further strengthen vaccination campaigns.

Looking forward

The Polio Eradication and Endgame Strategic Plan (2013–2018) brought the world ever closer to being polio-free. Despite every effort to achieve polio eradication by 2018, the "home straight" was marked with environmental and political obstacles and the challenges associated with a mobile population. In 2018, however, the Global Polio Eradication Initiative devised a new strategy for the period 2019–2023, building on lessons learned and mapping out how to achieve certification by 2023.

The overriding objective of the new strategy is to reach the very last remaining unvaccinated child. Inadequate vaccination of children is the underlying reason for the persistence of polio in any given area. From this, everything else follows. We must therefore focus on reaching and vaccinating the last child.

The new strategy builds on the lessons learned since 2013 in bringing the world to the brink of polio eradication. During that time, we have learned everything we need to know to be able to overcome any remaining obstacle to reaching that last unvaccinated child, be it conflict, access difficulties, population movement or management issues. The new strategy outlines the solutions to all of those challenges, to ensure that the last child is immunized and to bring an end to polio once and for all.

Key figures for 2018–2019

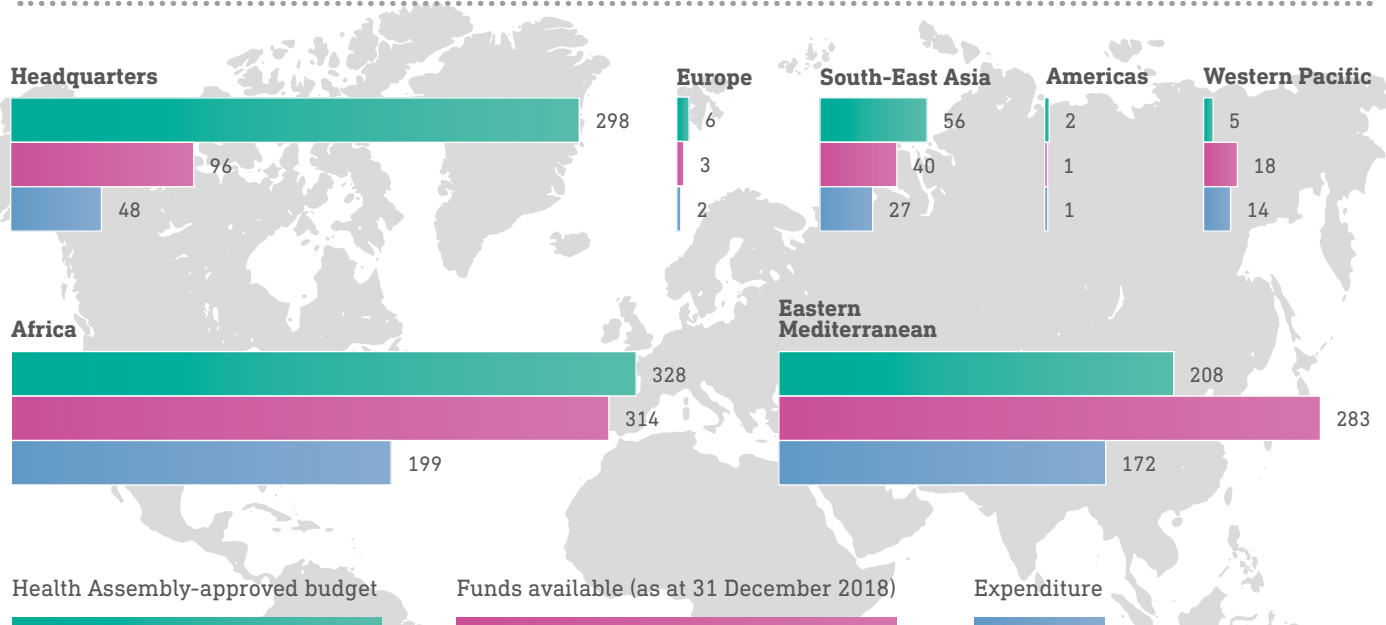
Approved Programme budget: US\$ 903 million

Funds available: US\$ 755 million (84% of Programme budget)

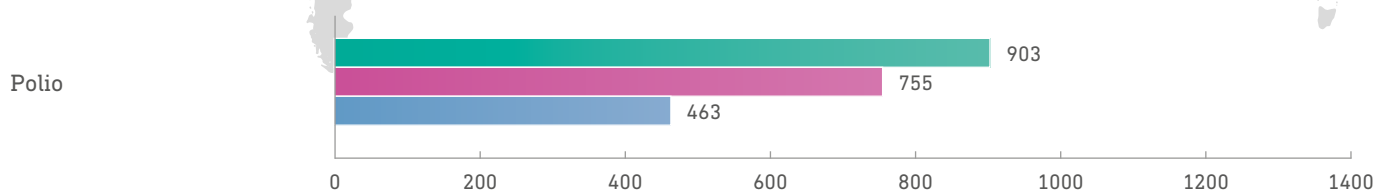
Expenditure: US\$ 463 million (51% of Programme budget, 61% of available resources)



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



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



Budget and implementation

Polio eradication was funded to a level of 84% of its approved budget, entirely from specified funding. The South-East Asia Region (71%), African Region (96%) and Eastern Mediterranean Region (136%) have relatively higher funding levels than the other regions, owing to the epidemiology in the regions and the scale of the polio eradication efforts. However, expenditure is lower than expected, particularly in the Eastern Mediterranean Region, probably due to crisis situation in many countries.

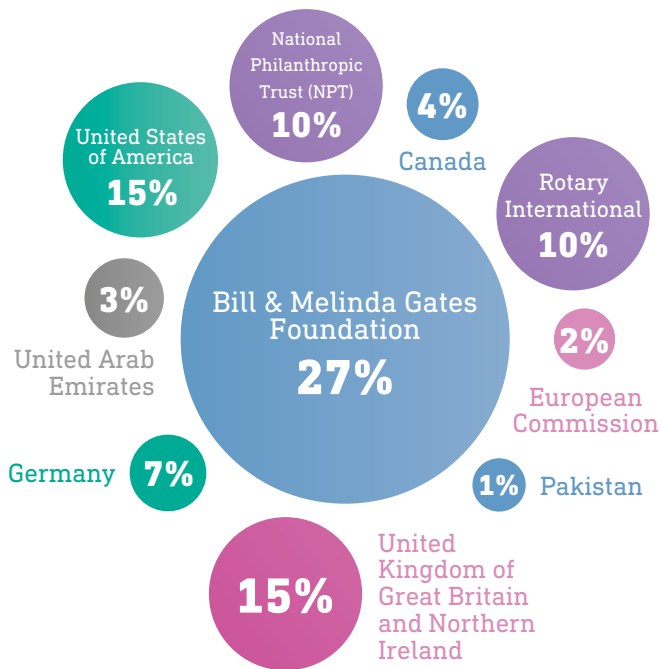
Expenditure at the country level was 82% of the total, while staff costs were 19%. At present, polio eradication remains capable of utilizing high levels of specified funding

through activity expenditures. The polio programme is activity intensive. Implementing key activities, especially surveillance and immunization, entails substantial costs. Future financial risks are related to increasing financial requirements and fewer flexible voluntary contributions to meet unforeseen needs.

For further details on the Programme budget funding and implementation for this category, please refer to the WHO Programme Budget Portal (<http://open.who.int/2018-19/our-work/category/10/about/key-figures> and <http://open.who.int/2018-19>).



Top 10 voluntary contributors (specified)



Funding source:

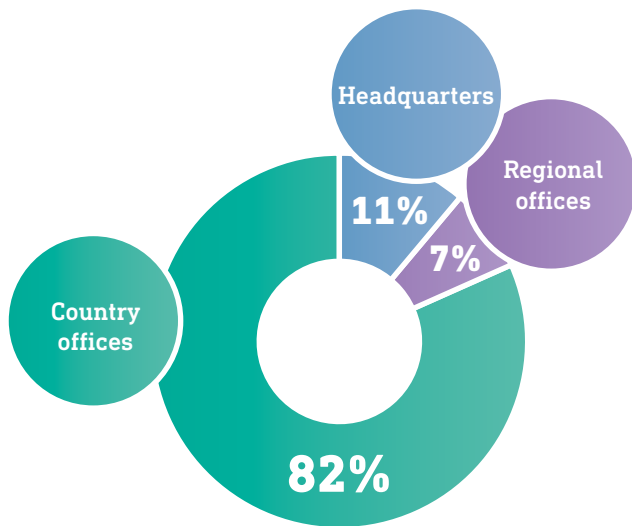
Flexible funding: 0%

Voluntary contributions specified: 100%

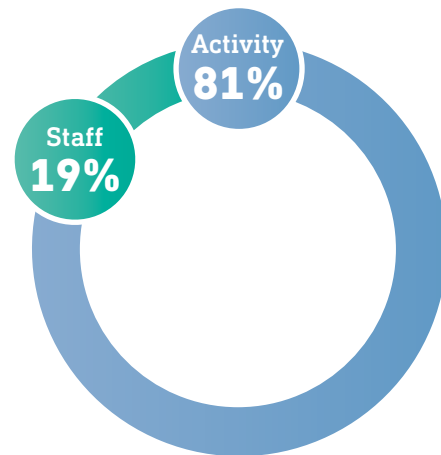
Of the total voluntary contributions specified, 94% were from 10 contributors (shown beside)



Expenditure by level



Expenditure: staff vs. activity



LEADERSHIP AND ENABLING FUNCTIONS



PROGRAMME AREAS

Leadership and governance

Transparency, accountability and risk management

Strategic planning, resource coordination and reporting

Management and administration

Strategic communications



“ I believe we should not put any limits on ourselves as we strive to deliver a measurable impact in the lives of the people we serve. We must work with unrelenting vigour and unrestricted belief that anything is possible. ”

Dr Tedros Adhanom Ghebreyesus
WHO Director-General

Key objectives

- to lead and convene decisions on public health issues between Member States and stakeholders
- to give the Organization a sharper focus on results
- to ensure adequate resources and good governance, with the highest standards of integrity and oversight
- to provide core administrative services that underpin the effective and efficient functioning of WHO
- to ensure that effective and efficient management and administration are consistently established across the Organization.

Key achievements

Setting the new strategic directions for WHO

Recognizing the potential of WHO to dramatically improve global health, the Seventy-first World Health Assembly approved a new strategic plan in 2018 for the following five years – the Organization’s Thirteenth General Programme of Work (GPW 13). Exactly 70 years after WHO was founded, GPW 13 sets out not just to transform WHO but to transform global health and individual human lives. Its objectives are ambitious but they come with concrete targets that demonstrate impact on people’s lives at the country level.

The triple billion targets will be met primarily through multisectoral policy, advocacy and regulation. GPW 13 is designed to help the world achieve the Sustainable Development Goals (SDGs), with a particular focus on Goal 3, “Ensure healthy lives and promoting well-being for all at all ages by 2030”. GPW 13 provides a vision, rooted in Article 1 of the WHO Constitution and based on the SDGs, of “a world in which all people attain the highest possible standard of health and well-being”.

Outcomes we are aiming to achieve in 2018–2019

- greater coherence in global health, with WHO taking the lead in enabling the different actors to play an active and effective role in contributing to the health of all people;
- accountable and transparent operations, with well-functioning risk management and evaluation frameworks;
- financing and resource allocation that is aligned with the priorities and health needs of Member States in a results-based management framework;
- improved public and stakeholder understanding of the work of WHO.

WHO’s new and 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.

Taking the lead on Sustainable Development Goal 3

In response to a request to develop a global action plan for Sustainable Development Goal 3 made by three global leaders, Chancellor Angela Merkel of Germany, President Nana Addo Dankwa Akufo-Addo of Ghana and Prime Minister Erna Solberg of Norway, supported by the United Nations Secretary-General, António Guterres, WHO coordinated the development of the Global Action Plan for Healthy Lives and Well-Being for All, which unites the work of 12 leading global organizations active in health. The Global Action Plan is a powerful platform for global health agencies to advance collective action and accelerate progress towards the SDGs. Maximizing this opportunity and platform will only be made possible by sustained engagement at the highest political levels to ensure further interministerial and intersectoral action.

With WHO coordination, the 12 global health organizations have identified areas in which collective action can be scaled up through key cross-cutting “accelerators”, bringing together resources, expertise and reach to create catalytic enablers that will significantly advance progress across the SDG agenda.

SDG 3 accelerators:

- Sustainable financing
- Primary health care
- Community and civil society engagement
- Determinants of health
- Research, development, innovation and access
- Data and digital health
- Innovative programming in fragile and vulnerable settings and for disease outbreak response.



Transforming WHO

WHO's transformation process aims to reposition, reconfigure and capacitate the Organization within the broader United Nations reform process so that its normative and technical work is of an even higher quality and more sharply focused on the needs, demands and expected actions of Member States and translates directly into results at country level.

The year 2018 was a critical one for building momentum for the transformation. Critical milestones that were achieved include the following.

- A new strategy was developed to align the work of the entire Organization with the targets of the health-related SDGs.
- A total of 13 of WHO's core technical, external relations and business processes were examined and prioritized for redesign, beginning with the programme budget process. These process redesigns were accepted for Organization-wide rollout at the first WHO Global Management Meeting, held in December 2018.
- The overall operating model, which was designed to deliver the Twelfth General Programme of Work, 2014–2019, was reviewed. Proposals were made after internal consultations on WHO's roles, structure and ways of working to align these across all major offices and the three levels of the Organization. Analyses focused initially on WHO's country presence and subsequently on its headquarters and regional offices. Broad agreement was established on the key principles that would underpin the new operating model, which was subsequently endorsed at the Global Management Meeting.
- Assessment of the underlying culture of WHO work led to the identification of a range of core actions to be taken at the corporate, major office and team levels to change the mindset and behaviour of all staff members, including senior management. A global dialogue among all staff members resulted in the drafting of the WHO Values Charter, which will be launched in 2019 and will include a plan for embedding the values in the daily work of all staff members, including leaders.
- The transformation process also triggered a rethinking of WHO's approach to external engagement in order to effectively communicate, finance and implement the new strategy.

Aligning transformation with United Nations reform at country level

As part of the United Nations country team, WHO has been proactively engaged in United Nations reform at country level to enhance the effectiveness of the United Nations presence in countries. A total of 128 WHO country offices reported that they had participated in the development of the United Nations Development Assistance Framework (UNDAF) in their country of assignment. Most of the priorities of the WHO country cooperation strategies are reflected in the UNDAF, which reflects the synergies between these two strategic frameworks and the complementary work of WHO and the United Nations.

Committing to making an impact on people's lives

WHO's clear focus on impact entails a commitment to monitoring and measuring the achievement of results. A well-defined measurement system has been proposed to monitor and measure progress towards achieving the impact set out in GPW 13.

The measurement system consists of an overarching and comparable measure of progress reported by:

- the healthy life expectancy (HALE) indicator that links the triple billion targets;
 - composite indices for each of the triple billion targets themselves; and
 - a set of outcome indicators, comprising 38 SDG indicators and 8 for other areas of work not covered by the SDG indicators (for example, antimicrobial resistance and emergencies).
- The triple billion targets will guide the most important actions and investments towards making an impact on people's lives – focusing on universal health coverage, health emergencies and healthier populations.

Measuring performance by delivering results

To measure its contribution to Africa's health and sharpen its focus on accountability, transparency and results, the Regional Office for Africa has invested in defining and institutionalizing the robust Africa Results Framework with the introduction of programmatic and managerial key performance indicators. The managerial key performance indicators have improved the internal effectiveness and efficiency of the Regional Office, while the programmatic key performance indicators have focused on driving change in the capacity of WHO country offices to serve Member States more effectively, making them more responsive and more fit for purpose.

Taking the lead at the country level

WHO continues to lead or co-lead donor coordination mechanisms with governments. WHO country offices have reported that they are increasingly playing a leadership role in 70% of the countries, territories and areas in which such mechanisms are active. WHO country offices are supporting governments and partners in implementing the SDGs by contributing to national SDG coordination platforms, advocacy, resource mobilization, coordination in setting national targets, monitoring and evaluation. A large proportion of WHO country offices (89%) have reported being engaged in providing technical support for the mainstreaming of SDGs into national plans, policies and programmes.

The 2030 Agenda for Sustainable Development reaffirms the need to enhance south-south and triangular cooperation, as well as regional and international cooperation, in ensuring access to science, technology and innovation for the achievement of the SDGs. Globally, half of the WHO offices in countries, territories and areas in all six regions reported supporting a total of 241 south-south and/or triangular cooperation initiatives.

Country impact-focused: making GPW 13 happen

Lessons learned from past initiatives show that a WHO focused on country impact will require multiple, interrelated changes in processes, methodologies, structures and most importantly in mindsets. The strong focus on impact in GPW 13 will drive these changes in the Organization. The following are critical to making the focus on impact a reality:

The focus on impact brought to light the need for a clear set of targets. In 2018, a wide-ranging consultation process on targets, indicators and methodologies was conducted. The WHO Impact Framework targets will provide the direction and country focus for every action and investment in WHO.

The new programme budget process has incorporated more impact-focused priority-setting at the country level. WHO has started to develop country support plans for the entire duration of GPW 13 to ensure that effective and coherent support is provided across the three levels of the Organization. An enhancement of the planning process – the Country Support Plan – will align the work across the three levels of the Organization, which is closely focused on delivering better support to countries.

Country focus cannot be achieved only by creating priorities, plans and budgets that support country delivery. Ensuring the effective measurement of the impact at country level and of the way WHO's work is helping to achieve that impact in countries is crucial to making both Member States and the Secretariat accountable for delivering it. WHO is introducing a new way of ensuring that results are measured at different levels of the results framework, including the triple billion indices, programmatic targets and a new approach to measuring the accountability of the Secretariat.

Continuing the commitment to transparency

The Secretariat has continued to enhance and further refine the data it publishes on the Programme budget web portal. Enhancements include new data, such as data on the mapping of global and regional governing body resolutions and on the work and financing of the Pandemic Influenza Preparedness Framework. The web portal maintains key features that meet compliance commitments under the International Aid Transparency Initiative. It has the potential to streamline the way the Organization provides information on its focus, what it does, what resources it has, how it spends its resources, what results are achieved and the assessment of its performance. WHO continues to demonstrate best practice as an instrument of organizational transparency.

Transforming resource mobilization

The WHO resource mobilization strategy aims to ensure that the Organization is sufficiently resourced to deliver GPW 13 and, in so doing, to achieve the Organization's triple billion targets. The resource mobilization strategy defines how the Organization will achieve its resource targets through tailored approaches, both traditional and innovative in nature, and through a greater variety of partnerships. The strategy also reflects opportunities to increase philanthropic support and leverage resource potential at the country level.

Maximizing impact through partnerships

WHO has a broad mandate – it is the world's only global health agency with a mandate that can change the world – but WHO can deliver only by working with others, welcoming and learning from them and sharing responsibility according to the comparative advantages of each partner. Guided by the realization that the world is too big to be served by only one agency, throughout 2018 WHO has strengthened its existing partnerships and established new ones.

Monitoring WHO's principal risks

Through the proactive use of risk management techniques, the Secretariat is managing and regularly monitoring risks to ensure timely achievement of the Organization's objectives. To further improve accountability and transparency across all levels of the Organization, the regional offices have established or are currently establishing regional compliance and risk management committees to support decision-making processes.

Partnering for better health outcomes

WHO began a partnership with Bloomberg in 2007 to support tobacco control and injury prevention. In the area of tobacco control, WHO's impact has been maximized through policies and specialized country programming, with a strategic focus on four priority countries who have the largest burden of tobacco users: Bangladesh, China, India and Indonesia. Overall, Bloomberg Philanthropies' support for tobacco control has enabled WHO to reach 4.7 billion people – 63% of the world's population – through tobacco control measures.

WHO has been a long-term partner of the Chinese Government and the Bloomberg Initiative to implement the requirements of the Framework Convention on Tobacco Control, a global health treaty ratified by more than 180 countries. The WHO China office has launched an anti-tobacco campaign that features four young celebrities and has millions of followers. Within its first week, the campaign reached more than 120 million social media users and engaged 80 million people in discussion threads. More than 184 media outlets covered the campaign and a video was displayed in landmark buildings and sites throughout China and in New York City's Times Square.

The campaign was built on a decade of collaboration between WHO China and Bloomberg to support China's tobacco advocates in pushing for tobacco taxes, advertising and promotion laws, graphic warnings and smoke-free legislation. WHO's engagement with non-traditional partners in entertainment and fashion has opened doors to reaching bigger audiences as a counterbalance to aggressive tobacco industry marketing.

Walking the talk on equitable gender representation

- 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**.
- The number of women holding senior positions at headquarters increased from **37% in 2017 to 41% in 2018**.

Making a case for investing in health impact and investing in WHO

WHO has published its first investment case: "a healthier humanity". For the first time, WHO has clearly expressed the expected return on investment, especially in terms of the impact that investments will make on people's lives by implementing GPW 13.

By 2023, to achieve:

30 million lives saved

100 million years of healthy living

4% of economic growth in low- and middle-income countries.

Cost:

US\$ 14.1 billion over 5 years.

The investment case helps to articulate what matters most and guides resource mobilization efforts to focus on results.

A HEALTHIER HUMANITY

The WHO Investment Case for 2019-2023



WHO has implemented training courses on the prevention of harassment, sexual harassment and abuse of authority, and zero tolerance for sexual exploitation and abuse. The courses have been made mandatory for all staff members and completion rates are all close to 100%.

As WHO is a data-driven organization and data have become more prone to cyberattacks, cybersecurity has been identified as one of WHO's principal risks and risk mitigation measures to protect against data loss and theft have been put in place. To this effect, the Organization has introduced mandatory cybersecurity awareness training for all users of WHO information systems. An initiative has also been launched to develop a comprehensive WHO data protection policy. WHO takes its data integrity seriously and continues to seek ways to enforce protection of its digital assets.

Enabling the achievement of impact

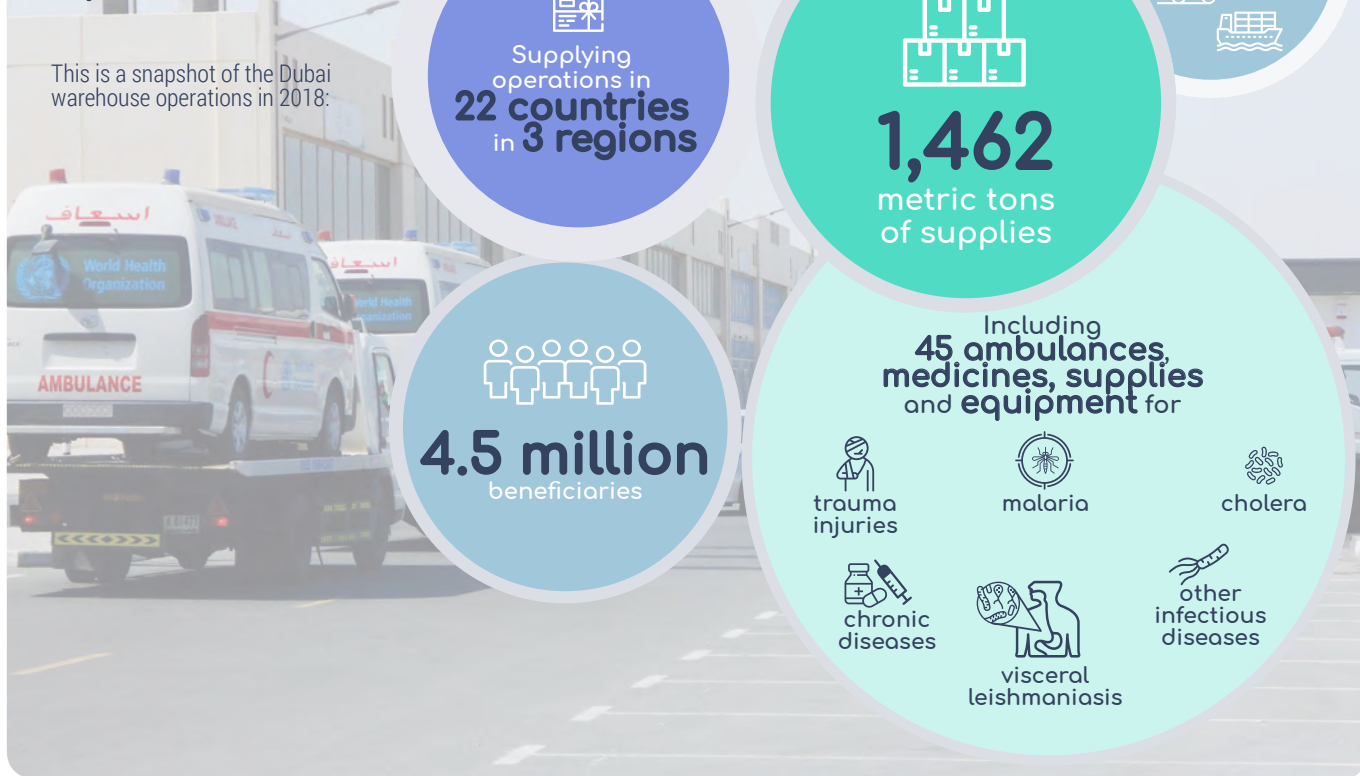
WHO makes a significant investment in management and administration, not only to maintain its integrity and ensure that the Organization remains accountable for its resources but also to facilitate its health impacts. Efficient management and administration can determine the success of a technical programme, such as by ensuring the timely recruitment of key staff members to provide much-needed expertise to release bottlenecks in a programme, the provision of experts to agree on standards for global public health goods or the procurement of equipment that will keep patients and WHO staff members safe.

The critical role of management and administration is exemplified by the successful security operations, supported at all three levels of the Organization, that were conducted during the response to the recent outbreaks of Ebola virus disease. Without the security the Organization provides for its staff members, partners and health workers, the treatment centres would stop operating, vaccinations would not be administered and the community mobilization efforts that are crucial for gaining people's support could not take place.

Supporting the Organization's emergency response has been a key achievement of the procurement units in many WHO offices.

Supplying emergency operations

This is a snapshot of the Dubai warehouse operations in 2018:



Procuring essential medicines

The updated WHO Quality Assurance Policy for the Procurement of Essential Medicines and other Health Products was published in June 2018. It sets out the principles and requirements that drive the procurement by WHO of essential medicines and health products, and it includes a set of clear and transparent criteria that are used to select among potential sources and suppliers. This policy applies to all WHO offices that procure medicines for both routine and emergency purposes. It is monitored by the WHO Quality Assurance Group.

Retaining talent

For a technical agency like WHO, its staff members are its most important asset. WHO is transforming its ways of working with human resources to retain the best people and place the right people in the right places.

The new **Short-term Developmental Assignments Policy**, launched in March 2018, has allowed 45 staff members in all categories and at all organizational levels to be temporarily exposed to different work environments at other duty stations or major offices for the purposes of career development. It is the first time that national professional officers and general service staff members have been provided with that opportunity.

The **Global Mentoring Programme**, introduced as a pilot in 2016, has been so successful that it was recently relaunched to recruit more mentors (70 mentors are available to date across the Organization) and offer more staff members the opportunity to capitalize on and share the wealth of internal experience and knowledge within WHO, while promoting networking and learning opportunities for all.

Protecting our staff members

Providing security for the safety and security of the staff members of the Organization is an essential part of WHO programme delivery and achieving impacts. The global security situation is changing, making programme delivery more difficult in many locations. WHO is required to deliver its mission to help countries achieve their priorities, including in conflict, fragile and vulnerable situations. For example, the Secretariat deployed additional dedicated field security officers to support operations in 2018 in Bangladesh, the Democratic Republic of the Congo, Libya, Mozambique and Yemen, among others.

WHO has increased the capacity of its security support services and will continue to strengthen and consolidate these services.

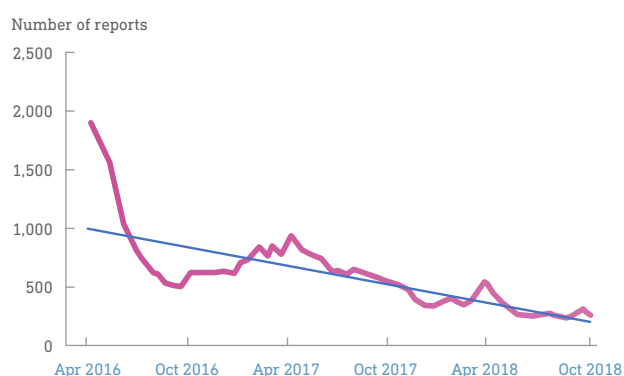
Procurement in emergencies

As part of broader initiatives to strengthen supply chains, WHO is expanding current operations based in the International Humanitarian City, Dubai, United Arab Emirates. In 2018, the operation experienced significant increases in demand for life-saving medicine and medical supplies. Recognizing the value of maintaining pre-positioned stocks of emergency health supplies and the strategic geographic location of Dubai, WHO is expanding the current operation from an initial 3000 square meters to over 12 000 square meters of temperature-controlled storage.

Saving costs on procurement

Under the oversight of the Quality Assurance Group, WHO has standardized its list of medical items. Tenders are issued for long-term agreements with suppliers with the aim of including the most frequently used pharmaceutical products in the WHO e-catalogue. This process will avoid repetitive procurement exercises for commodities with identical or very similar specifications. It is anticipated that the overall improvement in the procurement process, in terms of quality, timing, pricing and administrative costs, will yield significant cost savings for the Organization.

Number of overdue direct financial cooperation reports, Regional Office for Africa, 2016–2019



The Ebola response in the Democratic Republic of Congo presented its own unique challenges, with the programme and staff members increasingly being obliged to deliver services in the face of security threats. The operations required investment in armoured vehicles, emergency communication and personal protection equipment, as well as in training of personnel. As part of the United Nations security management system, WHO is leveraging the combined resources of the United Nations system, including the United Nations Department of Safety and Security and the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo, in support of the Ebola response. However, the situation remains unpredictable and the risks extremely high.

WHO is strengthening its capacity to deal with the increasing demands for emergency surge support and to maintain an effective international coverage. WHO operates on the premise that every staff member and every office must be made safe and secure and thereby enabled to deliver the support required in any situation on the ground.

Accounting for every dollar

According to the WHO Office of Internal Oversight Services, the effectiveness of internal control in the WHO African Region increased from 50% in 2015 to 75% in 2018. All functional domains witnessed significant improvements, especially the domain of direct financial cooperation, in which the operational effectiveness of controls more than doubled. One particularly striking indicator of progress was the reduction of outstanding reports. The number of overdue direct financial cooperation reports in the African Region was reduced from 1907 reports as of 1 April 2016 to 62 reports as of 15 February 2019 – a decrease of 84% over the past year, 91% over the past two years and 97% over the past three years.

The Regional Office for Africa developed a strategy, on the basis of which it designed and implemented a number of processes and tools that were employed in a systematic and disciplined approach, with a consistent focus. However, the key success factors were a deep sense of purpose and commitment; clear expectations and a clear understanding of each staff member's responsibilities and obligations; collaboration; open communication; and a strong sense of shared accountability and trust.

The October 2018 meeting of senior administrative staff of the African Region adopted a unanimous commitment to achieve "zero overdue direct financial cooperation reports". Current trends indicate that the Region may reach this never-before-achieved benchmark by June 2019.

Strengthened communications

Many WHO regional offices have reoriented their focus to strengthen communications at both regional and country levels, leading to more effective and timely communication on public health and the extension of WHO's work to reach key audiences.

Key actions in 2018 included the updating, restructuring and migrating of regional, country and area websites to a modern content management system and training staff members to use the new system. The team also focused on reaching out proactively to journalists and sending releases in a targeted manner, generating more than 100 WHO stories in print, online and broadcast media.

Another important activity was the continued deployment of communications experts to enhance countries' capacity to engage in effective emergency/risk communications and to promote universal health coverage. Examples of deployments in the Western Pacific Region included the direct support provided in response to the Papua New Guinea earthquake and polio outbreak, the flood in the Lao People's Democratic Republic and the Philippines dengue vaccine crisis, as well as the support provided by the Viet Nam country office for targeted communications to promote universal health care.

Building efficiencies and safety into WHO infrastructure

WHO is modernizing its headquarters in Geneva, bringing the campus into line with Swiss safety and environmental standards and United Nations security norms. To ensure its flexibility to adapt to future needs and in recognition of the ever-changing landscape in which WHO works, the Organization has adopted an agile and innovative approach to the configuration of infrastructure within the renovated campus.

WHO Member States, especially the Government of Switzerland, local Geneva authorities and other entities, have been supportive in enabling the project. Funding has been provided through the WHO Infrastructure Fund, a sustainable funding mechanism and an interest-free loan from Switzerland. This complex and important project is proceeding on time and within cost.

WHO is also redeveloping its Regional Office for South-East Asia. This project is also motivated by the need to comply with local safety and environmental standards and United Nations security norms and is made possible by a generous contribution from the Government of India, which is taking the lead in financing and managing this project, along with other regional Member States who have also pledged financial support. The new building will comply with the LEED Platinum rating specifications, ensuring a healthy workplace for staff and visitors, with appropriate spaces for movement and physical activity and a working design that encourages collaboration and cooperation.

Targeted communications to promote universal health coverage in Viet Nam

WHO is working with Viet Nam's Ministry of Health to strengthen its health system capacity to deliver quality and equitable services under the joint Health Cooperation Programme. As part of this Programme, WHO is supporting the Ministry of Health to advocate for advancing universal health coverage by, for example, advocating for increased financing to priority areas such as grass-roots level reforms. To support this priority further, the WHO country office has strengthened its communications support to the Viet Nam Ministry of Health. It has prepared communications products targeted at policymakers, technical experts, health workers and the general public and has also helped to strengthen the capacity of the Ministry of Health in risk communications by training senior officials. WHO Viet Nam has created an office-wide task force on communications and advocacy, with a strategy based on using strengthened communications to help achieve impacts at the country level.





Architects' visualizations of new extension for headquarters (top) and redevelopment for the Regional Office for South-East Asia (bottom)

Key figures for 2018–2019

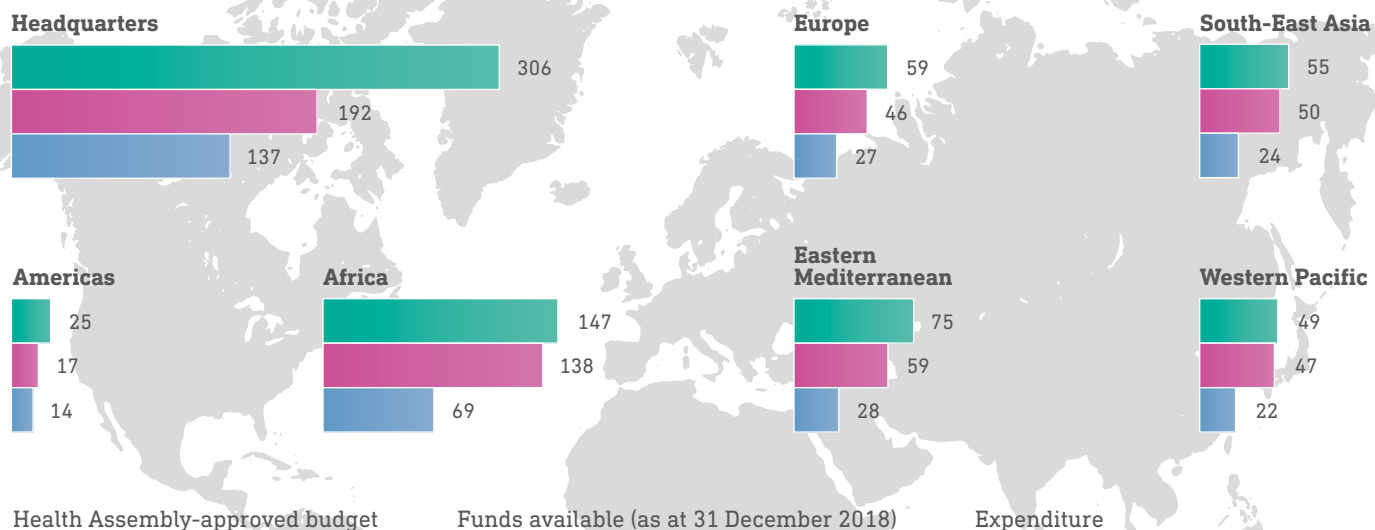
Approved Programme budget: US\$ 715.5 million

Funds available: US\$ 548 million (77% of Programme budget)

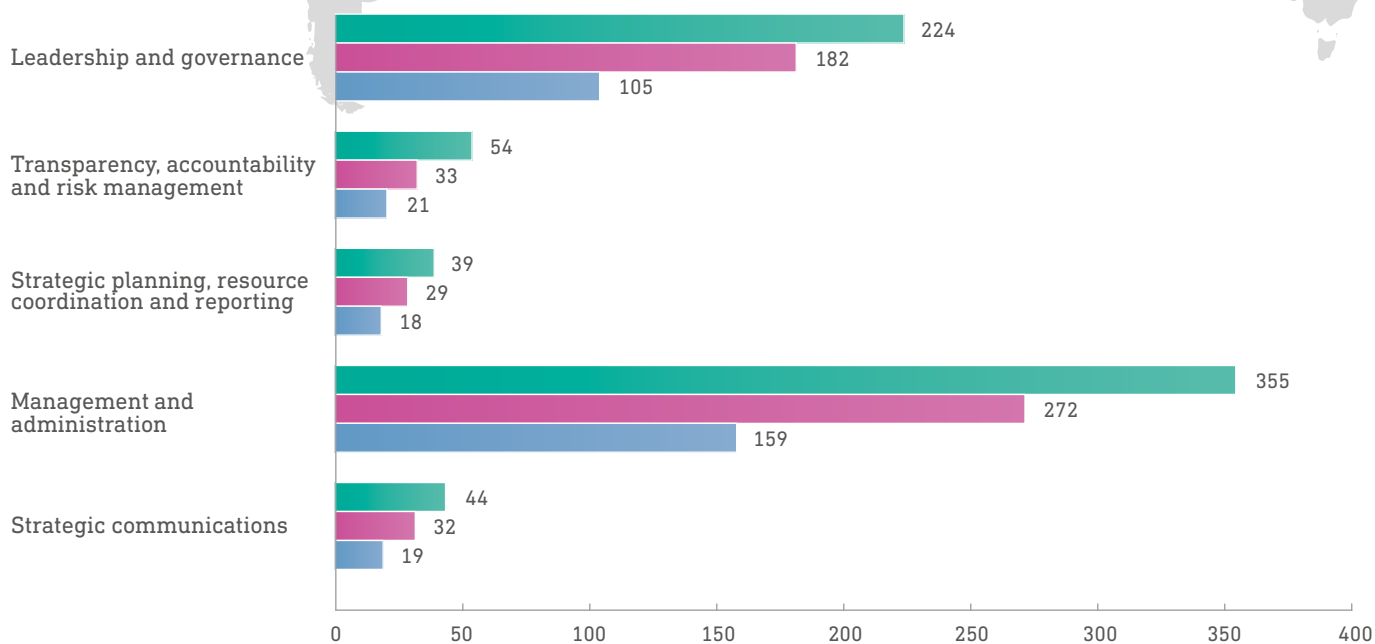
Expenditure: US\$ 321 million (45% of Programme budget, 58% of available resources)



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

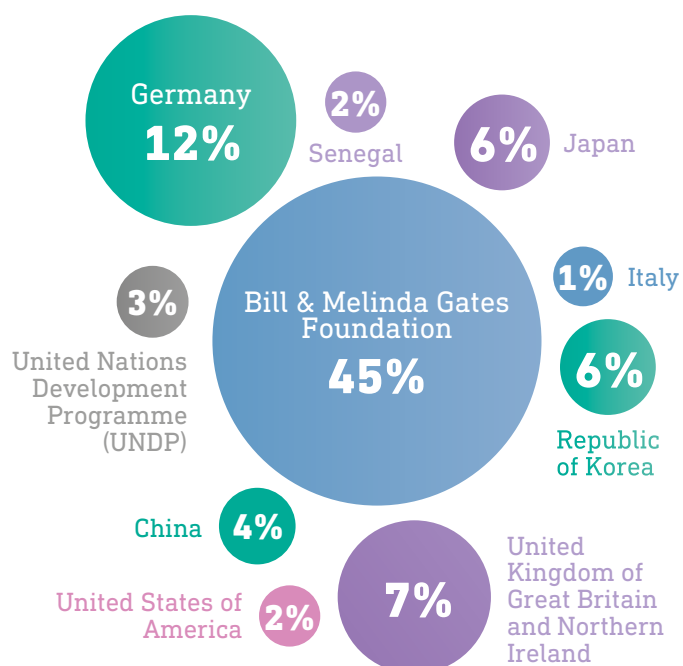


Budget, funds available and expenditure, by programme (in US\$ million)





Top 10 voluntary contributors (specified)



Funding source:

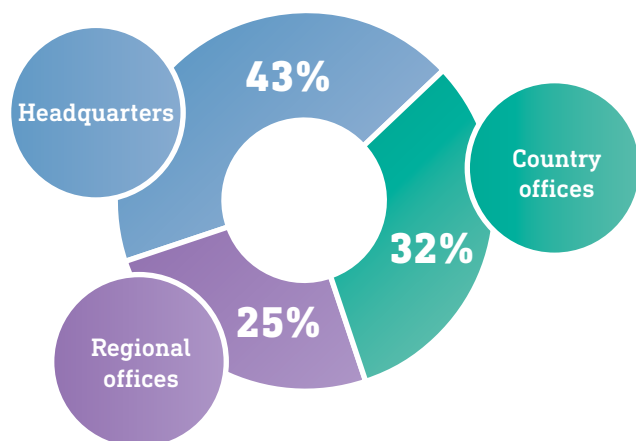
Flexible funding: 94%

Voluntary contributions – specified: 6%

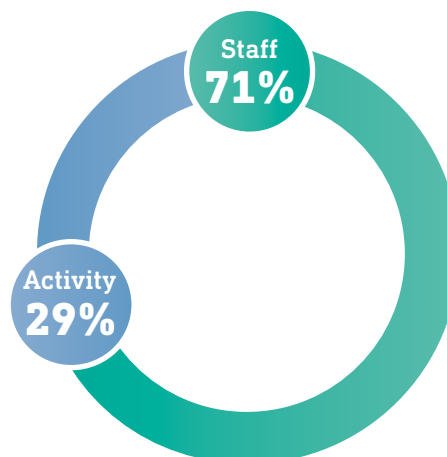
Of the total voluntary contributions specified, 88% were from 10 contributors (shown beside)



Expenditure by level



Expenditure: staff vs. activity



Budget and implementation

The leadership and enabling functions category was funded overall to a level of 77% of its approved budget. Across the three levels of the Organization, headquarters is the least well-funded, at 63%. The scale of headquarters operations is considerably bigger, however. Headquarters expenditure in this category in 2018 accounts for 43% of the total, compared with 32% at the country level.

Funding for this category is based on a different model from that used for the other categories and is also largely

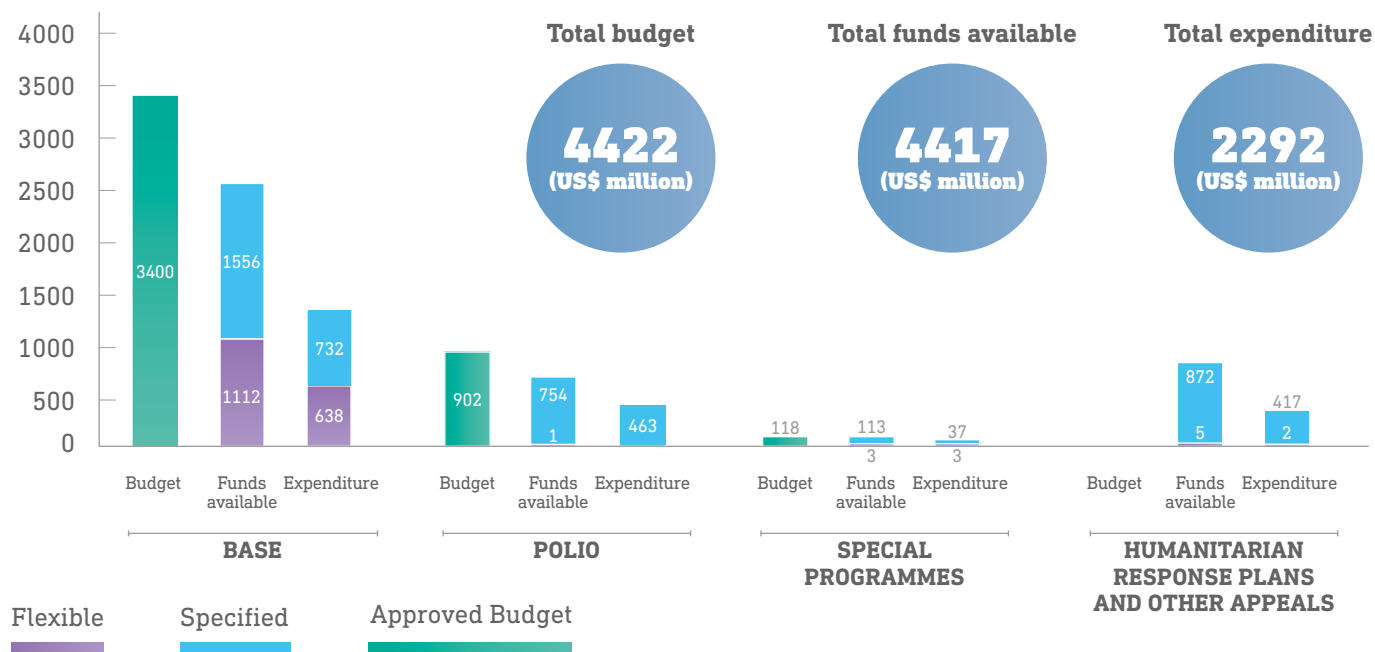
focused on staff costs (71% of total expenditure). This category is expected to be essentially funded in future, but will be kept as economical as possible through efforts such as increased efficiency gains.

For further details on programme budget funding and implementation for this category, please refer to the WHO Programme Budget Portal (<http://open.who.int/2018-19/our-work/category/06/about/key-figures> and <http://open.who.int/2018-19>).

Budget and financial highlights



Budget, funds available and expenditure for the Programme budget 2018–2019 by budget segment, as at 31 December 2018 (in US\$ million)



In May 2017, by resolution WHA70.5, the Seventieth Health Assembly approved the Programme budget 2018–2019 for a total of US\$ 4421.5 million. Base programmes represent 77% of the approved Programme budget, or US\$ 3400.3 million. The remaining Programme budget (US\$ 1021.2 million) was for polio and special programmes.

The graph above summarizes the approved budget, funds available and expenditure, presented for the budget segments, namely: base programmes, polio, and special programmes. Funds available comprise the revenue recorded in the current biennium, together with the funds brought forward from the previous biennium, less any funds carried forward to the next biennium. For the biennium 2018–2019, there was no approved budget for humanitarian response plans and other appeals due to the event-driven nature of this segment of the budget. There is therefore no budget level against which to compare available resources or expenditure.

Total funds available for 2018 for all budget segments were US\$ 4417 million, of which US\$ 2668 million was available for base programmes (representing 78% of the total budget for that segment).

The graph above also includes a split between the two major types of financing for the programme budget. Specified funding comprises voluntary contributions that are tightly earmarked for detailed activity or expenditure line reporting. Flexible funding comprises assessed contributions, voluntary contributions - core, core voluntary contributions account (CVCA) and programme support

costs.¹ Financing from specified funding represents 58% of the base programme and 99% of polio, special programmes and humanitarian response plans and other appeals.

The graph on the next page summarizes the following, by budget segment and major office: the approved budget, available financing and expenditure. There continues to be a disparity in the financing of the Programme budget across major offices, as well as across segments, categories and programme areas (see the category chapters of this report). Headquarters is usually the best funded of the major offices. Although the Programme budget as a whole is well-funded at a global level, and the technical progress of almost all programme areas is rated as being on track to achieve their objectives for the biennium, a significant proportion of programme areas across all major offices nevertheless cited constraints in funding as a potential risk for the full achievement of results by the end of biennium.

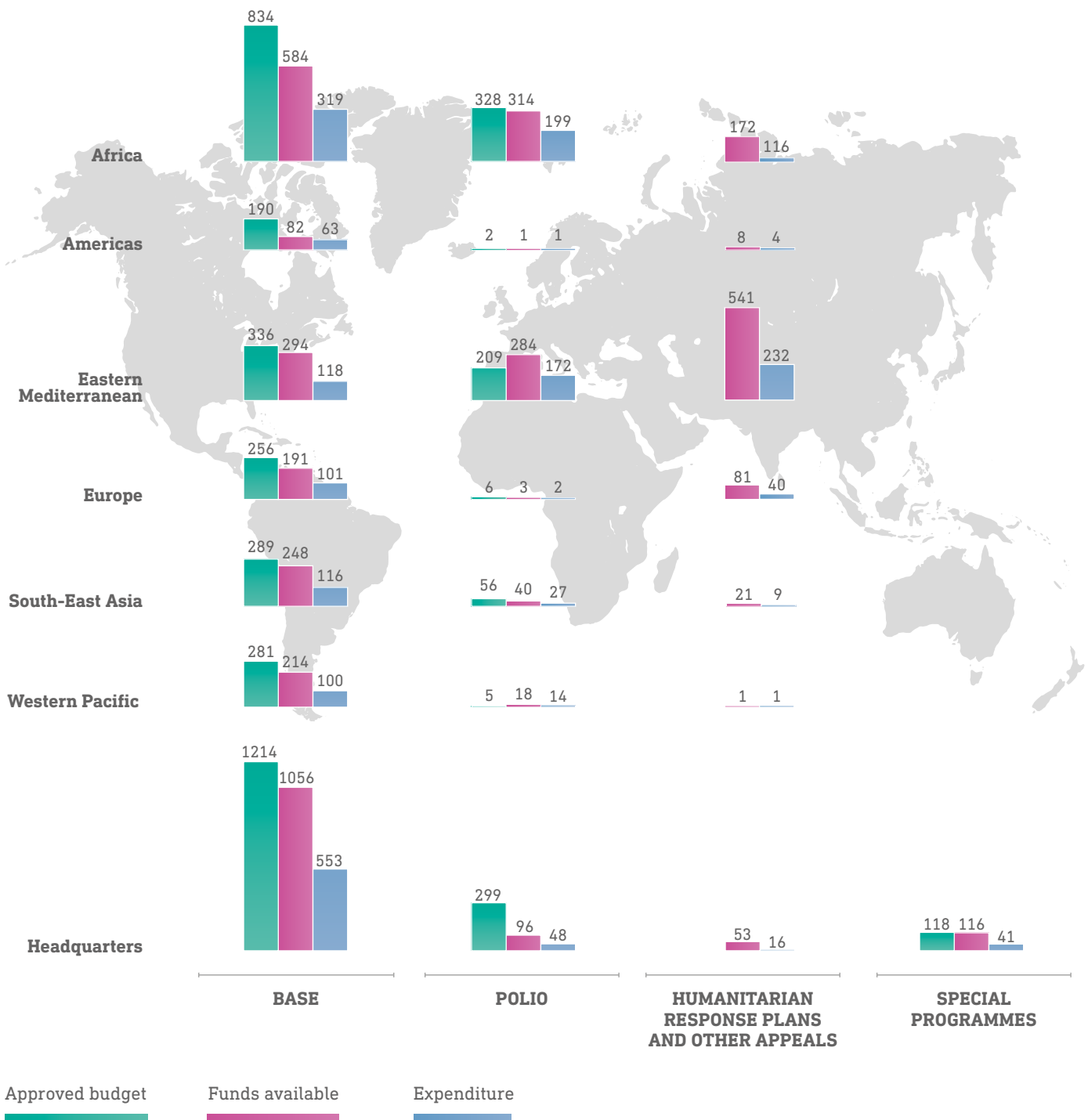
Expenditure appears to be limited where funding is unpredictable. This constrains long-term planning, especially human resources planning. Insufficient flexibility of funds can cause misalignment between financial resources and the Programme budget. However, comparisons over the past two decades indicate that the scale of this misalignment has actually decreased in the longer term.

Further information on budget, funds available and expenditure – presented by major office, country office, category and programme area – is available through the WHO Programme Budget Portal (<http://open.who.int/2018-19>).

¹ See documents A72/37 and A72/INF./5 for further details.

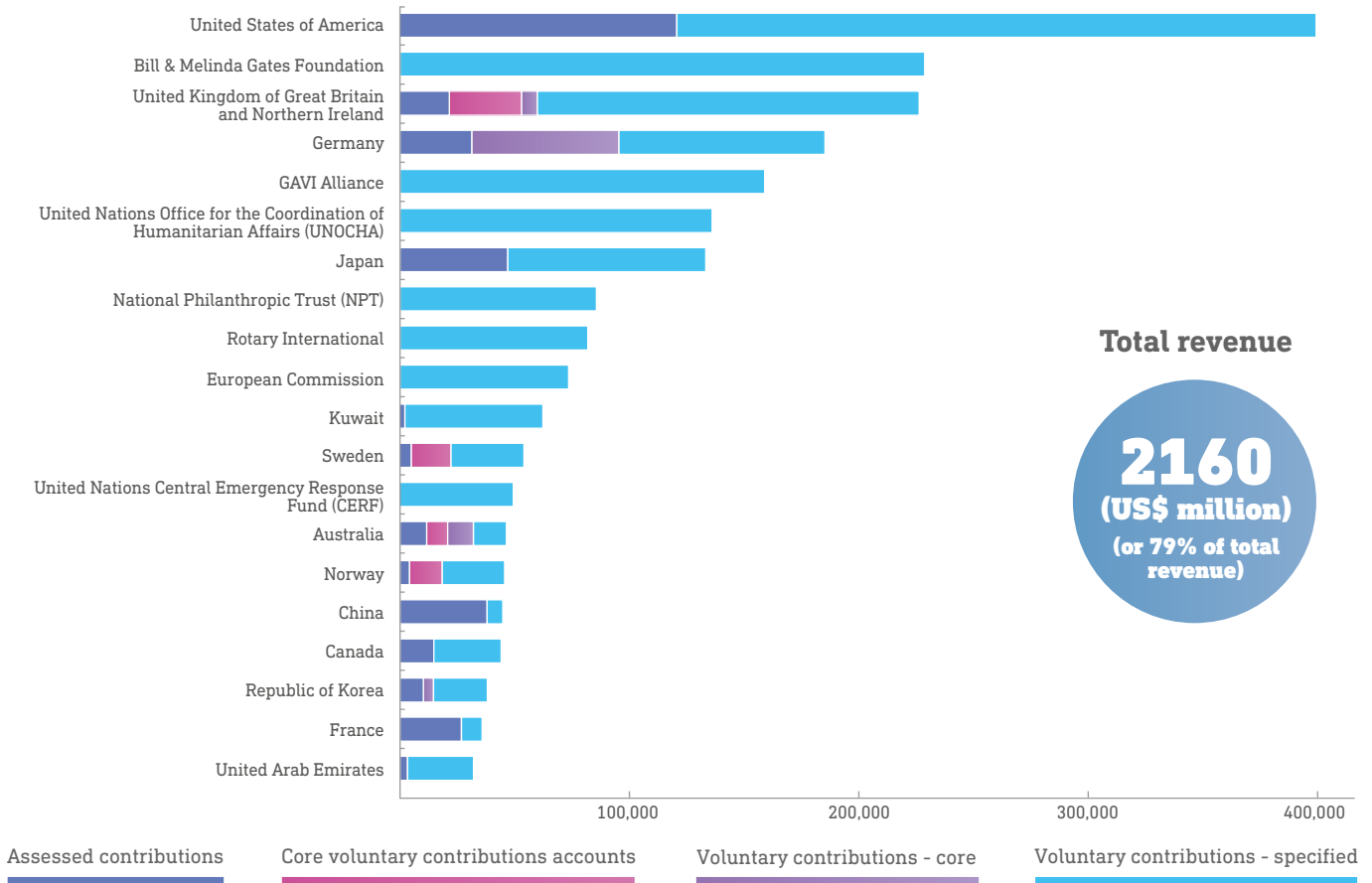


Budget, financing and expenditure for the 3-approved segments of the budget (Base, Polio, Special programmes) and Humanitarian response plans segment





Top 20 contributors to the Programme budget 2018 (US\$ thousands)



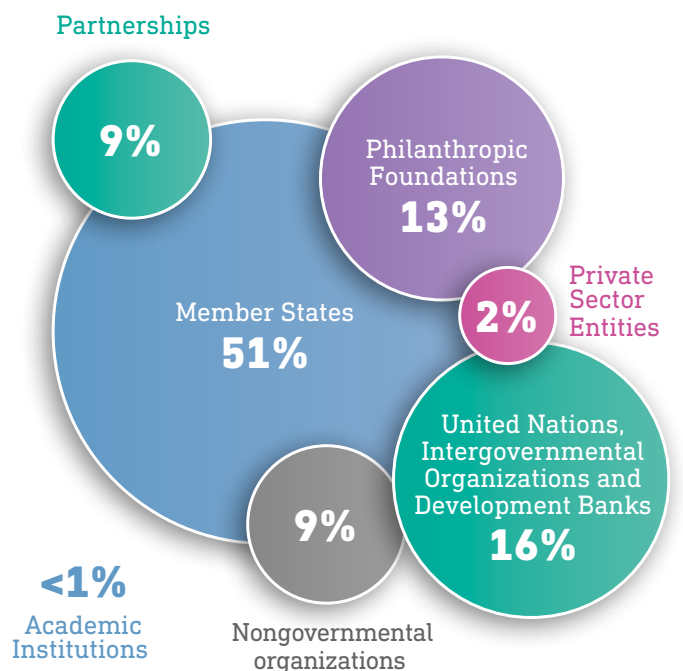
Where is WHO funding coming from?

Total Programme budget revenue recorded for 2018 was US\$ 2744 million, comprising assessed contributions from Member States of US\$ 501 million and voluntary contributions of US\$ 2243 million.² The top 20 contributors, whose contributions account for 79% of total revenue, are summarized in the graph above.

Revenue by source

Member States continue to be the largest source of voluntary contributions, contributing 51% of total voluntary contributions in 2018. Contributions from philanthropic foundations decreased from 2017, when a sharp increase was recorded in contributions to the Global Polio Eradication Initiative.

Revenue in 2018, by source



² A full list of all 2018 voluntary contributions, by fund and by contributor are provided in document A72/INF./5

Flexible voluntary contributions

In 2018, total funding revenue from core voluntary contributions was US\$ 181 million,³ including both CVCA and “voluntary contributions – core”. Voluntary contributions – core includes funding earmarked for purposes within the Programme budget that is considered designated or medium level of flexibility. CVCA funding is fully or highly flexible and is received to support the Programme budget as a whole.

At US\$ 89.7 million in 2018, voluntary contributions – core showed a significant increase compared with the level of US\$ 13.7 million³ in 2017. This was mainly due to the contributions from Germany. The funding represented by voluntary contributions – core, which is also referred to as a “thematic and strategic engagement funding”, has been negotiated at a corporate level to meet the strategic needs of both contributors and WHO, thereby providing more effective and efficient earmarked funding to WHO.

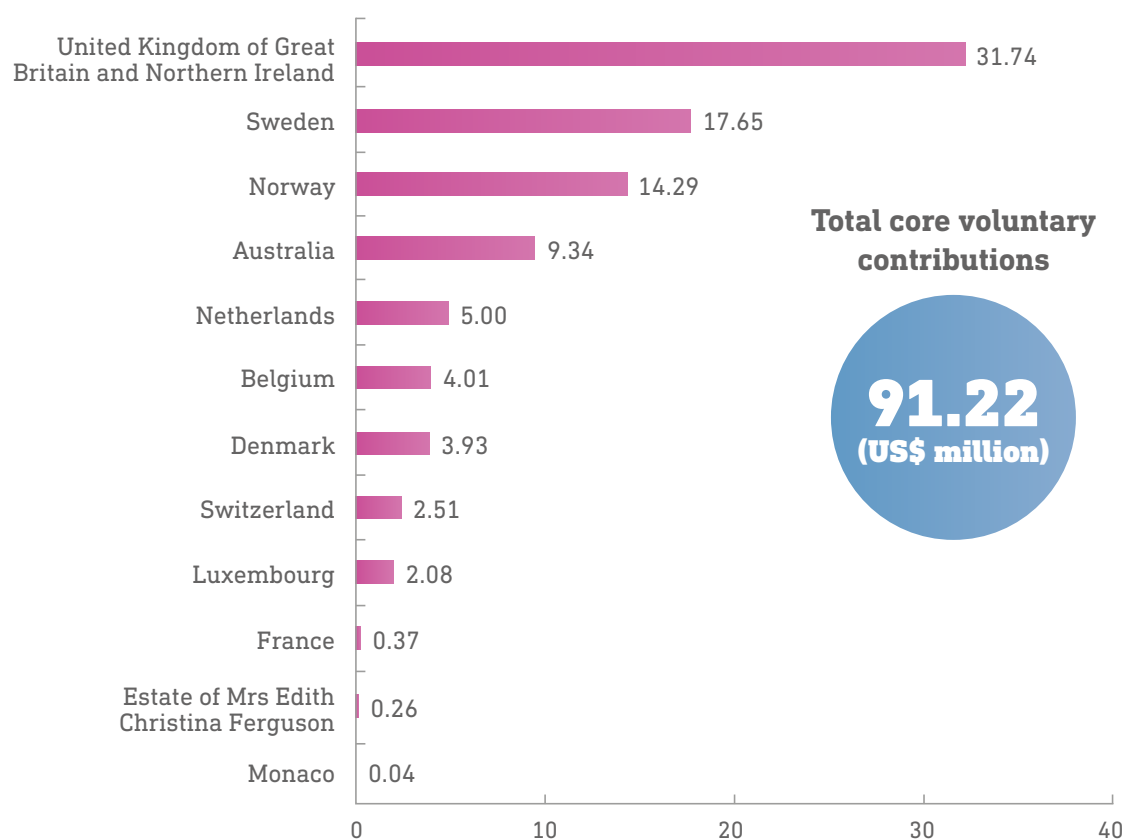
Specified resources form the bulk of WHO funding, but in areas where such resources do not cover full cost and

have no flexibility for cross-cutting approaches, it can be hard to leverage full impact without catalytic use of CVCA. CVCA offers an important flexibility for meeting otherwise unfunded requirements in all major offices and all categories, enabling critical strategic management of resources in order to deliver WHO’s programmatic results for the Health Assembly-approved Programme budget. Importantly, in view of the Organization’s high dependency on flexible funds, CVCA is used in conjunction with specified resources to leverage the full potential of the latter.

The graph below summarizes the revenue of CVCA by donor for 2018. This stood at US\$ 91 million⁴ (or 4% of the total Programme budget revenue). To date, contributions to the CVCA show an increase over 2017 (US\$ 67 million) and 2016 (US\$ 81 million). However, the level of funding of CVCA is still well below target and earlier levels.



Contributors to the Core voluntary contributions account for 2018 (US\$ million)



³ Details of CVCA and voluntary contributions – core are provided in document A72/INF./5.

⁴ This includes contributions from Luxembourg for noncommunicable diseases and health systems that are fully flexible and are normally recorded under CVCA. In 2018, these were recorded and reported in official documents as voluntary contributions – core and will be corrected in 2019.

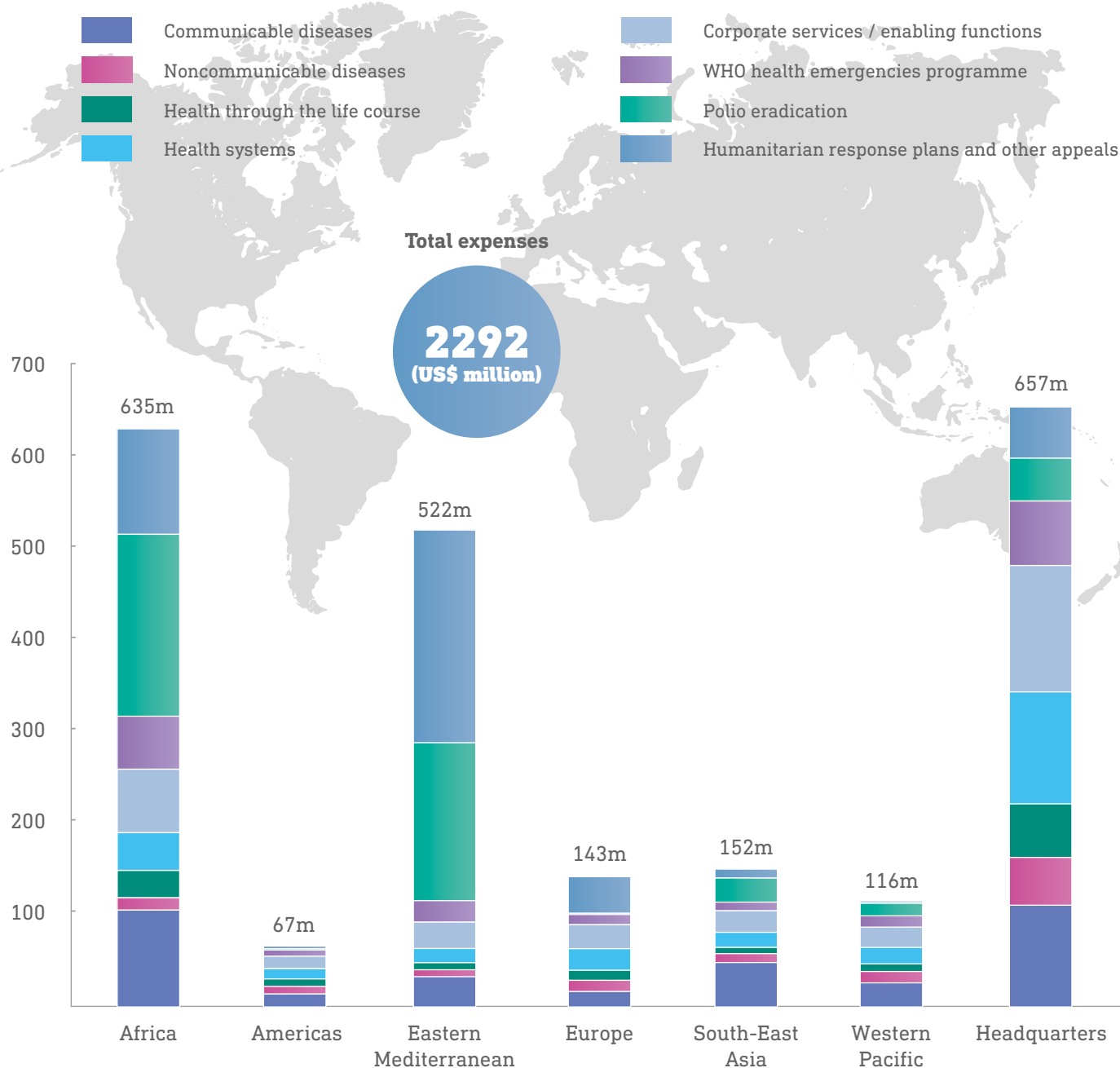
Where is WHO funding spent?

In 2018, total Programme budget expenditure was US\$ 2292 million, which represented a decrease of 4% from 2017 (US\$ 2390 million). If the figures at the midpoint of the current biennium are compared with those at the midpoint of the previous biennium, expenditure increased by 5%. The graph below summarizes the expenditure by major office and by category. In 2018, base programmes represented 60% of expenditure (62% in 2017), and polio, emergencies and special programmes represented 40% (38% in 2017).

Expenditure breakdown by category of work and budget segment varies significantly among major offices, shaped by the event-driven nature of the humanitarian response as well as by Polio eradication activities. For example, in the Eastern Mediterranean Region in 2018, 77% of expenditure was incurred on polio eradication and humanitarian response, and only 21% on base programmes.

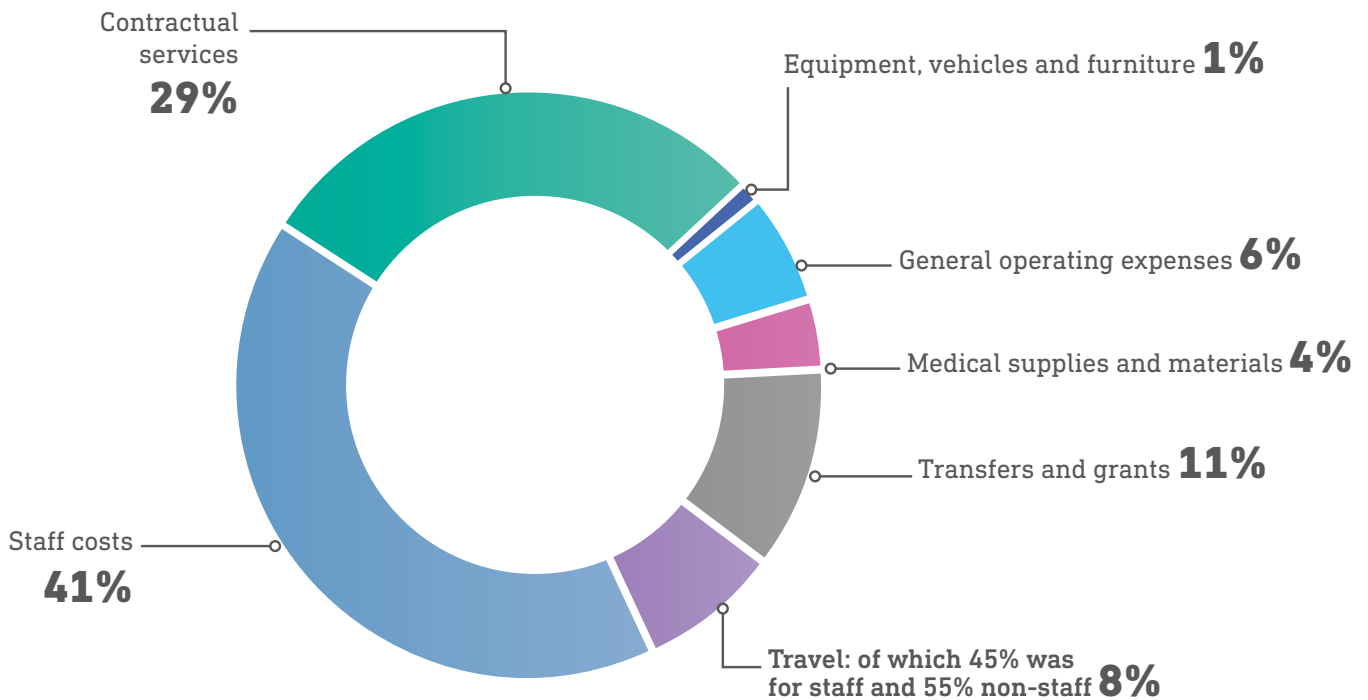


Programme budget expenses, by major office and category, 2018 (US\$ million)





Programme budget expenses by expenditure type in 2018



Staff costs

Staff costs form the largest expenditure type, representing 41% of total costs in 2018. Staff costs increased by 1% compared with 2017 and by 4% compared with 2016. Increases were seen in the WHO Health Emergencies Programme and in WHO offices in countries, territories and areas experiencing emergencies.

Contractual services

The second-largest expenditure type is contractual services, representing 29% of total costs in 2018. Costs for these services decreased by 9% compared with 2017 and by 3% compared with 2016. The decreases were mainly seen at headquarters and the in the Eastern Mediterranean Region. In the Eastern Mediterranean Region, a shift away from contractual services towards transfers and grants (grants to nongovernmental organizations in emergency settings) was noted. In the African Region higher spending was noted in special services agreement and direct implementation activities due to polio (mainly in Nigeria) and direct implementation activities due to Ebola virus disease (Democratic Republic of the Congo).

Travel

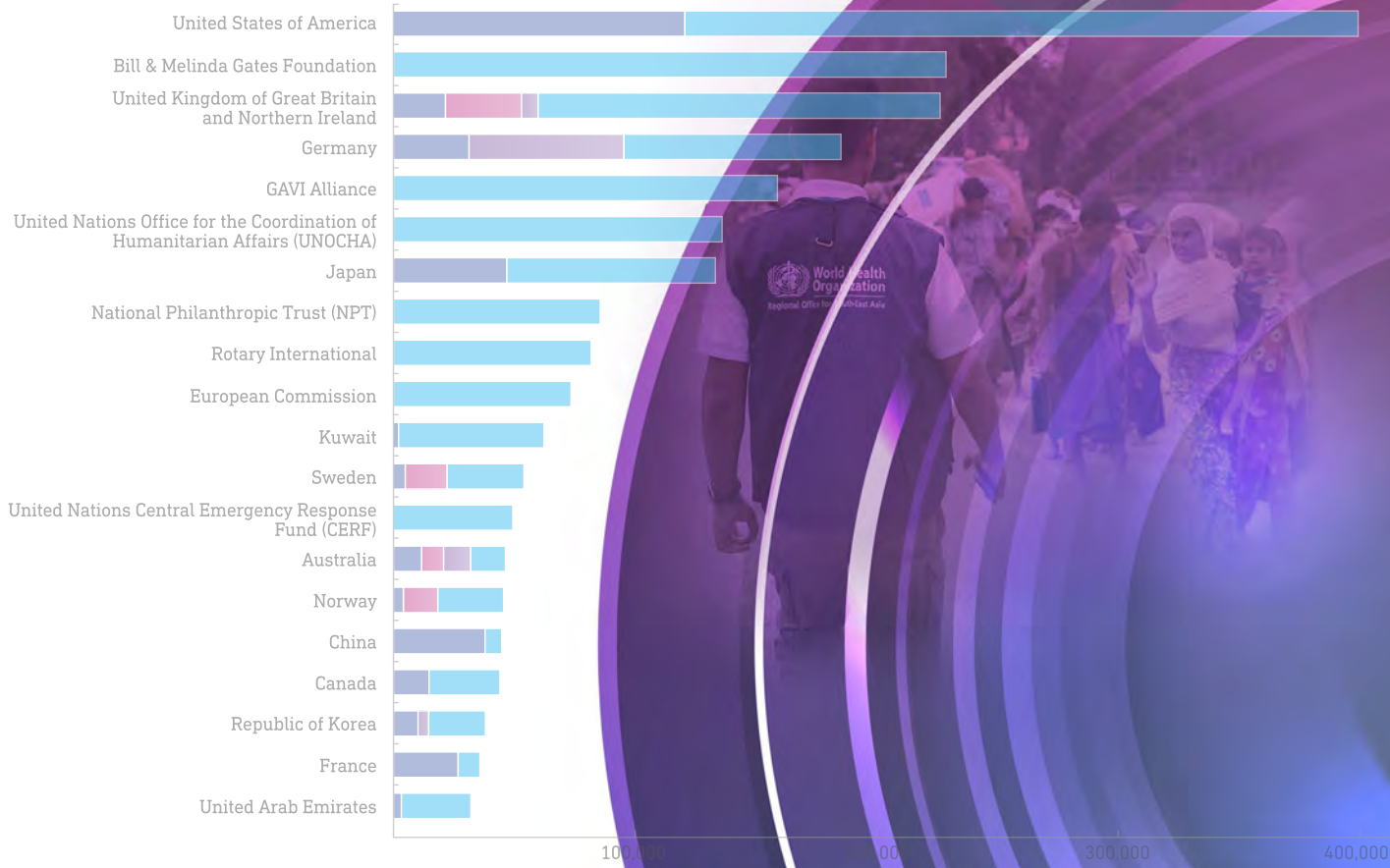
Travel expenses decreased by 1% from 2017 and by 4% from 2016. There was no reduction in the number of trips undertaken, but the price per trip decreased from 2017 owing to changes in travel policy and better enforcement of that policy. In particular, the more stringent travel policy has reduced the average amount spent per ticket. Of total travel expenditure, only 45% was for staff travel, the rest was incurred for non-staff travel, mainly for meeting participants nominated by Member States.

Transfers and grants

In 2018, following a change in expenditure policy, transfers and grants to counterparts increased by 10% compared with 2017, and by 2% compared with 2016. Under the revised policy, since late 2017 equipment purchased for third parties (health ministries), which was previously reported under equipment, has been reported under transfers and grants. The reduction in the largest component of this expenditure category, namely Direct Financial Cooperation grants to Member States, which decreased by 20% from 2017, partially offsets the increase caused by equipment for third parties.



HEALTHIER
POPULATION



Partnerships

