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Overview of implementation of the Programme budget 2018–2019 in the WHO European Region

This document presents an overview of implementation of the Programme budget 2018–2019 by the WHO Regional Office for Europe in the first 18 months of the biennium. Budget and financial figures are based on data from the Global Management System and the programme budget web portal. This document is part of the commitment of the Regional Office to its governing bodies to provide transparency and accountability. It is intended to enable Member States to execute the functions of oversight and strategic direction for the Regional Office.

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Introduction

1. This document provides an update on implementation of the Programme budget (PB) 2018–2019 by the WHO Regional Office for Europe, and complements document A72/35, the WHO headquarters report on key achievements and results. The present report serves two purposes: to ensure that the Regional Office is accountable to the regional governing bodies and to identify areas that require guidance and direction from Member States.

2. A glossary of terms and abbreviations used in the present report and in the wider WHO context is provided in Annex 1.

3. In May 2017, the Seventieth World Health Assembly approved PB 2018–2019 (documents A70/7 and A70/7 Add.1 Rev.1) in resolution WHA70.5. PB 2018–2019 sets out the programmatic priorities of WHO for the 2018–2019 biennium and serves as the key mechanism for corporate accountability of the Organization.

4. At its 67th session, in September 2017, the WHO Regional Committee for Europe approved the regional plan for implementation of PB 2018–2019 (document EUR/RC67/16 Rev.1) which outlines the WHO European Region's contribution to the global outputs defined in PB 2018–2019.

5. The regional plan for implementation of PB 2018–2019 forms a contract for joint accountability between the Regional Office and Member States, and reflects the adjustments made to the PB for the European Region approved by the Seventieth World Health Assembly, within the delegated authority of the Regional Director for Europe. The Secretariat will present a full assessment of implementation of PB 2018–2019 to the Regional Committee at its 70th session in September 2020. The present document presents the progress made by the end of the third quarter of the 2018–2019 biennium.

6. The current status of PB 2018–2019 as it applies to the Regional Office is characterized by a realistic budget; funding which is adequate overall but misaligned, with technical implementation progressing according to plan; and slightly delayed utilization of financial resources in some programmes. The Secretariat continuously monitors performance to ensure that programmatic implementation remains on track.

7. Budget and financial data are drawn from the Global Management System as at the end of June 2019 and the PB web portal as at March 2019, those being the latest data available at the time of writing.

Implementation of PB 2018–2019

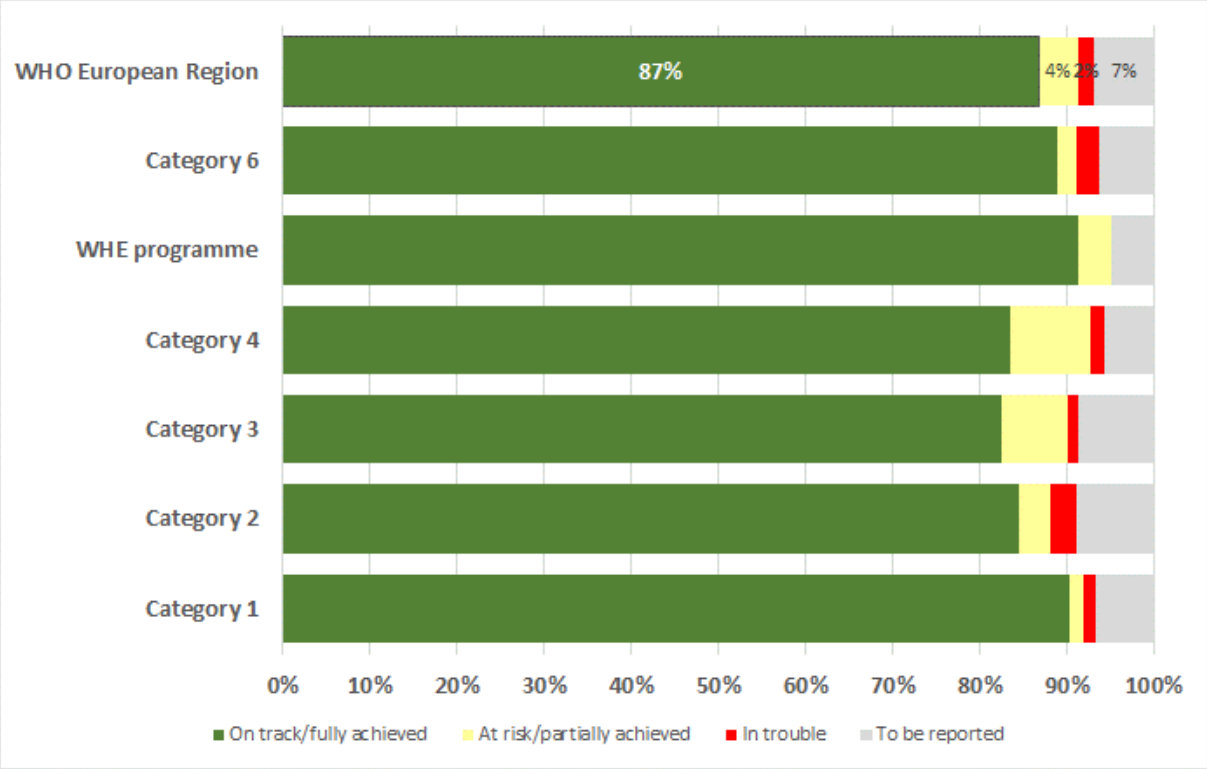
8. PB 2018–2019 is the third and last of the three biennial budgets under the Twelfth General Programme of Work, which covers the period 2014–2019. The PB 2018–2019 results chain is structured by categories and programme areas that provide the operational framework for WHO's work, as shown in Annex 2.

9. For PB 2018–2019, the Regional Office has a portfolio of 918 outputs. These outputs represent the deliverables for the Secretariat at the regional and country levels. The present

report summarizes the progress made towards achieving these regional outputs on the basis of an assessment of the first 18 months of the biennium.

10. Achievement of the outputs is monitored and analysed through reviews at six-monthly intervals. From the third assessment of the biennium in June 2019, 87% of outputs were reported to be on track, 6% to be at risk or in trouble and 7% of the outputs were still to be reported (see Fig. 1).

Fig. 1. Overview of technical implementation – output progress status in the WHO European Region by category, as at end June 2019



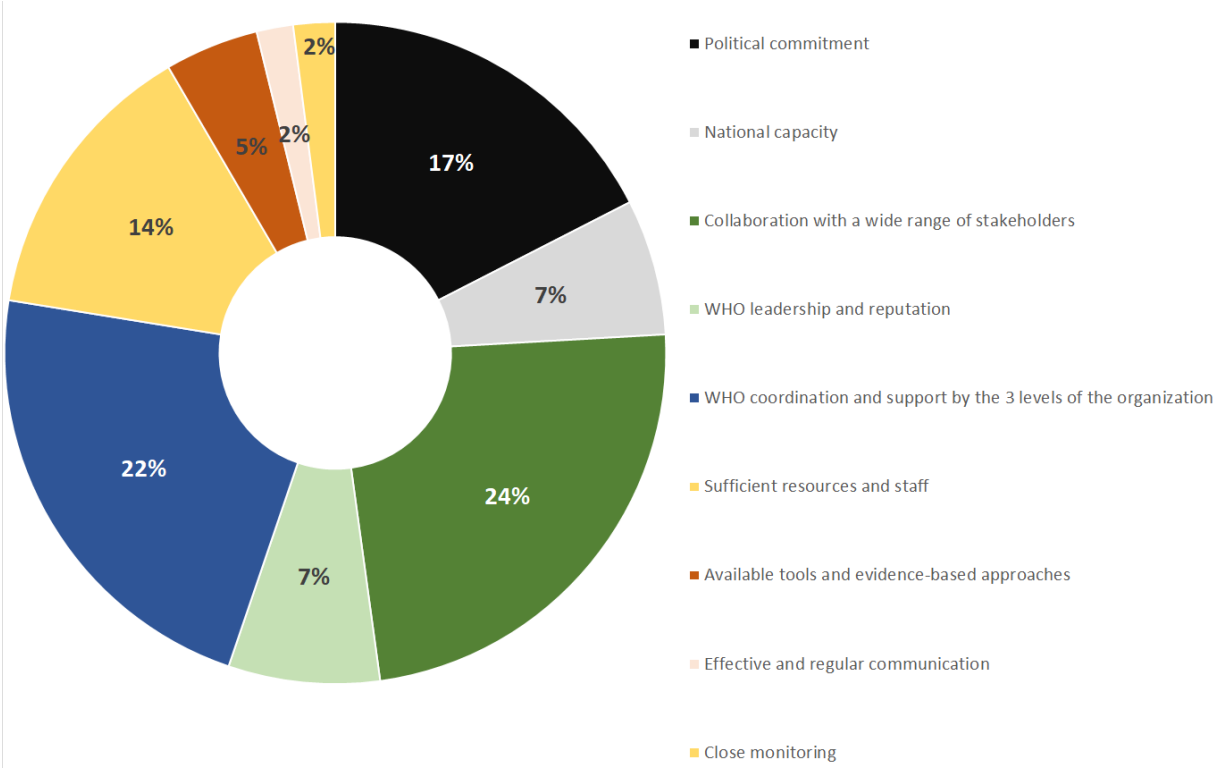
11. Category 4 (Health systems), closely followed by category 3 (Promoting health through the life course), have the highest percentage of outputs reported to be at risk or in trouble. For category 4, the increasing demand for WHO's technical support and insufficient funding have, in turn, delayed the achievement of the agreed results. Continuing the trend of the two previous bienniums, a low level of funding from voluntary contributions has hindered the implementation of some programme areas in category 3: e.g. programme area 3.5 (Health and the environment) and programme area 3.6 (Equity, social determinants, gender equality and human rights). Corporate flexible funding levels in 2018–2019 were sufficient to fill only part of the funding gap.

12. The momentum to build technical capacity and strengthen partnerships continued from the previous biennium. However, the smaller WHO country offices in the Region and a few technical programmes with small numbers of staff continue to experience challenges in meeting technical and administrative demands.

13. Strong political commitment, national capacity and collaboration with a wide range of stakeholders are the most notable success factors that enable the achievement of results at

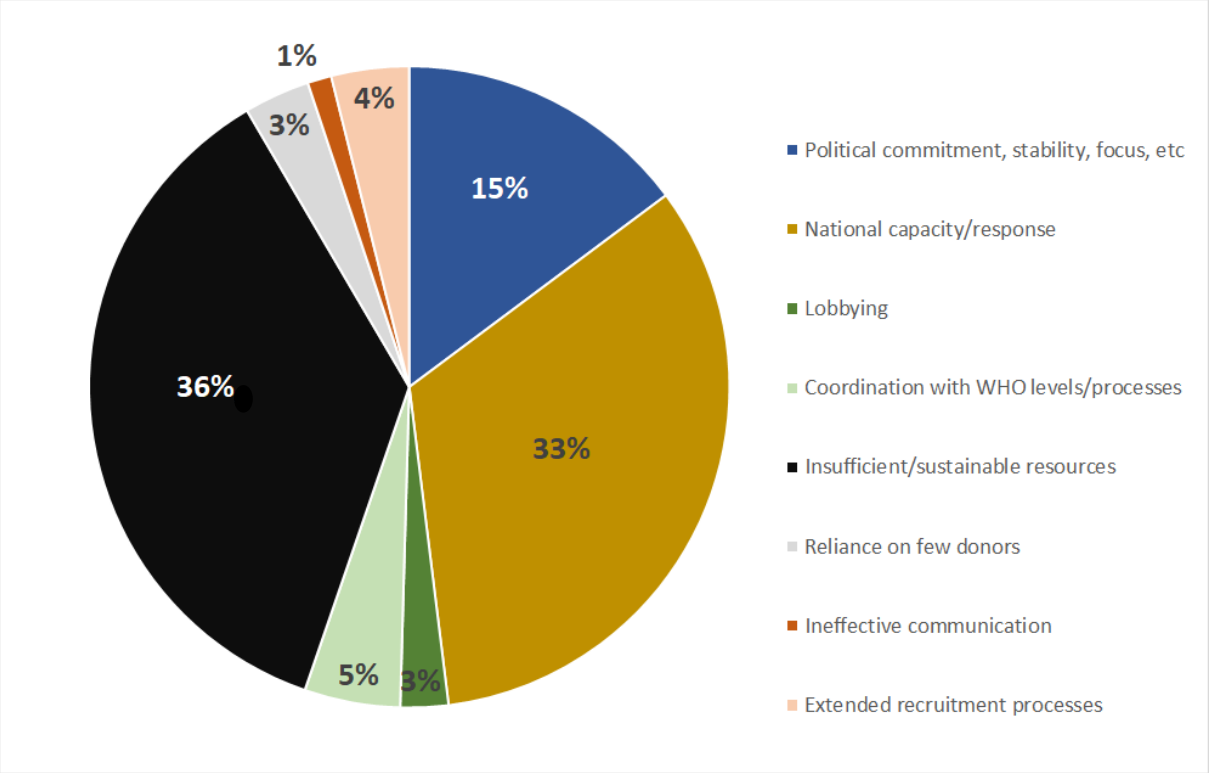
national level. WHO's reputation and the leadership and support provided at the various levels of the Organization are the most frequently cited drivers for the achievement of results from an overall organizational perspective. Where sufficient resources and adequate staffing, tools and evidence-based approaches are available, they contribute positively to the achievement of results, as do effective and regular communication and close monitoring (see Fig. 2).

Fig. 2. Success factors contributing to the achievement of results



14. On the other hand, the most frequently cited barriers to the achievement of results include lack of political commitment, focus, stability and national capacity and response. Lack of sufficient, sustainable resources and reliance on a limited number of donors were also cited, as well as ineffective communication and long recruitment processes (see Fig. 3).

Fig. 3. Challenges to the achievement of results



Overview of technical progress

15. This section is to be read in conjunction with the Regional Director's report on the work of WHO in the European Region in 2018–2019 (document EUR/RC69/5).

16. In 2018–2019, the Secretariat continued its policy dialogues with Member States, providing them with technical assistance, building capacity, and providing surveillance and monitoring support in response to communicable diseases. Interprogrammatic and interdivisional work in line with the United Nations Sustainable Development Goals (SDGs), intersectoral work, health systems strengthening, the public health approach and addressing the needs of people in health emergencies were prioritized across all programme areas.

17. In response to the increasing number of new HIV infections in the Region, the first ministerial policy dialogue on HIV and related comorbidities in eastern Europe and central Asia was organized in July 2018 under the Regional Director's leadership and in close collaboration with key partners, with the aim of revitalizing political commitment. Country roadmaps were developed to accelerate the achievement of the 2020 targets outlined in the Action Plan for the Health Sector Response to HIV in the WHO European Region. Progress has also been achieved in the development of comprehensive national action plans on viral hepatitis, in line with the Action Plan for the Health Sector Response to Viral Hepatitis in the WHO European Region, and the updating of national guidelines, using a public health approach.

18. A sustainable increase in treatment success has been documented for tuberculosis (TB) and multidrug-resistant TB, from 75.8% to 77.2% and from 48.7% to 57.2%, respectively. However, these rates are still below the regional targets of 85% and 75%, respectively. During

the reporting period, 35 countries, including all high-priority countries for TB control in the Region, aligned their national plans with WHO's global strategy and targets for tuberculosis prevention, care and control after 2015 (the End TB Strategy) and the Tuberculosis Action Plan for the WHO European Region 2016–2020, demonstrating high-level commitment and adapting the regional and global strategies to country contexts and needs. Work to remove barriers, stigma and discrimination, and to empower civil society organizations and communities was further intensified and appropriate strategies developed by a regional collaborating committee; the latter's mandate was expanded in 2018 and it was renamed the Regional Collaborating Committee on Accelerated Response to Tuberculosis, HIV and Viral Hepatitis.

19. With no indigenous malaria cases reported since 2015, the Region has maintained its malaria-free status. In 2018, Uzbekistan achieved malaria-free certification. The signature in 2017 of the Ashgabat Statement on preventing the re-establishment of malaria transmission in the WHO European Region demonstrated Member States' commitment to maintaining their malaria-free status. Since then, the procedures for malaria-free certification have been successfully initiated. Despite these achievements, the risk of re-establishment of malaria transmission remains high, since the Region is subject to large-scale importation of malaria from endemic countries.

20. In January 2019, the Regional Office published a manual on prevention of establishment and control of mosquitoes of public health importance in the Region, and the work on zoonotic neglected tropical diseases, specifically rabies and echinococcosis, was accelerated. The first subregional workshop on zoonotic diseases brought together over 70 participants from both the human and the animal health sectors from nine countries of central Asia and the southern Caucasus. The Regional Office continued its work to strengthen country capacity for the prevention of soil-transmitted helminthiasis, and surveillance and case management of leishmaniasis.

21. In line with the statement of intent on immunization signed in Montenegro in February 2018 by the ministers of health of the South-eastern Europe Health Network, the implementation of the middle-income country immunization strategy proceeded with the development of roadmaps to address common challenges faced by the countries in the Network. This represented a critical leap in addressing inequity in the provision and utilization of immunization services in the Region. During the reporting period, the number of Member States with verified measles elimination increased, although a few countries lost their elimination status. The occurrence of measles cases and the delay in rapid containment of outbreaks in the Region are evidence of significant programmatic gaps in identification of and response to outbreaks of vaccine-preventable diseases in general. The Regional Office declared measles circulation in the Region a grade 2 health emergency during the reporting period as a mechanism to accelerate support for affected countries.

22. The technical progress made in this biennium has been supported by strong coalitions with key partners. Examples include the first Joint Meeting of the Antimicrobial Resistance, Antimicrobial Consumption and Healthcare-associated Infections Networks (Copenhagen, Denmark, 13–15 June 2018), the joint production of regional resistance maps and the move towards joint reporting with Member States and partners on antimicrobial resistance, to start in 2020. Similarly, the tripartite coalition with the Food and Agriculture Organization of the United Nations and the World Organisation for Animal Health led to the development of One Health strategies in several countries of the Region. The open online course on

antimicrobial stewardship launched in January 2018 has attracted over 22 000 users in 174 WHO Member States, guiding prescribers in more appropriate use of antibiotics.

23. The progress made in respect of noncommunicable diseases (NCDs) in the Region is a major success story. Premature mortality continues to decline steadily. If current trends continue, it is likely that the Region will meet or even exceed the SDG target of a one third reduction in mortality by 2030. The demand for technical implementation support remains high, and the ongoing interprogrammatic work is focused on developing packages for a comprehensive and aligned approach to health systems strengthening. During the reporting period, the Region supported several high-level initiatives. In 2018, these included the third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases (New York, United States of America, 27 September 2018); the Global Conference on Primary Health Care (Astana, Kazakhstan, 25–26 October 2018); and the high-level regional meeting, Health Systems Respond to NCDs: Experience in the European Region (Sitges, Spain, 16–18 April 2018). Another milestone, in 2019, was the WHO European High-level Conference on Noncommunicable Diseases: Time to Deliver – Meeting NCD Targets to Achieve the Sustainable Development Goals in Europe (Ashgabat, Turkmenistan, 9–10 April 2019).

24. Mental health is increasingly being recognized as a public health priority. This perception has been further reinforced by the declaration issued after the third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, in which mental health conditions were formally recognized as the fifth NCD for prioritized action. Since 2018, efforts have been made to build national capacities to identify and manage mental health conditions in non-specialized care settings. The mhGAP intervention guide has been used in Ukraine and several central Asian countries to improve the integration of mental health into general health care and enhance universal health coverage for people with mental health conditions. A large intercountry assessment project on standards of care in institutions for people with intellectual and psychosocial disabilities was completed in 2018, and mental health care professionals in four countries have benefited from training in strategies to improve quality of care and reduce seclusion and constraint.

25. The *Global status report on road safety 2018* highlighted the Region's progress in preventing road traffic injuries. The European Region saw a 13% reduction in road traffic mortality between 2010 and 2016; while encouraging, this achievement is still a long way from the goal of a 50% reduction by 2020 set under SDG target 3.6. In view of the Region's prevailing jurisdictions for road safety, priority was given to scaling up engagement of the transport and police sectors; during the reporting period, a workshop on road traffic injuries was conducted for senior police officers from the 10 countries with the highest mortality rates in the Region. With regard to preventing injury in children, 45 of the 53 Member States of the Region participated in the *European status report on preventing child maltreatment* (2018).

26. As part of the health systems strengthening initiative, in 2018 the Regional Office started a new four-year programme to support Member States in scaling up rehabilitation activities for people with disabilities in the Region. Tajikistan introduced new approaches to rehabilitation as part of a reform of the system that provides rehabilitation services and assistive devices, while Georgia and Ukraine initiated similar work. An increase in the number of requests by Member States for technical support demonstrated that reform of health systems to better respond to the needs of people with disabilities is high on political

agendas in a growing number of countries in the Region. As a result, and supported by partners, the Regional Office has strengthened its capacity to support Member States to implement policies to improve access to health care for people with disabilities, to strengthen rehabilitation services as part of universal health coverage and to build the evidence base relating to disability and rehabilitation.

27. Important progress has been made by Member States inspired by the European Food and Nutrition Action Plan 2015–2020 and the global NCDs agenda. The priority actions included in the Action Plan have placed Member States of the Region at the forefront of global discussions on policy development, evaluation and surveillance. One of the priority areas is appropriate early nutrition for health. With high-level participation, the Best Start in Life conference (Moscow, Russian Federation, 7–8 November 2018) focused on the importance of breastfeeding for the prevention of NCDs. An evaluation of the composition and inappropriate promotion of commercially available complementary foods for infants and young children was conducted during the reporting period, and a discussion paper was prepared that outlined the first steps in developing a nutrient profile model to drive product composition, packaging and promotion. The fifth round of the Childhood Obesity Surveillance Initiative was conducted with the participation of 43 Member States and over 600 000 children. The data have allowed countries to track the evolution of the childhood obesity epidemic. Two reports (on severe obesity and on breastfeeding and obesity) were launched in spring 2019, attracting a large amount of media interest. The Region's mandate on nutrition has also enabled the Regional Office to bring countries and relevant stakeholders together in several ways, namely via the WHO Action Network on Reducing Food Marketing Pressure on Children and the WHO Action Network on Salt Reduction.

28. The publication *The burden of foodborne diseases in the WHO European Region* indicates that 23 million people fall ill from consuming unsafe food each year, with 4700 deaths. The overall burden of foodborne disease in the Region is estimated at 413 020 disability-adjusted life years. To raise awareness about food safety, a report and a set of communication materials were launched as part of the first World Food Safety Day (adopted by the United Nations General Assembly in December 2018), which was held on 7 June 2019, and which was promoted in the Region by the Regional Office in cooperation with the Food and Agriculture Organization of the United Nations and Codex Alimentarius. Currently, 49 of the 53 Member States of the Region ensure that their national agencies actively participate in the International Food Safety Authorities Network, which has led to the detection of a greatly increased number of food safety events involving produce from countries in the Region. The increase demonstrates recognition of the subject in different dimensions of trade, including increased recognition of food safety events within various categories of produce and hazard.

29. During the reporting period, an assessment of sexual, reproductive, maternal, newborn, child and adolescent health in the context of universal health coverage was undertaken in six Member States, to support the strengthening of policies and service delivery for the progressive realization of universal access in these areas. In addition, the development of treatment guidelines for children and adolescents and for sexual and reproductive health was initiated to meet the needs of the Region. The Schools for Health in Europe network developed core materials, including the Schools for Health in Europe manual and assessment tools, and a guide on water and sanitation in schools, to advance the school health programme. Member States were supported in the implementation of the Global Standards for Health Promoting Schools and the health literacy framework. A progress report on the

European Child and Adolescent Health Strategy 2015–2020 was submitted to the Regional Committee in 2018 (document EUR/RC68/8(E)), and a progress report on the Action Plan for Sexual and Reproductive Health is being submitted to the Regional Committee in 2019 (document EUR/RC69/8(D)).

30. At a meeting jointly organized by the WHO European Centre for Primary Health Care (Almaty, Kazakhstan) and the ageing programme and programme for gender and human rights based in the Regional Office, experts from 27 countries in the Region came together to review trends in long-term care reform and to share innovative country practices. A regional workshop involving over 30 countries that was held in 2019 in Moscow, Russian Federation, confirmed good progress in the implementation of the Strategy and Action Plan for Healthy Ageing in Europe, 2012–2020, and work has begun on a comprehensive progress report based on a 2019 survey of Member States.

31. Major achievements in environment and health during the reporting period include the publication of the new WHO ambient noise guidelines; the update of the WHO air quality guidelines; and the publication of the second assessment report on environment and health inequalities in Europe and of standard operating procedures for human biomonitoring for mercury exposure under the Minamata Convention on Mercury. Support continued to be provided for the implementation of relevant multilateral agreements and policy platforms (on air pollution, water and health, transport, and health and environment) and technical work and capacity building were conducted in the following areas: improving air quality; assessing the health effects of air pollution; improving chemical safety; and action on climate change.

32. The regional high-level conference, Accelerating Progress towards Healthy and Prosperous Lives for All in the WHO European Region (Ljubljana, Slovenia, 11–13 June 2019) was attended by 33 Member States and international organizations, United Nations agencies and nongovernmental organizations. Thirty-five real-world solutions for increasing equity in health were presented and discussed, ending with the adoption of the Ljubljana Statement on Health Equity. A document entitled “Healthy, prosperous lives for all in the European Region” was produced to support and inform the discussions, describing the status of health gradients and gaps between social groups, by sex and life stage, within countries of the Region and progress made in closing them. The document is underpinned by a new interactive data set with more than 110 indicators that enable Member States to assess the relationships between health gaps, underlying determinants and the implementation of policies for health equity. Tools adapted for individual countries have been developed, including health equity snapshots for all 53 Member States and guidance on reducing health inequities at key stages of the life course. The Health Equity Policy Tool was launched, with 51 policies that can be used to reduce inequities in health.

33. Groundbreaking evidence and methods were developed to quantify the impact of the health sector on national economies. Four country-specific analyses were carried out and used to support dialogue between ministries of health and finance, presenting health as an investment sector that contributes to gross domestic product, fiscal sustainability, household-level income and inclusive growth.

34. The Strategy on the Health and Well-being of Men in the WHO European Region, adopted by the Regional Committee at its 68th session, complemented the gender policy framework in the Region that was initiated with the Strategy on Women’s Health and Well-being in the WHO European Region (adopted in 2016). These two strategies and the

respective reports that support their recommendations have moved the work on gender and rights forward across the Region. This has translated into the development of several interdivisional and interprogrammatic packages on strengthening gender-sensitive responses to NCDs by health systems, assessing primary health capacity in sexual and reproductive health and rights, monitoring health systems' response to violence against women, and redressing the gender imbalance in unpaid care.

35. Technical assistance in relation to the implementation of the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region continues to be provided for priority countries. The first WHO report on the health of refugees and migrants in the WHO European Region was launched jointly with the ministries of health of six countries. A first expert group meeting on NCDs in the migrant population in the Commonwealth of Independent States initiated discussions between countries on the way forward. The second Summer School on Migration and Health was held in 2018 in Italy, with participation from 20 European countries as well as countries from the African Region, the Region of the Americas, and the South-East Asia Region, and the third such Summer School was held in July 2019 in Turkey.

36. The 2018–2019 programme budget period was influenced by the adoption of the Thirteenth General Programme of Work, 2019–2023 (GPW 13) and the United Nations 2030 Agenda for Sustainable Development. The former made explicit the Organization's dedication to universal health coverage and saw a reorientation of many activities towards delivering this goal. The 2030 Agenda also required that due consideration be paid to reporting on implementation of activities.

37. In view of the global agendas on universal health coverage, and the push towards achieving universal health coverage, relevant national health policies, strategies and plans were in high demand during the reporting period. The Regional Office worked with 25 countries to ensure consistency of these policies, strategies and plans with SDG commitments and helped to overcome insufficient capacity in developing these policies and strategies. The technical programmes supported this work by helping to improve overall stewardship ability in ministries of health and in the design of legislation and plans. Further work to ensure wider governance for health in a cross-cutting and cross-sectoral manner, including at municipal level through the WHO Healthy Cities Network, was key to this area of work. Good health financing policies are fundamental for delivering universal health coverage and the SDGs; accordingly, striving to increase financial protection for all continued to be a Regional Office priority. Twenty-five Member States were reviewed using the new regional methodology (supported by external parties such as the European Commission, the Organisation for Economic Co-operation and Development and the World Bank) and country reports were produced containing targeted recommendations. In addition, the large-scale reform programme for universal health coverage provided support for countries under the Universal Health Coverage Partnership.

38. The 2018 Astana Declaration on Primary Health Care, agreed during the Global Conference on Primary Health Care (Astana, Kazakhstan, 25–26 October 2018), made explicit Member States' and, accordingly, WHO's obligations to pursue primary health care as a cornerstone of the work to deliver universal health coverage around the world. The European Framework for Action on Integrated Health Services Delivery informed the deliberations at the Conference (at Member States' request). Areas of collaboration under the Framework and under the regional framework for action on achieving a sustainable health

workforce (endorsed by the Regional Committee in resolution EUR/RC67/R5 in 2017), were identified and embarked upon. This work will continue to be strengthened through the next reporting period. Furthermore, given the interconnected nature of these areas, under programme area 4.2 the Regional Office continued to support the work of the Coalition of Partners, a crucial public health community of practice dedicated to improving leadership and participatory governance for health and acting as a catalyst for new ideas, plans for joint action and intercountry work.

39. The extremely high prices of many new medicines and health technologies has led to renewed global attention to the issue of access to medicines. While WHO has been pursuing work in this area for some 40 years, there is perhaps a window of opportunity to make significant progress on this issue during the current biennium, now that higher-income countries are also affected. The Regional Office's support for countries during the reporting period focused on quality assurance, promoting responsible use and prescribing, improving regulation and regulatory capacity, and promoting affordability. Since pharmaceutical expenditure makes up a significant component of national health budgets, and out-of-pocket payments for medicines push people into poverty in many jurisdictions, work to support countries in promoting affordability of medicines is essential in helping countries to deliver universal health coverage and achieve the SDGs.

40. Many Member States are struggling to assess achievement of their SDG commitments because of unsatisfactory, or even non-existent, health information systems. The Regional Office has supported countries in strengthening the use of evidence, information and research for policy-making in line with the European Health Information Initiative. The priority areas of focus of the Regional Office during the reporting period included better collection, analysis and reporting of health information (data and statistics) through the Health for All database and joint data collection activities with the European Commission and the Organisation for Economic Co-operation and Development; promotion of the systematic use of health-research evidence in policy-making in countries through the Evidence-informed Policy Network; and organization of the flagship Autumn School on Health Information and Evidence for Policy-making. Other relevant initiatives include the promotion of a range of health information networks and support for a functional advisory committee on health research.

41. The work of the WHO Health Emergencies Programme in the Region is guided by the Action Plan to Improve Public Health Preparedness and Response in the WHO European Region, which was endorsed by the Regional Committee in resolution EUR/RC68/R7 in 2018. To accelerate its implementation, a high-level meeting and consultation early in 2019 gave the Regional Office a stronger mandate to coordinate action to strengthen countries' political and financial commitments. Furthermore, in line with the WHO transformation agenda, the business model for WHO's work in countries was fully rolled out, increasing the Regional Office's capacity to support Member States in preparing for and mitigating risks and, where necessary, to lead an operational response. Countries were further supported with technical expertise, surge capacity and capacity-building activities. The Regional Office continued to collaborate closely and coordinate its activities with the European Centre for Disease Prevention and Control, the South-eastern Europe Health Network and the Eurasian Economic Commission.

42. The Regional Office continued to focus both on pandemic preparedness and on prevention and control of seasonal influenza through: (a) capacity-building initiatives (five priority countries); (b) support for sharing of virus samples and genetic data; and (c) promotion of seasonal influenza vaccination. While in four countries the number of doses

increased in total from approximately 250 000 in the 2015–2016 season to over 540 000 in the 2018–2019 season, some Member States saw a general decline in uptake of seasonal influenza vaccine. Poor access to vaccines in lower-resourced Member States and the fact that fewer than one in three pandemic plans has been revised since 2009 presents a continuing challenge in combating influenza and preparing for the next pandemic. Weak surveillance and lack of resources in some countries are also matters of concern in respect of emerging and re-emerging high-threat pathogens (such as Middle East respiratory syndrome coronavirus, anthrax and plague). The Better Labs for Better Health initiative has brought measurable improvements in laboratory quality and an increase in the number of countries wishing to participate in the initiative.

43. Substantial progress was made in the development of national policies and plans, monitoring and evaluation of implementation of the International Health Regulations (IHR) (2005), as well as improvements in designated points of entry, strategic risk assessment, hospital safety, mass casualty management, risk communication and effective partnerships. The Region has a high capacity with regard to IHR (2005) capacity, with the 2018 annual reporting exercise for States Parties recording an average score of 3.7 (74%) across all 13 IHR technical areas among reporting countries; 3.0 (60%) in priority countries of the Health Emergencies Programme; and 3.9 (78%) in other countries of the Region. Between January 2018 and June 2019, six countries completed a joint external evaluation. National action plans for health security were finalized in three countries and are under development in a further six countries. After-action reviews were conducted in three countries. The functional simulation exercise for joint assessment and detection of events tested communication and coordination between national IHR focal points in 27 countries and the WHO regional IHR contact point. Six countries conducted risk assessments using the WHO Strategic Tool for Assessing Risks.

44. The Regional office has also undertaken work in the following areas in the reporting period: a total of 151 hospitals in the Region have been assessed in the reporting period using the WHO Hospital Safety Index tool, and a training package on mass casualty incident management was developed and piloted in central Asian countries; in addition, risk communication is one of the areas where the Regional Office has scaled up its support – as of July 2019, 19 countries and territories in the European Region were enrolled in the emergency risk communication five step capacity-building package, which has also been rolled out globally.

45. Since January 2018, rigorous event-based surveillance of over 30 000 signals (data and/or information considered to indicate a potential acute risk to human health) was conducted in the Region; 3000 of these signals were assessed in more detail, leading to the detection of 67 recorded acute public health events. For the most significant events, a formal internal rapid risk assessment template was used. A rapid risk assessment was conducted for the measles situation in the Region in May 2019, for example, and used for the internal grading of measles circulation in the Region as a grade 2 emergency. This work was complemented by the new global Epidemic Intelligence from Open Sources tool, which provides backup and redundancy in the detection of all significant public health events. The tool was used for enhanced event-based surveillance during the 2018 FIFA World Cup soccer tournament in the Russian Federation in June and July 2018.

46. Health emergencies experts in the Regional Office and country offices worked closely with health partners to pre-position life-saving health intervention materials and essential

health packages for emergencies, that are linked with country-specific capacities to implement the IHR (2005), essential public health functions and universal health coverage. Countries were guided in addressing critical shortcomings, identified through IHR monitoring and evaluation activities, and in moving from emergency relief to recovery and rehabilitation. During the reporting period, the Health Emergencies Programme intensified its collaboration with partners, especially with the Global Outbreak Alert and Response Network, emergency medical teams, health cluster partners, stand-by partners, international nongovernmental organizations and WHO collaborating centres.

47. During the reporting period, the Regional Office has responded to the humanitarian crises in Ukraine (grade 2) and, under the Whole-of-Syria approach, in the Syrian Arab Republic (grade 3), in and from Turkey. In May 2019, WHO scaled up its support for measles-affected countries and declared a grade 2 multicountry measles emergency, with the response led jointly by the Vaccine-preventable Diseases and Immunization and Health Emergencies programmes of the Regional Office. The necessary expertise is thus provided by both programmes working jointly through the WHO Emergency Response Framework.

48. The year 2018 was marked by bold leadership and far-reaching governing body decisions and resolutions, which demonstrated Member States' clarity of vision and will to act by advancing the transformation agenda in the European Region. The 68th session of the Regional Committee took place in Rome, Italy, in September 2018, with an agenda based on 19 working documents; it concluded with eight resolutions and two decisions, and highlights of the session included the following topics: WHO reform, the *European health report 2018*; the Joint Monitoring Framework for the SDGs, Health 2020 and the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020; public health preparedness and response in the WHO European Region; financial protection in health care; the health and well-being of men in the WHO European Region; vaccine-preventable diseases and immunization; and countries at the centre.

49. The Regional office supported two evaluations commissioned by WHO headquarters in relation to, respectively, the country offices in Romania, in the fourth quarter of 2018, and Kyrgyzstan, in the second half of 2019. The planned measles and rubella programme evaluation was postponed following an extensive audit of the Vaccine-preventable Diseases and Immunization programme and will not take place in the present biennium. With the increased emphasis on evaluation in GPW 13, it is hoped that the technical monitoring and evaluation function will receive the resources it requires at regional level to ensure that the necessary technical monitoring, quality assurance and reporting capacity is in place.

50. A regionwide exercise has been undertaken to prepare for PB 2020–2021, based on countries' priorities, including regional planning meetings involving staff from country offices and the Regional Office and, for the first time, a dedicated planning session with headquarters colleagues to discuss the support and assistance from headquarters that is required at the country level.

51. With reliable indications that the programme budget will be well funded, efforts have been exerted to accelerate implementation of planned commitments, particularly at the country level. The Regional Office has been an active participant in two ongoing global developments, namely revision of the methodology for monitoring and reporting for PB 2020–2021, and deciding on the future of the Global Management System. The reporting period has also seen stronger cooperation with headquarters on the new resource mobilization

strategy, donor negotiations and donor visibility. Management information has been improved through the development of a new set of dashboards.

52. Enabling functions continued to meet the increasing demand for services, while improving the effectiveness and efficiency of service delivery. Mandatory training was completed by all staff in pertinent areas, including prevention of harassment and sexual harassment, cybersecurity, and United Nations safety and security measures. Three sets of induction workshops for newcomers have been conducted since the start of the biennium, while numerous on-the-job training courses have been held for specific categories of staff in country offices and the Regional Office. Regular financial and administrative reviews of country offices have been conducted to provide an overview of compliance, controls and capacities, and to ensure accuracy of financial reporting. Country offices in central Asia as well as those in Ukraine and Turkey, which have large health emergencies programmes, received particular attention. Additional investment was devoted to information and communications technology services and infrastructure to improve the delivery of expected results. Standard procedures and tools for travel, conference services, security, fixed assets and premises were updated and improved. The Regional Office contributed substantially to the shaping and formulation of various WHO human resources policies. The European Region will be the first to launch the new consultant policy. Innovative approaches, including new tools and applications, are under development to facilitate further improvement in the effectiveness and timeliness of monitoring and decision-making, as well as in the responses to demands received from countries by the Regional Office and country offices.

53. The communications function has highlighted the Regional Office's contribution to public health in the Region and beyond, through credible, reliable, understandable, relevant, timely and easily accessible information and messaging, shared with target audiences through appropriate platforms, including the Regional Office website, social media channels and media outreach. The website serves over 2 million users annually, and 240 000 people subscribe to the corporate social media channels. Since early 2018, consistent efforts have been made to illustrate WHO's impact at country level for key audiences, by sharing evidence-based findings and compelling human stories. The fundamental importance of achieving universal health coverage and health equity have been recurring themes across communications activities and campaigns. The strategic priorities, goals and impact of Health 2020 and the 2030 Agenda are fully integrated into communications strategies and products.

54. Country office capacity with regard to communications has been strengthened through the establishment of a country office communications group and the development of templates for strategies, action plans, campaigns and brochures. Five missions to countries were conducted, which strengthened communications capacity and identified opportunities for collaboration with ministries, boards of health and other stakeholders.

Overview of funding and financial implementation

By category/programme area

55. The approved PB for 2018–2019 for the European Region is US$ 261.9 million, of which US$ 256.4 million is for the base programmes and US$ 5.5 million for Poliomyelitis

(Polio). Outbreak and crisis response and scalable operations was not included in the approved PB for 2018–2019.

56. Overall, as shown in Table 1, the approved base PB is well financed in the Region as at the end of June 2019, with 89% funds available with reference to the approved budget, as opposed to 83% at the same point in the previous biennium. Including the projected voluntary contributions, this figure is expected to increase to 96% by the end of the biennium.

57. The overall utilization of the approved base PB stands at 67% as at the end of June 2019, compared with 57% at the same point in the previous biennium; although not ideal, this figure is in line with the overall Organization-wide average (see Table 2).

Table 1. Financing and utilization of the European Region's approved total PB 2018–2019 by category, as at end June 2019

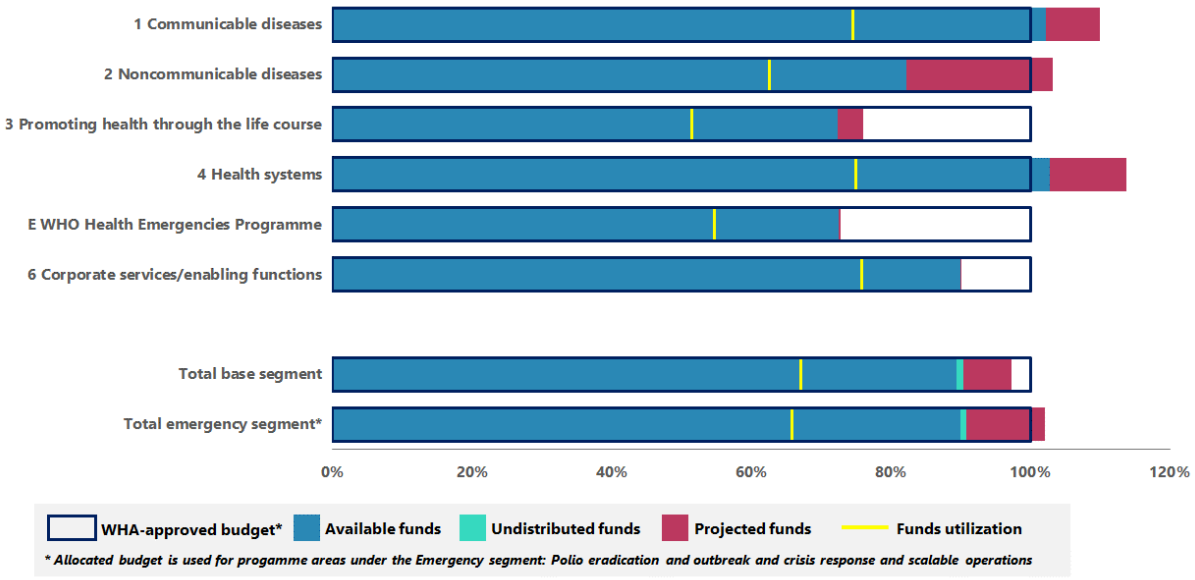
Category	WHA-approved budget (US$ millions)	% available funds against approved budget	% available funds + projections against approved budget	% utilization of available funds against approved budget	% utilization of available funds
1 Communicable diseases	39.7	102	110	75	73
2 Noncommunicable diseases	35.1	82	103	63	76
3 Promoting health through the life course	39.7	72	76	51	71
4 Health systems	49.5	103	114	75	73
E WHO Health Emergencies Programme	33.2	72	73	55	75
6 Corporate services/enabling functions	59.2	90	90	76	84
Total base segment	256.4	89	96	67	75
Total emergency segment	5.5	74	74	62	73
Total European Region	261.9	89	96	67	75

58. As shown in Table 1 and Fig. 4, despite the overall healthy state of financing, the variations in the level of financing between the different categories are clear, with categories 1 and 4 attracting the highest contributions, while category 3 and the Health Emergencies Programme are the least well financed for the second biennium in a row.

59. Considering the projected voluntary contributions (shown in Fig. 4), the funding situation by category is not expected to change; category 2 has the highest level of projected funding, categories 1 and 4 are still expected to have the highest level of funding overall by the end of the biennium, while major increases in the funding levels of category 3 and the Health Emergencies Programme are not foreseen.

60. In line with the funding levels, categories 1 and 4 are leading in terms of utilization of funds against the approved budget, at 75%, followed by category 2 at 63%, while category 3 and the Health Emergencies Programme are lagging at 51% and 55%, respectively.

Fig. 4. European Region approved total PB 2018–2019, funding and utilization by category (US$ millions), as at end June 2019, and projected funding by the end of the biennium



WHA: World Health Assembly.

61. Table 2 presents a comparison across major offices. Despite the increase in the level of PB funding for the European Region as compared with the previous biennium, base PB funding is still well below the Organization-wide average in the present biennium, as at the end of June 2019. Other major offices, particularly headquarters and the African, South-East Asia and Eastern Mediterranean regions, are better funded. The European Region is the most successful major office in terms of utilization of available funds, at 75%.

Table 2. Financing and utilization of base PB 2018–2019 by major office, as at end June 2019

Major office	Funding as % of approved budget	Utilization as % of approved budget	Utilization as % of available funds
African Region	90	62	69
Region of the Americas	70	51	72
South-East Asia Region	99	71	72
European Region	89	67	75
Eastern Mediterranean Region	93	64	68
Western Pacific Region	88	64	73
Headquarters*	110	74	67
Total WHO	97	67	69

* Headquarters available funds may include global grants that are yet to be distributed to the regions.

62. Although the overall base PB 2018–2019 funding for the European Region is below the Organization-wide average, we can see from Table 3 that the funding levels for categories 2 and 4 in the Region are higher than the Organization-wide average, and for category 4 funding is equal to that of the African Region and equal highest of all the regions (but not as high as headquarters).

Table 3. Funding levels, percentage of base PB across all major offices by category, as at end June 2019

Category	African Region	Region of the Americas	South-East Asia Region	European Region	Eastern Mediterranean Region	Western Pacific Region	Headquarters	TOTAL WHO
1 Communicable diseases	97%	93%	127%	102%	187%	92%	121%	113%
2 Noncommunicable diseases	54%	55%	92%	82%	61%	86%	98%	80%
3 Promoting health through the life course	63%	45%	78%	72%	78%	71%	127%	85%
4 Health systems	103%	83%	82%	103%	79%	91%	117%	102%
E WHO Health Emergencies Programme	91%	46%	74%	72%	69%	69%	86%	80%
6 Corporate services/enabling functions	98%	98%	96%	90%	86%	96%	88%	92%
TOTAL BASE*	**90%**	**70%**	**99%**	**89%**	**93%**	**88%**	**110%**	**97%**

63. Looking more closely at the funding of programmes in the European Region, Table 4 shows that the funding of 11 out of 30 base programme areas is higher than the overall average of 89%. The best funded programme area is programme area 1.4 (Neglected tropical diseases), which is funded at almost double its approved budget; the funding of seven other programme areas has also exceeded the approved budget.

64. On the other hand, the funding of three programme areas is below or equal to 50% of their approved budget, namely programme areas 6.2 (Transparency, accountability and risk management), 2.6 (Food safety) and 2.5 (Nutrition) at 38%, 46% and 50%, respectively. The highest funding gap in terms of value in US dollars is seen, however, in programme area 3.5 (Health and the environment) for the second biennium in a row, with a gap of US$ 7.1 million, as opposed to US$ 7.7 million at the same point in the previous biennium.

65. As can also be seen from Table 4, the two technical programme areas with the highest level of funding in terms of absolute value in US dollars are 2.1 (Noncommunicable diseases) and 4.2 (Integrated people-centred health services), where funding stands at US$ 20.0 million and US$ 17.9 million, respectively, as at end of June 2019. These figures tie up very well with the results of country prioritization for 2018–2019, during which these two programme areas were selected as a priority by the highest number of countries in the European Region.

66. The level of utilization of funds is consistent across programmes (around the average of 75%). The exceptions to this occur in two areas, the first being programme area 2.4 (Disabilities and rehabilitation) where funds utilization lies at 52%.

67. The second exception to the consistent utilization of funds is found in all of category 6, where three out of the five programmes already stand at 93–95% of their allocated funds. This is mainly due to the strengthening of WHO leadership capacity at country level that has taken place during the present biennium.

Table 4. Funding and utilization of total PB 2018–2019 in the European Region by programme area (US$ millions), as at end June 2019

Programme area	WHA-approved budget	Available funds	Funding gap	Utilized funds	Available funds against approved budget	Utilized funds against approved budget	Utilized against available funds
1.1 HIV and hepatitis	7.8	6.3	1.5	4.3	81%	56%	69%
1.2 Tuberculosis	11.5	12.3	(0.8)	8.5	107%	74%	69%
1.3 Malaria	1.0	0.6	0.4	0.4	64%	44%	68%
1.4 Neglected tropical diseases	0.4	0.8	(0.4)	0.6	197%	145%	73%
1.5 Vaccine-preventable diseases	14.3	16.6	(2.3)	13.1	116%	91%	79%
1.6 Antimicrobial resistance	4.7	3.9	0.8	2.7	84%	58%	69%
Category 1 subtotal	39.7	40.6	(0.9)	29.6	102%	75%	73%
2.1 Noncommunicable diseases	21.8	20.0	1.8	15.8	92%	73%	79%
2.2 Mental health & substance abuse	5.9	4.3	1.6	2.7	72%	47%	64%
2.3 Violence and injuries	2.6	1.7	0.9	1.3	64%	51%	80%
2.4 Disabilities and rehabilitation	1.1	1.2	(0.1)	0.6	106%	54%	52%
2.5 Nutrition	2.7	1.3	1.4	1.1	50%	41%	83%
2.6 Food safety	1.0	0.5	0.5	0.3	46%	32%	69%
Category 2 subtotal	35.1	28.9	6.2	22.0	82%	63%	76%
3.1 Reproductive, maternal, newborn, child & adolescent health	7.4	5.4	2.0	4.1	73%	55%	76%
3.2 Ageing and health	1.5	0.9	0.6	0.7	58%	49%	84%
3.5 Health and the environment	21.5	14.4	7.1	10.2	67%	47%	71%
3.6 Equity, social determinants, gender equality & human rights	9.3	8.1	1.2	5.4	87%	58%	67%
Category 3 subtotal	39.7	28.7	11.0	20.4	72%	51%	71%
4.1 National health policies, strategies and plans	16.7	17.6	(0.9)	12.9	106%	77%	73%
4.2 Integrated people-centred health services	16.6	17.9	(1.3)	14.0	108%	84%	78%
4.3 Access to medicines and other health technologies & strengthening regulatory capacity	5.5	6.2	(0.7)	4.8	112%	87%	77%
4.4 Health systems, information and evidence	10.7	9.1	1.6	5.5	86%	51%	60%
Category 4 subtotal	49.5	50.9	(1.4)	37.1	103%	75%	73%
E.1 Infectious Hazard Management	6.3	5.7	0.6	4.4	91%	70%	77%
E.2 Country Health Emergency Preparedness and the International Health Regulations (2005)	13.0	9.1	3.9	6.8	70%	53%	75%
E.3 Health Emergency information and risk assessment	3.9	2.1	1.8	1.5	54%	39%	72%
E.4 Emergency Operations	5.8	4.3	1.5	3.4	74%	58%	78%
E.5 Emergency Core Services	4.2	2.8	1.4	2.0	66%	48%	73%
Category E subtotal	33.2	24.1	9.1	18.1	72%	55%	75%
6.1 Leadership and governance	33.5	29.4	4.1	23.9	88%	71%	81%
6.2 Transparency, accountability and risk management	2.4	0.9	1.5	0.9	38%	36%	93%
6.3 Strategic planning, resource coordination and reporting	2.5	2.2	0.3	2.0	87%	82%	93%
6.4 Management and administration	16.5	16.3	0.2	13.8	99%	84%	85%
6.5 Strategic communications	4.3	4.5	(0.2)	4.3	105%	99%	95%
Category 6 subtotal	59.2	53.3	5.9	44.9	90%	76%	84%
Undistributed funds		2.8					
Base subtotal	**256.4**	**229.2**	**27.2**	**172.2**	**89%**	**67%**	**75%**
Polio eradication	5.5	4.1	1.4	3.4	74%	62%	84%
Outbreak and crisis response and scalable operations	-	90.3		66.3			73%
Undistributed funds		0.9					
Emergency subtotal	**5.5**	**95.2**	**1.4**	**69.7**	**74%**	**62%**	**73%**
WHO European Region Total	**261.9**	**324.4**	**28.6**	**241.8**	**89%**	**67%**	**75%**

WHA: World Health Assembly.

68. Under the oversight of senior management, plans are monitored and regularly readjusted to ensure timely implementation of the approved PB. Measures in place to accelerate implementation include:

(a) the redistribution of funds between programmes;

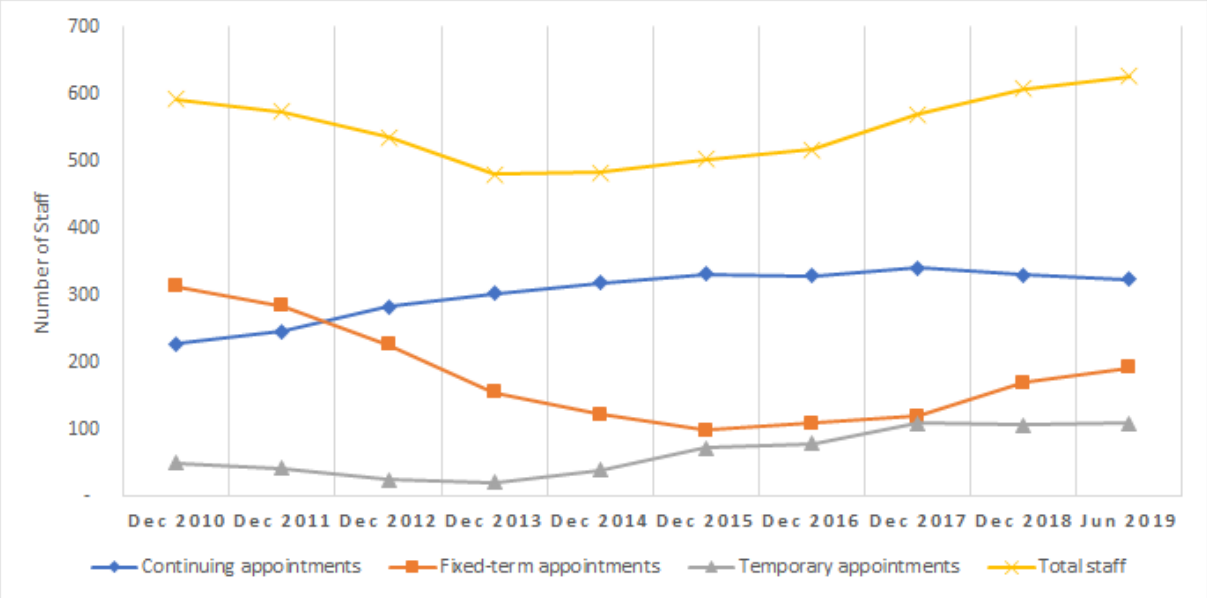
(b) concerted efforts by programme managers and country offices with large projects to implement before the end of the biennium;

(c) a clear process and timeline for the reallocation of unused flexible resources to underfunded areas that have the capacity for implementation.

Human resources capacity to implement PB 2018–2019

69. In respect of implementation of the human resources plan for 2018–2019 in the Region, we see a 9.8% increase in the number of staff in the present biennium (Fig. 5). Unlike the previous biennium, where the major increase was seen in the number of temporary positions, this biennium has shown an increase in the number of fixed-term positions and a decrease in the number of continuing appointments.

Fig. 5. Trends in numbers of staff in the Regional Office by contract type, December 2010 to June 2019



70. In the human resources plan for 2018–2019, there were 95 positions for priority recruitment. Of these 95 positions, 43 have been filled and another 12 are currently under recruitment. The remaining 40 positions are on hold for a variety of reasons, mostly owing to a lack of funding. In addition, 63 “other priority” recruitments have been concluded in the current biennium and recruitment for a further 50 positions is ongoing; many of these are project-related positions funded by highly specified voluntary contributions.

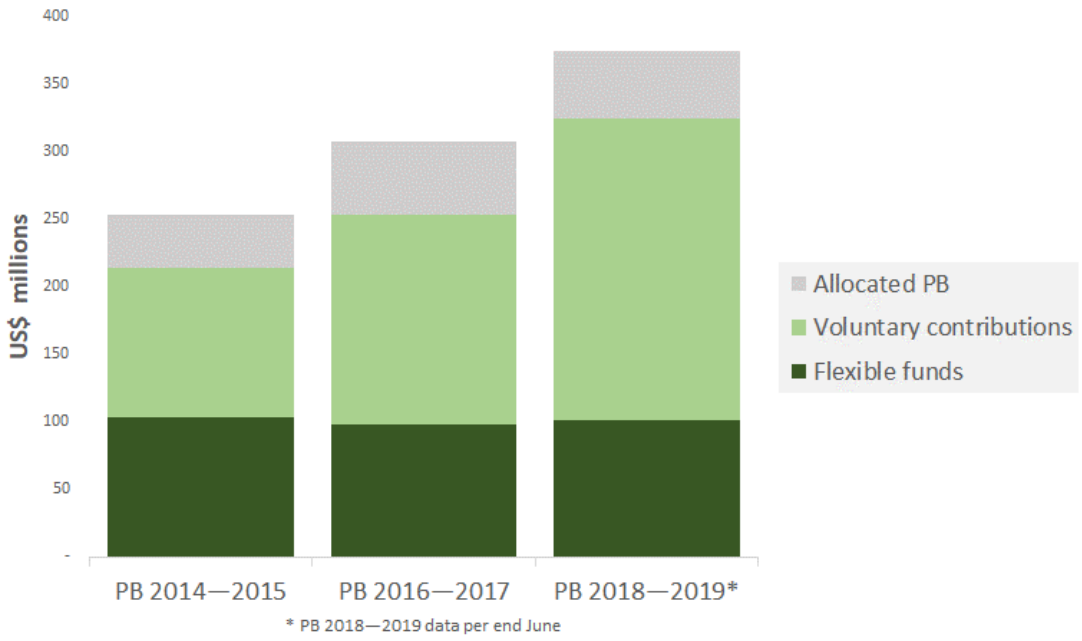
Resource situation

Financial resources of the Regional Office

71. Funding of the European Region's total allocated budget has increased over the last three bienniums, as shown in Fig. 6, thanks to an increase in voluntary contributions. This increase in funding has been accompanied, however, by a high level of earmarking for specific technical programmes and countries, leaving pockets of low funding in other programme areas. Fig. 6 also shows that the level of corporate flexible funding has remained almost constant across the last few bienniums.

72. The flexible resources available represent 31% of the allocated funds for PB 2018–2019, as opposed to 38% in the previous biennium. This percentage will further reduce to 29% by the end of the biennium, given the level of projected voluntary contributions. By the end of June 2019, US$ 223 million of voluntary contributions were available for implementation. The voluntary contributions were 99% specified.

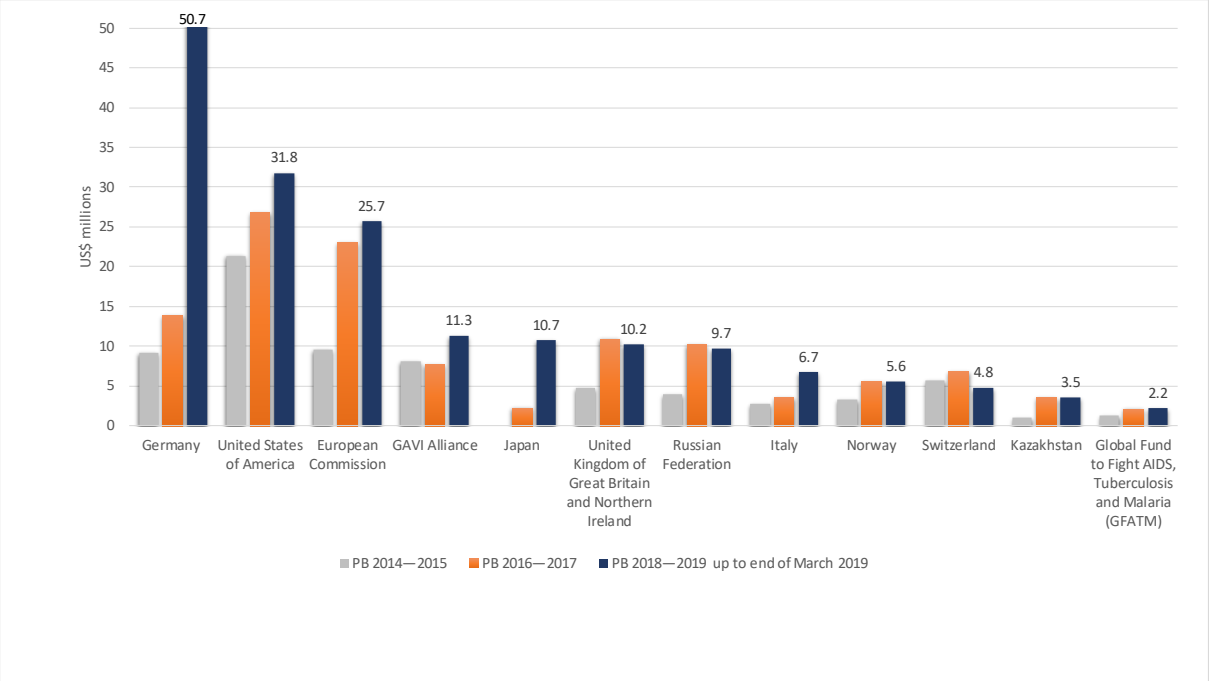
Fig. 6. European Region total allocated PB funding levels by biennium and funding type (US$ millions), as at end June 2019



73. The reduced proportion of flexible funding continues to challenge the Regional Office's efforts to manage the available resources more efficiently and to secure sufficient funding for the identified country priorities, particularly for chronically underfunded programmes.

74. The increase in voluntary contributions received during this biennium by the European Region is driven by a limited number of contributors that have provided increased contributions. Fig. 7 highlights the top 12 donors to the European Region in the present biennium.

Fig. 7. European Region, total PB financing over three bienniums and top 12 contributors (US$ millions), as at end March 2019

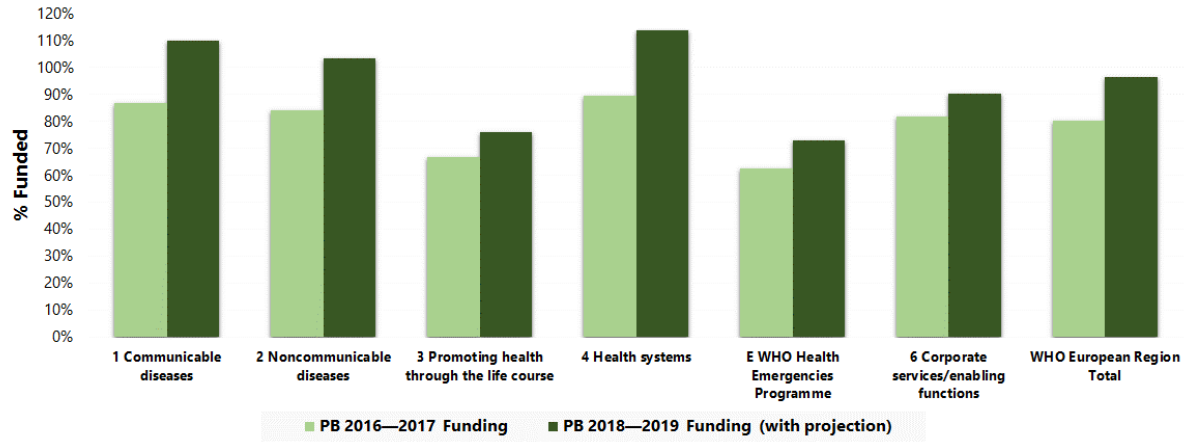


Source: PB web portal data.

Financing the base PB

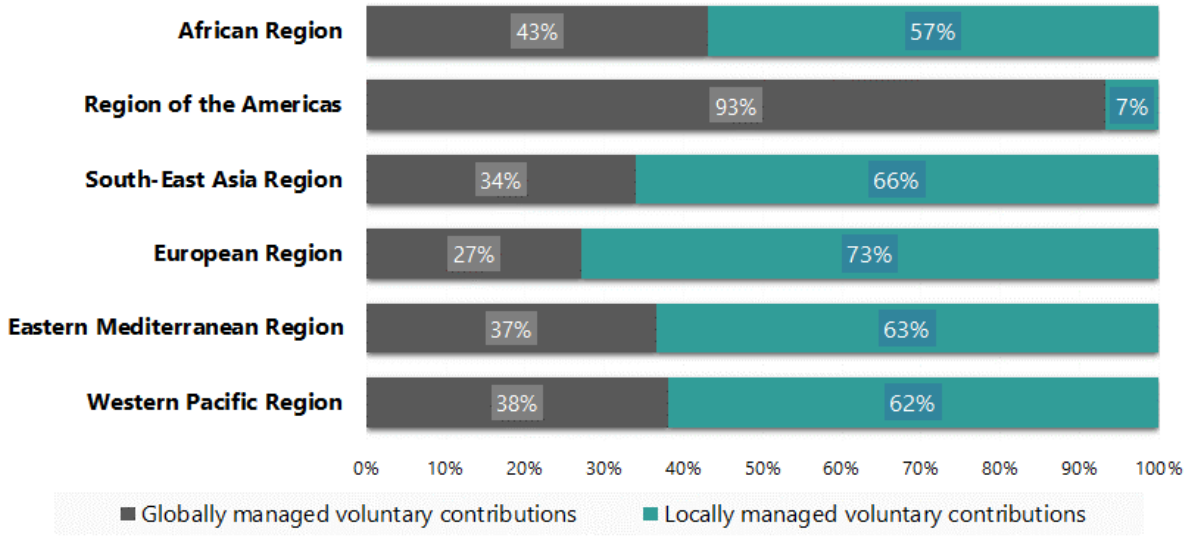
75. Fig. 8 compares the funding by category between the last and the current biennium. All categories have higher projected funding levels in 2018–2019 compared with 2016–2017, with categories 1, 2 and 4 projected to receive substantially more funding this biennium. Category 3 and the WHO Health Emergencies Programme are the least well-funded.

Fig. 8. European Region, base PB funding by biennium and category, as at end June 2019



76. As shown in Fig. 9, the European Region is the region with the highest reliance on locally managed voluntary contributions; the figure has increased in the current biennium to 73%, as compared with 54% at the same point in the previous biennium.

Fig. 9. Proportions of globally managed and locally managed voluntary contributions for PB 2018–2019 base programmes by region, as at end June 2019

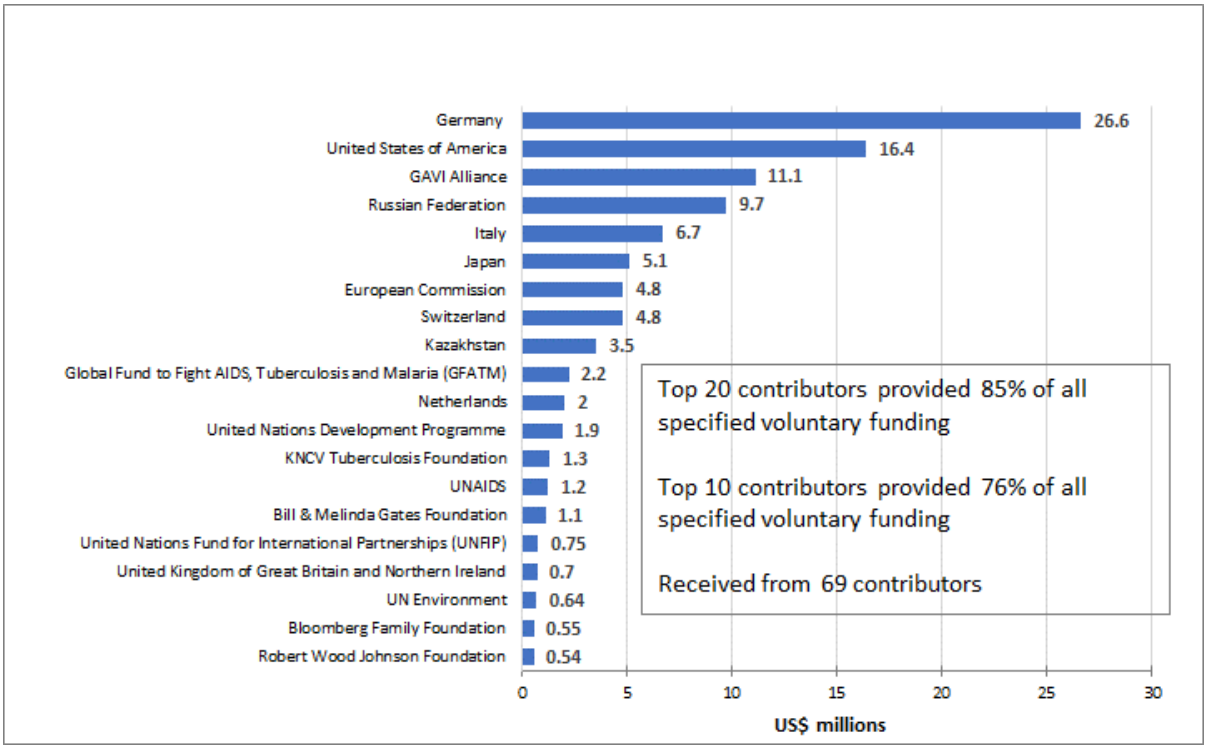


77. This indicates the high level of commitment among Member States and partners to invest in and make an impact on people's health in the Region, as well as the efforts exerted by the Regional Office to mobilize resources. It does, however, also show the lower level of globally managed contributions that the European Region receives compared with other major offices.

78. In all, 85% of voluntary contributions were received from the 20 top contributors (see Fig. 10). Expansion of the donor base is a key priority.

79. The Regional Office expresses its appreciation to all contributors and will continue working towards a fully funded approved PB, including by increasing the flexibility of funds received. To that end, the Regional Office has strengthened its capacity in relation to external relations, resource mobilization and collaboration as part of the United Nations reform at country level.

Fig. 10. Top 20 contributors to the base programmes for 2018–2019 (US$ millions), as at end March 2019



Source: PB web portal.

Annex 1. Glossary of terms and abbreviations

Administrative support funds (AS): part of programme support costs, which can be used only to fund category 6 activities.

Allocated budget: the budget as revised and approved by the WHO Director-General, following World Health Assembly approval.

Assessed contributions (AC): regular contributions made by all Member States, calculated on the basis of an assessment key determined by the United Nations. When the World Health Assembly endorses the appropriation resolution, it decides how AC funds should be used. In past PBs, this was at the level of strategic objectives, with 13 appropriation sections. In the current programme budget, it is by category and programme area.

Base programmes: the part of the programme budget for which WHO has full, exclusive managerial control.

Biennial collaborative agreements (BCAs): agreements between WHO and Member States in the European Region that outline the work during a given biennium.

Core voluntary contributions account (CVCA): a mechanism to receive, allocate and manage resources provided to WHO by donors and which are flexible at the programme budget or strategic priority levels (excluding administration).

Country-specific mode (CS): used for outputs that are specifically tailored to an individual country.

Flexible resources: resources managed by the Organization with a high degree of flexibility, including allocating, spending, according priority and filling budget financing gaps. They are also known as **corporate resources** or **corporate flexible funds** and include AC, AS, CVCA and POC funds.

Geographically dispersed office (GDO): part of the Regional Office with a specific technical focus, located outside Copenhagen, Denmark.

Global Management System (GSM): the enterprise resource planning system used by WHO; the software provider is Oracle.

Health impact: the final achievement of the results chain, defined as improvements in both the level and the distribution of health in European populations.

Intercountry mode (IC): used for outputs that will benefit all countries in the Region.

Output: an element in the results chain representing deliverables by the Secretariat, such as guidelines, norms and standards, policy options, capacity-building packages and technical advice, required by Member States to achieve a health impact.

Post occupancy charge (POC): included in the staff costs charged to each project or workplan to recover any direct costs associated with project staff that are not otherwise covered. This is a WHO-wide charge that is applied to all salaries. In order to avoid double-counting, the POC is applied outside the PB.

Priority outcome: element in the results chain deemed to be a priority by Member States. The measure of achievement of a priority outcome is "the number of Member States that have …".

Programme budget (PB): the biennial WHO Programme budget as presented to the World Health Assembly before the start of the biennium. Budget envelopes are often adjusted during the biennium, resulting in the so-called "allocated budget".

Results chain: describes and illustrates the transformation of inputs (money, staff, information, etc.) into public health impacts, expressed in terms of the overarching goal of improving the level and distribution of health in the European population.

Secretariat: the staff and organizational, managerial and physical structures of WHO.

Specified voluntary contributions (VCS): VC that are closely earmarked by the contributor, specifying for what and how they can be used.

Sustainable Development Goals (SDGs): United Nations development goals with an agreed deadline of 2030 for their achievement.

Utilization: a measure of the PB comprising expenditures and encumbrances combined. Expenditures are funds paid out upon delivery of goods or services. Encumbrances are funds reserved to cover future financial commitments.

Voluntary contributions (VC): contributions other than AC, AS and CVCA.

World Health Organization (WHO): this term means both the Member States and the Secretariat.

Annex 2. Programme budget 2018–2019 by category and programme area

Category		Programme area	
1	Communicable diseases	1.1 HIV	HIV and hepatitis
		1.2 TUB	Tuberculosis
		1.3 MAL	Malaria
		1.4 NTD	Neglected tropical diseases
		1.5 VPD	Vaccine-preventable diseases
		1.6 AMR	Antimicrobial resistance
2	Noncommunicable diseases	2.1 NCD	Noncommunicable diseases
		2.2 MHS	Mental health and substance abuse
		2.3 VIP	Violence and injuries
		2.4 DIS	Disability and rehabilitation
		2.5 NUT	Nutrition
		2.6 FOS	Food safety
3	Promoting health through the life course	3.1 RMC	Reproductive, maternal, newborn, child and adolescent health
		3.2 AGE	Ageing and health
		3.5 HEN	Health and the environment
		3.6 GER	Equity, social determinants, gender equality and human rights
4	Health systems	4.1 NHP	National health policies, strategies and plans
		4.2 IPH	Integrated people-centred health services
		4.3 AMT	Access to medicines and health technologies, and strengthening regulatory capacity
		4.4 HIS	Health systems, information and evidence
E	WHO Health Emergencies Programme	E.1 IHM	Infectious hazard management
		E.2 CPI	Country health emergency preparedness and the International Health Regulations (2005)
		E.3 HIM	Health emergency information and risk assessment
		E.4 EMO	Emergency operations
		E.5 MGA	Emergency core services
6	Corporate services/ enabling functions	6.1 GOV	Leadership and governance
		6.2 TAR	Transparency, accountability and risk management
		6.3 SPR	Strategic planning, resource coordination and reporting
		6.4 ADM	Management and administration
		6.5 COM	Strategic communications
	Polio and outbreak and crisis response	10 POL	Polio eradication
		13 OCR	Outbreak and crisis response and scalable operations

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