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End-of-biennium performance assessment: regional plan for implementation of the programme budget 2016–2017

This document provides the WHO Regional Committee for Europe with a final assessment of the implementation of the regional plan for implementation of the Programme budget (PB) 2016–2017 as well as performance against the objectives set in document EUR/RC65/14, using the PB as a strategic tool for accountability.

The performance assessment contains an analytical overview of the performance of the WHO Regional Office for Europe, with summary tables. It describes the background and context of technical achievements, the financial situation, and technical and managerial challenges faced during the biennium. It highlights achievements in countries with a WHO country presence and achievements by category.

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Introduction

1. This document is presented to the 68th session of the WHO Regional Committee for Europe (RC68) to provide a regional perspective on the delivery of programmatic results as specified in the approved Programme budget (PB) 2016–2017 and the regional plan for its implementation[1] by the WHO Regional Office for Europe.

2. The present report provides an overall executive perspective on the WHO 2016–2017 end-of-biennium performance assessment report, including technical and financial implementation, resource situation, and challenges and lessons learned. It also provides a more in-depth review of the achievements of the countries in the WHO European Region that have a WHO presence as well as the technical implementation of each of the six categories, including a detailed account of the European Region's contributions to the overall output achievements. A background document giving a detailed account of the European Region's contribution to the global programme budget indicators and rating of outputs is available on the Regional Office website.[2]

3. The 2016–2017 biennium was the second biennium of implementation of the WHO Twelfth General Programme of Work (GPW 12), the second full biennium since the adoption of the Health 2020 policy framework by RC62 in 2012, followed later by the unanimous adoption of the 2030 Agenda for Sustainable Development at a special United Nations summit in September 2015.

4. Health 2020 addresses the special requirements and experiences of the European Region and is aligned with the six global leadership priorities: advancing universal health coverage; accelerating the 2030 Agenda for Sustainable Development; addressing the challenges of noncommunicable diseases (NCDs) and mental health, violence and injuries, and disabilities; implementing the provisions of the International Health Regulations (IHR) (2005); increasing access to quality, safe, efficacious and affordable medical products; and addressing the social, economic and environmental determinants of health as a means to promote health outcomes and reduce health inequities within and between countries. This document highlights the Regional Office's progress in achieving the global leadership priorities.

5. All strategies, action plans, and high-level meetings of the Regional Office have been based on the Health 2020 policy framework since its adoption in 2012, and have served as important vehicles for developing national health policies, strategies and plans in the European Region. Strategies and action plans adopted in the years just prior to Health 2020 have been implemented in alignment with the vision and strategic objectives of the policy framework. Furthermore, since 2017, the roadmap to implement the 2030 Agenda for Sustainable Development, endorsed by Member States at RC67, connects Health 2020 with the Sustainable Development Goals (SDGs) and identifies a unifying approach through five strategic objectives and four enablers.

6. Building on the close alignment between GPW 12 and the SDGs, with a strong focus on SDG 3 (Good health and well-being) but taking into account the wide portfolio of SDGs, the

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[1] Documents EUR/RC65/14 and EUR/RC65/Inf.Doc./1.
[2] See: http://www.euro.who.int/en/about-us/governance/regional-committee-for-europe/68th-session/documentation/background-documents/european-region-s-contribution-to-the-global-programme-budget-2016-2017-indicators-and-rating-of-outputs/.

Regional Office embedded its 2018–2019 planning within the implementation of the roadmap to implement the 2030 Agenda and an SDG monitoring framework that will allow the Region to evaluate contributions across the various goals and targets.

7. Within the Regional Office, the two levels of the organization, at times backstopped by headquarters, contributed to the delivery of the approved PB in the Region. This report highlights achievements and success stories in the countries of the Region with a WHO presence as well as the attainments by category.

8. The European Observatory for Health Systems and Policies, a hosted partnership of the Regional Office, although operating outside the PB, aligned its efforts in generating the evidence requested by Member States with the PB, and significantly contributed to the success of the ongoing policy dialogues.

9. The extensive section in the present report on countries' achievements and technical implementation by category uses stories from countries and/or programmes to illustrate the work done during the two-year period and to illustrate the technical highlights of the Regional Office's work in 2016–2017.

PB 2016–2017

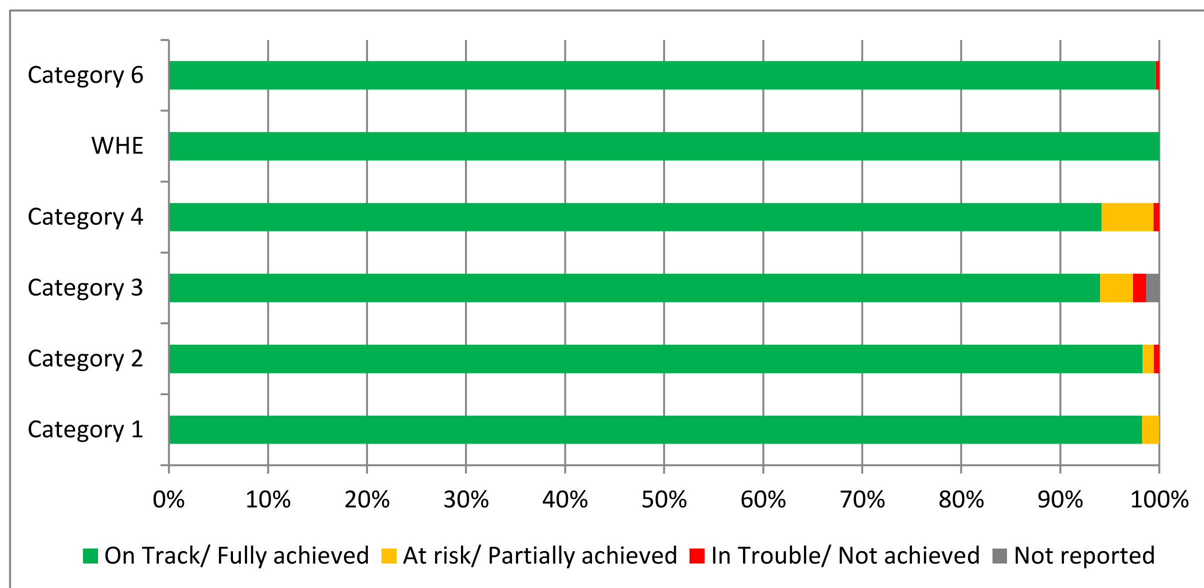
End-of-biennium overview of technical implementation

10. For 2016–2017, the Regional Office had a portfolio of 937 outputs. These are outputs for the global PB 2016–2017 that are specified at the regional and country levels. Achievement of outputs is monitored and analysed through reviews at six-month intervals at the regional level. In the end-of-biennium assessment, 97% of outputs were reported to be achieved, 2% partially achieved and 1% not achieved (see Fig. 1).

11. As in the previous biennium with the results not achieved (outputs rated as partially or not achieved), resource scarcity was the main challenge. Limited financial and/or human resources prevented the completion of some deliverables.

12. Delays or postponement of programmed activities were mainly due to delayed decisions related to political changes at country level. In a few instances over the biennium, limited implementation of WHO-recommended evidence-based policies posed additional technical challenges and required escalating to higher levels, both at government level and within WHO.

Fig. 1. Overview of technical implementation – output achievement by category



13. Category 3 remained the one with the highest percentage of partially or not achieved outputs. Continuing the trend of 2014–2015, resource mobilization efforts continued without much success and programme areas 3.4 (Social determinants of health) and 3.5 (Health and the environment) remained highly dependent on voluntary contributions raised by the programmes themselves; for the most part, these funds were highly specified. The Regional Office received a lower level of flexible funding in 2016–2017 compared to the previous biennium. Strategically distributed, these funds were not sufficient to fill all the funding gaps.

14. The momentum to build technical capacity and to strengthen partnerships continued from the previous biennium as a driver to advance the regional health agenda into 2016–2017. Some WHO country offices in the European Region and a few technical programmes continued with an insufficient number of staff and experienced challenges in meeting various technical and administrative demands.

15. The approval of the WHO Health Emergencies Programme (WHE) midway through the biennium posed some challenges, with the additional efforts made by a modestly resourced team. Some of the newly created programme areas faced delays in implementation due to funding shortages that were only partially rectified closer to the end of the biennium.

16. The full end-of-biennium assessment of PB 2016–2017 is a global exercise. The Regional Office's programme area and category leads contributed to the process, providing regular assessment reports, and focusing on the main achievements, challenges and risks for implementation. These reports were consolidated into a global high-level results report[3] presented to the Seventy-first World Health Assembly in May 2018, complemented with finer granularity of detail in the Programme Budget Web Portal update on the 2016–2017 achievements. A high-level summary of technical and administrative lessons learned by the Regional Office stemming from the end-of-biennium assessment is presented in this document.

[3] Document A71/28, WHO results report: Programme budget 2016–2017.

Promoting the implementation of the SDGs in European Member States

17. The United Nations system as a whole, including WHO, plays an important role in supporting the implementation of the 2030 Agenda. Aligned United Nations Development Assistance Frameworks (UNDAFs), country cooperation strategies and/or biennial collaborative agreements (BCAs) are the main means of implementing the global agenda at the national and local levels.

18. The SDG health targets address most national health concerns, and all of the main priorities of GPW 12, as well as the majority of WHO's programme areas.

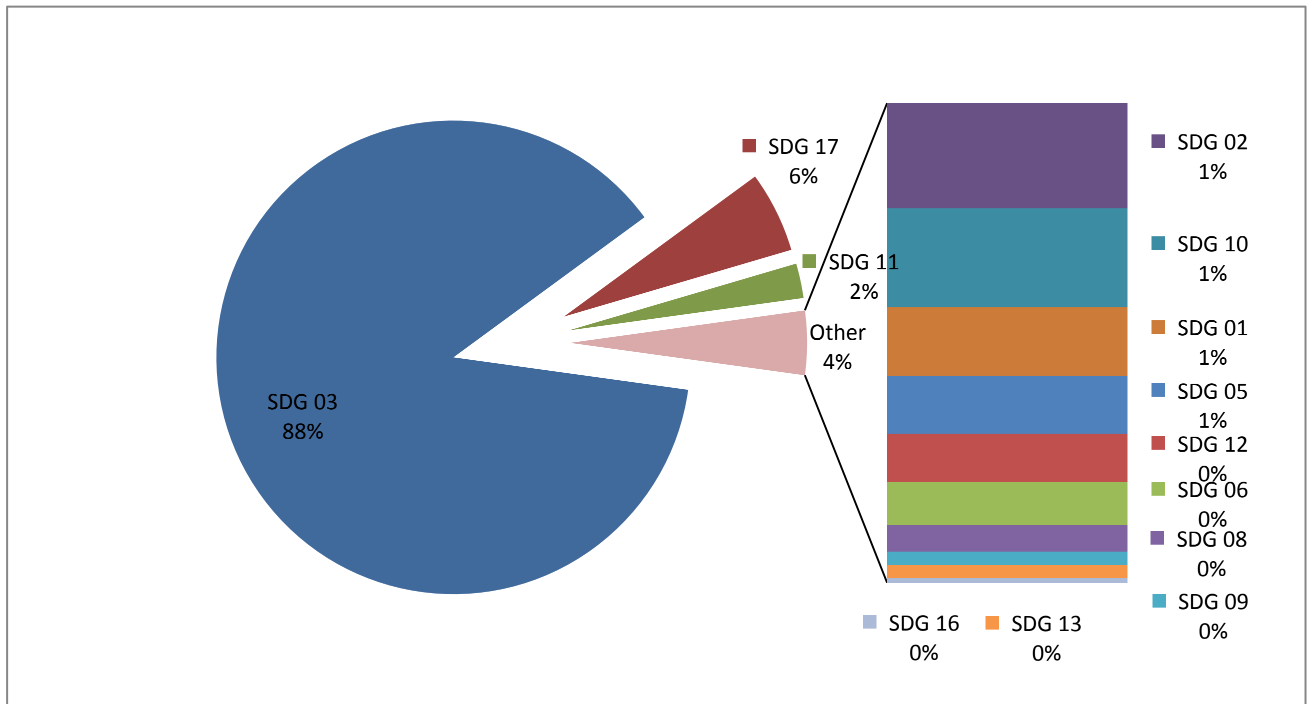
19. Achieving the new health targets required WHO to maintain and strengthen its core functions as set out in GPW 12, particularly in terms of:

- advising on the most cost-effective interventions and delivery strategies;
- defining indicators;
- defining research priorities; and
- supporting countries to generate the necessary funding.

20. The approval of the 2030 Agenda late in 2015 posed a challenge to ensuring full consistency between the SDG goals, GPW 12 and the already approved PB 2016–2017. The European Region, spearheading WHO's regions in an effort to enhance monitoring capacity and to support Member States, piloted a solution to ensure that Region-wide planning for PB 2018–2019 had clear links to the SDG goals and targets, building on the roadmap to implement the 2030 Agenda.

21. This innovative mapping will allow the Regional Office to continuously monitor the contribution of workplans to the SDGs during 2018–2019 (Fig. 2).

Fig. 2. Overview of WHO Regional Office for Europe 2018–2019 planning – planned activities by SDG



Outbreak and crisis response

22. An unprecedented volume of activities under the outbreak and crisis response segment took place in the Region during 2016–2017. More than US$ 57 million was made available for the two ongoing responses, in Turkey (under the whole-of-Syria approach) and in Ukraine, with close to 90% of the funds being implemented during the period and the remaining funds to be used for continuing activities in 2018–2019.

Turkey

23. Throughout 2016–2017, within the whole-of-Syria approach, the WHE team in Turkey continued its work to mitigate the effects of the humanitarian crisis in the Syrian Arab Republic on the health of about 4 million Syrian refugees, in support of the Ministry of Health of Turkey.

24. WHO, through its Country Office in Ankara and the field office in Gaziantep, maintained oversight of all activities, within the framework of WHE, ensuring alignment with common strategies by national authorities and other partners, accountability to donors and responsibility for public information. Through the coordination of partners, both in northern Syrian Arab Republic and Turkey, WHO ensured an adequate response in support of the most vulnerable people in need of health assistance.

25. WHO continued its efficient management of health-related data both in northern Syrian Arab Republic and Turkey, to promote data-driven decision-making by all partners. The WHO office in Gaziantep and partners in north-western Syrian Arab Republic also monitored the attacks on health care, following rigorous verification processes. In 2017 WHO verified 112 violent attacks against health facilities.

Box 1. Key numbers for 2017 outbreak and crisis response operations in relation to the crisis in the in the Syrian Arab Republic

465 tonnes of medical supplies and medicines delivered to health facilities in northern Syrian Arab Republic.

Over 1100 Syrian health professionals trained in trauma management, mental health and chronic disease management in northern Syrian Arab Republic.

70 000 Syrians assisted by 18 WHO-supported health facilities in Idleb.

Four poliomyelitis (polio) vaccination campaigns conducted, covering **750 000 children** per round in northern Syrian Arab Republic.

3.25 million doses of oral polio vaccine used to protect children in northern Syrian Arab Republic.

More than 1200 Syrian health workers trained and certified to serve in the Turkish health care system, providing health services to their compatriots.

More than 433 000 free and culturally and linguistically-sensitive health consultations provided to Syrian refugees.

Seven refugee health training centres supported with medical supplies and equipment.

413 000 Syrian children reached by routine immunization services in Turkey.

26. WHO's life-saving support to people in northern Syrian Arab Republic focused on alleviating the health needs of millions of people by delivering much-needed medicines and medical supplies through the health cluster partners; supporting childhood immunization, even in volatile and hard-to-reach areas; reinforcing systems for the early detection and control of diseases; and training the Syrian health workforce.

27. In Turkey, in close collaboration with the Turkish Ministry of Health, and in line with the Regional Refugee and Response Plan, efforts were aimed at providing linguistic and culturally sensitive health services to Syrian refugees, through training of Syrian doctors and nurses and by enabling them to serve, under the Ministry of Health, at the WHO–Ministry of Health refugee primary health care centres.

Ukraine

28. Throughout 2016–2017, around 2.5 million people living in conflict-affected regions in eastern Ukraine were supported with essential and life-saving medicines and medical supplies needed for primary and secondary health care, such as safe deliveries, paediatric asthma prevention and care, preparedness for and treatment of diarrheal diseases, life-saving surgical interventions, trauma care and psychosocial support.

29. In 2017 WHO increased its capacity to provide life-saving support to the affected population of eastern Ukraine by strengthening its field office capacity, in both Government-controlled areas (GCAs), and non-Government-controlled areas (NGCAs). The teams in the field facilitated the work of implementing partners in delivery of services, medications and

supplies and the training of health-care staff. Field staff also conducted assessments and monitoring activities.

30. With WHO support, nine health facilities underwent minor repairs and medical equipment was repaired and maintained. Blood banks were upgraded and an estimated 50 000 people received safe blood transfusions during the biennium.

Box 2. Key numbers for 2017 outbreak and crisis response operations in Ukraine

28 719 people benefited from primary health-care consultations through the re-establishment of five mobile clinics for primary health care, including psychosocial support.

42 surgical kits that allow **4200 surgical interventions** for major trauma have been delivered to the health authorities of Lugansk and Donetsk Oblasts (regions) in both GCAs and NGCAs.

754 940 people benefitted from the WHO-supplied deliveries in a total of 245 health facilities.

352 health-care workers were trained in vaccination (27), mental health care (12), rehabilitation (42), safe laboratory practices (202), and trauma (69).

Nine public health laboratories were assessed**.**

25 international and 31 national nongovernmental organizations' emergency response efforts were coordinated by WHO, ensuring effective delivery of humanitarian programmes in the field.

31. Through a network of mobile emergency primary care units, supported by WHO, consultations were provided in difficult-to-reach areas along the contact line. In addition, mobile community mental health teams were established, providing both specialist mental health services to conflict-affected communities and support for longer-term recovery through reform of the mental health system.

32. Health-care practitioners were trained in areas identified as having the most impact on quality and outcome of treatment, such as laboratory quality management systems, trauma care and rehabilitative care.

33. Assessments of the public health laboratory system in eastern Ukraine were conducted, including of human resources and epidemiological services at regional public health centres in both GCAs (three oblast-level public health laboratories) and Donetsk NGCA (six laboratories), aiming to identify gaps and weaknesses in laboratory systems and to plan appropriate activities to maintain high-quality detection and surveillance of diseases of public health importance.

European Observatory on Health Systems and Policies

34. The European Observatory on Health Systems and Policies (Observatory), a hosted partnership within the Regional Office, supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health-care systems in Europe. During the biennium, Member States have had their evidence needs met by the Observatory through a series of initiatives.

35. Over a dozen new Health in Transition (HiT) systematic and comparable reviews of national health systems were launched during the biennium.

36. The Observatory published conceptual frameworks, case studies and evidence syntheses in response to partners' and policy-makers' priorities, which were designed to give insights into and support the challenges faced in shaping decisions. The areas covered during the 2016–2017 biennium were multi-morbidity and chronic disease; antimicrobial resistance; structuring cross-border collaboration on procurement and workforce; hospital governance; governance for intersectoral action; civil society; voluntary insurance; co-benefits; the right of the child to health; and economic impacts of poor diet and low levels of exercise.

37. The HiT reviews represent a consistent effort to reflect on performance in country monitoring and, during the biennium, interventions were undertaken to support three Member States in their own performance reviews (Hungary, Portugal and Slovenia).

38. The Observatory worked with two Regional Office technical divisions – the Division of Health Systems and Public Health (DSP) and the Division of Policy and Governance for Health (PCR) – to present evidence obtained across the region: in Austria, Belgium, Bosnia and Herzegovina, Estonia, Finland, Ireland, Israel, Latvia, Lithuania, Kazakhstan, Malta, the Netherlands, Republic of Moldova, Romania, Switzerland and Ukraine, among others. Tools included policy dialogues, presentations and workshops (at events such as the European Health Forum Gastein and the European Public Health Conference), and the annual Venice Summer School (on primary care and putting the person at the centre of health systems). Several hard-copy publications (e.g. studies, policy briefs, Health Reform Monitor of Health Policy articles and Eurohealth) were distributed, complemented by online dissemination (e.g. through Twitter, e-bulletins and other Internet-based platforms) to help promote evidence uptake.

39. Austria combined national policy dialogue, policy briefs and a facilitated dialogue with Slovenia and the Veneto Region of Italy to explore ways of developing multi-professional, interdisciplinary primary care.

40. Estonia, Latvia and Lithuania met in the annual Baltic dialogue, supported by the Observatory and the Regional Office, to explore evidence and share experiences on quality of care, patient safety strategies, regulation, monitoring and incentives.

41. Finland convened an expert panel and requested the Observatory and the Regional Office to provide an evidence-informed pre-review of their draft reform proposals with the aim of identifying prerequisites for success and potential challenges.

42. Malta commissioned Observatory policy briefs and dialogue inputs on structured cooperation between European Union (EU) countries on health workforce issues during Malta's Presidency of the EU.

43. The Observatory supported the Netherlands in holding a ministerial conference on antimicrobial resistance (AMR).

Lessons learned from implementation of the 2016–2017 regional plan for implementation

44. The following are some of the most pertinent lessons learned from the 2016–2017 biennium from the technical and strategic perspectives, as a result of this self-assessment:

- ensuring political commitment from and engagement with Member States is crucial to advancing programmes;
- continuing priorities over the biennium leads to a stronger and more sustained impact of the interventions;
- the trust of and respect for WHO by political decision-makers and high-level officials is the key to harmonizing country policy frameworks and catalysing political decision-making;
- engaging the Regional Director's leadership to cooperate with Member States, using the SDGs as an opportunity to engage with the highest level of government and foster high-level policy dialogue can further scale up responses/interventions in the Region.
- leveraging high-level global forums, such as the United Nations General Assembly, is a means of increasing global political commitment and availability of resources, and boosting research and innovation;
- increasing cooperation with United Nations agencies, aligned around the SDGs, provides new opportunities for joint action, in particular in those areas which require combined, scaled-up action;
- using other political agendas (e.g. EU accession agendas) or international frameworks and obligations stemming therefrom (e.g. United Nations Conventions, the WHO Framework Convention on Tobacco Control (WHO FCTC), etc.), membership in networks (e.g. the South-eastern Europe Health Network (SEEHN) and the small countries initiative), as well as local leadership and networks (e.g. the WHO European Healthy Cities Network and the Regions for Health Network), can be a means of generating political commitment for action;
- high-level visits to the Regional Office and/or exposure of high-level government officials to international forums can be effective mechanisms for orienting policy directions in key areas of work;
- having an ongoing policy dialogue and technical cooperation between the Secretariat and Member States is critical to achieving long-term health gains in the Region;
- advocacy and health diplomacy work and close interaction with national and international actors at the country level contribute to the advancement of the health agenda and to promoting WHO's work and visibility;
- collaborating with other ministries (labour, finance, internal affairs, etc.), beyond the ministry of health, local governments and parliament, ensures intersectoral and whole-of-government approaches to key health issues (e.g. NCDs, AMR, health systems strengthening);
- investing in strengthening partnerships with United Nations partners, ministries of health, other sectors and donors is important for positioning WHO among key high-level national and international partners, while ensuring a focus on the health and well-being of the population;
- strengthening WHO country offices with international leadership leads to stronger coordination with stakeholders and development partners;

- promoting the inclusion of the SDGs in national health strategies and aligning national health strategies with the SDGs can foster partnerships with other United Nations agencies and partners around common goals and targets. UNDAFs, roadmaps for implementation of the 2030 Agenda and other national instruments can be used as opportunities for improved coherence among United Nations agencies;
- providing a flexible and rapid response to the changing needs of, or ad hoc requests from, Members States helps build trust in WHO;
- coordinating the three levels of WHO (headquarters, regions and countries) in order to deliver as one leads to the most effective and highest impact interventions;
- communication and advocacy are paramount in work at country level, and the review and reorganization of communications and WHO's web presence functions at the Regional Office helped to shift the focus to countries;
- investing in resource mobilization resulted in visible progress in technical assistance in certain areas. While many donors and partners have resources for health projects, implementation in most cases is in accordance with their visions and missions and not necessarily in line with health ministries' or WHO's missions, visions and priorities;
- periodic reporting on relevant technical progress and achievements at the Regional Committees increases Member States' commitment to and accountability for common results;
- planning country needs, and developing and approving collaborative arrangements with Member States, requires ample time and should start early in year two of the current biennium to ensure uninterrupted activities and operations in countries;
- regular evaluation exercises help to bring perspective to the day-to-day operations of WHO staff, e.g. by revisiting the larger results framework and assessing the current context, and thus are conducive to the ultimate goal of improving the health of the populations served;
- ensuring early availability of funding at the onset of the biennium is a good practice that should be continued;
- funding predictability is crucial across all programme areas. Distributing funds to the country level leads to a better reflection of the needs and efforts of countries and ensures that the Organization's focus on countries is implemented;
- Using technology can facilitate processes and make them more effective but requires investment in capacity building;
- staffing should be aligned and balanced with technical programme requirements and technical support required by ministries of health.

End-of-biennium overview of funding and financial implementation

By category

45. The Regional Office portion of the WHA-approved budget for 2016–2017 was US$ 246 million. Distribution of the budget by category is shown in Table 1 and in Fig. 3. Among the technical categories, category 4 (Health systems) had the largest share of the budget (20%) followed by category 3 (Promoting health through the life course).

46. The approval of the WHE programme during the Sixty-ninth World Health Assembly in May 2016 led to the creation of a new category for WHE, the phasing out of the category 5 emergency-related programmes and an increase in overall regional budget for emergencies.

Table 1. Levels of WHA-approved and currently allocated PB for the Regional Office (US$ millions)

Category	WHA-approved budget	Allocated budget	Variation
1	33.8	33.8	-
2	33.9	33.9	-
3	38.3	38.3	-
4	48.2	48.2	-
5	21.3	10.5	(10.8)
6	59.9	59.9	-
WHE		15.1	15.1
Base	235.4	239.8	4.4
Emergencies	10.4	67.5	57.1
Total European Region	**245.8**	**307.2**	**61.4**

47. As presented in Table 1, throughout the course of the biennium the European Region's WHA-approved base budget was adjusted to accommodate the implementation of the WHE programme, resulting in a final increase of US$ 4.4 million to US$ 240 million from US$ 236 million. The new budget is referred to as the current allocated budget or allocated PB.

48. In addition, during the biennium the emergencies component was increased by US$ 57.1 million to accommodate the ongoing emergency operations. As a result, the total budget envelope of the Regional Office, as at 31 December 2017, stood at US$ 307.2 million, reflecting a 25% increase vis-à-vis the approved figure.

Table 2. Funding and utilization of PB 2016–2017 by budget and by category

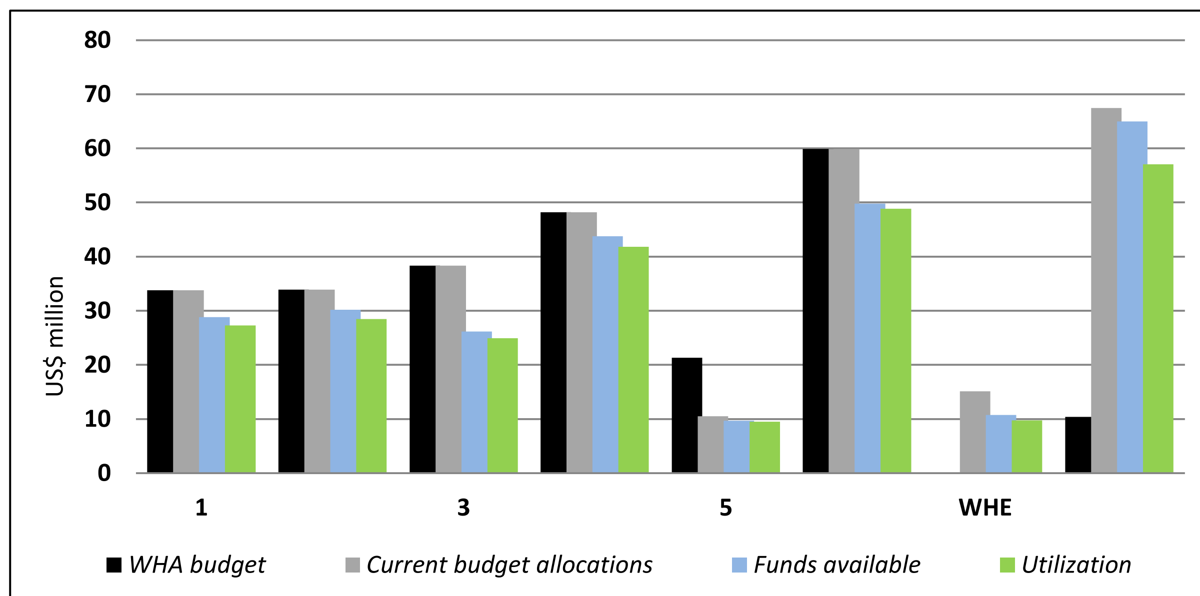
Category	% funds available of WHA-approved PB	% funds available of allocated PB	% utilization of WHA-approved budget	% utilization of allocated PB	% utilization of funds available
1	85%	85%	81%	81%	95%
2	89%	89%	84%	84%	94%
3	68%	68%	65%	65%	95%
4	91%	91%	87%	87%	96%
5	45%	92%	45%	90%	98%
6	83%	83%	82%	82%	98%
WHE		71%		64%	90%
Base	80%	83%	77%	79%	96%
Emergencies	NA	96%	NA	85%	88%

49. Although by the end of the biennium 83% of the allocated PB was funded, by means of coordinated efforts from staff at regional and at country level, thorough monthly regular monitoring exercises and intensified scrutiny during the last semester of the biennium, the Regional Office reached 96% utilization of available funds. Building on the lessons learned from the previous biennium to maintain regular monitoring throughout the biennium, which was further intensified during the latter part of the biennium, the Regional Office proactively and promptly mitigated the risks for low utilization.

50. A review of the funding levels by category shows important variations among the technical categories with regard to the funding of the WHA-approved PB. While category 3 was just over two thirds funded, category 4 was funded at 91%. The budgetary review led to a more even distribution of the allocated PB funding among the categories. Category 5, with the approval of WHE and transition of the emergency-related programmes from category 5 to WHE, led to a skewed picture of the WHA-approved budget.

51. Utilization of the funds available at the end of the biennium reached 96%, with WHE having the lowest levels of utilization (90%) mainly due to the very late arrival of the funds.

Fig. 3. PB 2016–2017: WHA-approved and allocated budget, available funds and implementation by category, as at 31 December 2017



By programme area

52. The six categories and WHE are divided into 33 programme areas. Table 3 summarizes the budget, funding and utilization situation by programme area.

53. As Table 3 shows, 13 out of 23 base programmes (from category 1 to category 4 and category 6) had more than 75% of the WHA-approved budget funded, in keeping with the positive trend seen during the previous biennium.

54. While during 2014–2015, categories 2 and 3 had the most underfunded programme areas (similarly to the global situation), in 2016–2017 they were joined by two underfunded programme areas from category 1 (HIV and Malaria). As all these underfunded programmes represent regional and global priorities, the Regional Office has tried to offset the imbalance with flexible funds as far as possible.

55. All programme areas, without exception, demonstrated good capacity to implement the resources that were made available during the biennium.

Table 3. PB2016–2017 by programme area – budget, funding and utilization as at 31 December 2017

Programme area	WHA Approved PB	Allocated PB	Funds available	Utilization	% funds available of WHA-approved PB	% funds available of allocated PB	% utilization WHA-approved PB	% utilization allocated PB	% utilization of funds available
1.001 HIV	6,900	5,650	4,723	4,603	68%	84%	67%	81%	97%
1.002 TUB	10,800	11,500	8,711	8,079	81%	76%	75%	70%	93%
1.003 MAL	3,100	861	607	609	20%	71%	20%	71%	100%
1.004 NTD	600	539	536	525	89%	99%	88%	97%	98%
1.005 VPD	12,400	15,250	14,243	13,446	115%	93%	108%	88%	94%
sub-total Cat 1	**33,800**	**33,800**	**28,820**	**27,262**	**85%**	**85%**	**81%**	**81%**	**95%**
2.001 NCD	19,200	23,900	22,567	21,509	118%	94%	112%	90%	95%
2.002 MHS	5,200	4,200	3,243	2,788	62%	77%	54%	66%	86%
2.003 VIP	6,900	2,000	1,834	1,784	27%	92%	26%	89%	97%
2.004 DIS	500	1,100	856	832	171%	78%	166%	76%	97%
2.005 NUT	2,100	2,700	1,661	1,541	79%	62%	73%	57%	93%
sub-total Cat 2	**33,900**	**33,900**	**30,161**	**28,455**	**89%**	**89%**	**84%**	**84%**	**94%**
3.001 RMC	6,500	6,900	4,314	4,290	66%	63%	66%	62%	99%
3.002 AGE	1,400	1,400	888	857	63%	63%	61%	61%	96%
3.003 GER	1,000	1,100	886	847	89%	81%	85%	77%	96%
3.004 SDH	7,900	7,800	5,767	5,056	73%	74%	64%	65%	88%
3.005 HEN	21,500	21,100	14,321	13,887	67%	68%	65%	66%	97%
sub-total Cat 3	**38,300**	**38,300**	**26,177**	**24,937**	**68%**	**68%**	**65%**	**65%**	**95%**
4.001 NHP	15,000	16,234	15,457	14,132	103%	95%	94%	87%	91%
4.002 IPH	15,400	17,051	15,574	15,210	101%	91%	99%	89%	98%
4.003 AMT	7,100	4,781	4,357	4,185	61%	91%	59%	88%	96%
4.004 HSI	10,700	10,134	8,374	8,278	78%	83%	77%	82%	99%
sub-total Cat 4	**48,200**	**48,200**	**43,762**	**41,805**	**91%**	**91%**	**87%**	**87%**	**96%**
5.001 ARC	8,200	2,704	2,608	2,608	32%	96%	32%	96%	100%
5.002 EPD	8,000	5,554	5,224	5,086	65%	94%	64%	92%	97%
5.003 ERM	4,100	1,275	1,235	1,235	30%	97%	30%	97%	100%
5.004 FOS	1,000	1,000	585	579	59%	59%	58%	58%	99%
sub-total Cat 5	**21,300**	**10,532**	**9,652**	**9,507**	**45%**	**92%**	**45%**	**90%**	**98%**
6.001 GOV	33,100	32,891	27,099	26,618	82%	82%	80%	81%	98%
6.002 TAR	2,800	2,413	1,798	1,784	64%	75%	64%	74%	99%
6.003 SPR	4,600	2,730	2,296	2,205	50%	84%	48%	81%	96%
6.004 ADM	16,400	16,787	14,548	14,375	89%	87%	88%	86%	99%
6.005 COM	3,000	5,079	4,016	3,885	134%	79%	130%	76%	97%
sub-total Cat 6	**59,900**	**59,900**	**49,757**	**48,868**	**83%**	**83%**	**82%**	**82%**	**98%**
12.001 IHM	-	3,759	3,309	2,705		88%		72%	82%
12.002 CPI	-	6,202	3,080	2,922		50%		47%	95%
12.003 HIM	-	1,639	792	787		48%		48%	99%
12.004 EMO	-	2,153	2,367	2,060		110%		96%	87%
12.005 RED	-	1,381	1,198	1,232		87%		89%	103%
sub-total WHE	**-**	**15,135**	**10,747**	**9,707**		**71%**		**64%**	**90%**
Base	**235,400**	**239,767**	**199,076**	**190,540**	**85%**	**83%**	**81%**	**79%**	**96%**
5.005 POL	7,400	7,400	7,087	5,321	96%	96%	72%	72%	75%
5.006 OCR	3,000	60,076	57,859	51,747	1929%	96%	1725%	86%	89%
Emergencies	**10,400**	**67,476**	**64,946**	**57,068**	**624%**	**96%**	**549%**	**85%**	**88%**

Resources

Financial resources of the Regional Office

56. The Regional Office received US$ 167.8 million of voluntary contributions between January 2016 and December 2017 as a result of considerable resource mobilization efforts at the global, regional and country levels. These voluntary contributions represented 66% of the overall funding of the Regional Office, which is similar to the 64% in the previous biennium. Seven per cent of overall funding of the Regional Office came from the core voluntary contributions account (CVCA, representing flexible voluntary funding), which is a decrease from the 16% in 2014–2015.

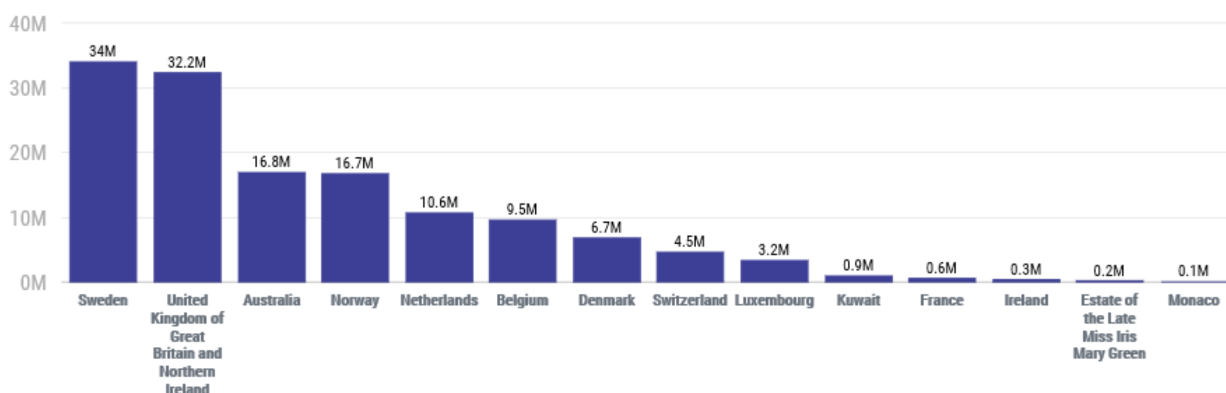
Resource mobilization coordination and donor analyses

57. The availability of information through the PB portal[4] has enabled a more in-depth analysis to be made of donations and funding flows across WHO, and has increased transparency and accessibility within and outside WHO.

58. In the Region, voluntary contributions have been received from 90 contributors, mainly Member States (representing 44% of overall funding), intergovernmental organizations (10%), United Nations organizations (5%), partnerships (4%), local governments (2.2%), philanthropic foundations (1.5%), academic institutions (0.4%), and private sector entities and nongovernmental organizations (NGOs) (0.3% each).

59. CVCA funds provide a vital source of catalytic funding: they allow less well-funded activities to benefit from a better flow of resources and ease implementation bottlenecks that arise when immediate financing is lacking. As shown in Fig. 4, 11 out of the 13 contributors of the total flexible voluntary funding received by WHO at global level are Member States of the European Region. Their contribution represented 85% of the total amount of contributions to the CVCA in 2016–2017.

Fig. 4. PB 2016–2017: contributors of flexible voluntary funding to WHO (global)



60. In 2016–2017, funding from the 10 top donors represented 68% of all specified voluntary contributions received in the Region, as shown in Fig. 5.

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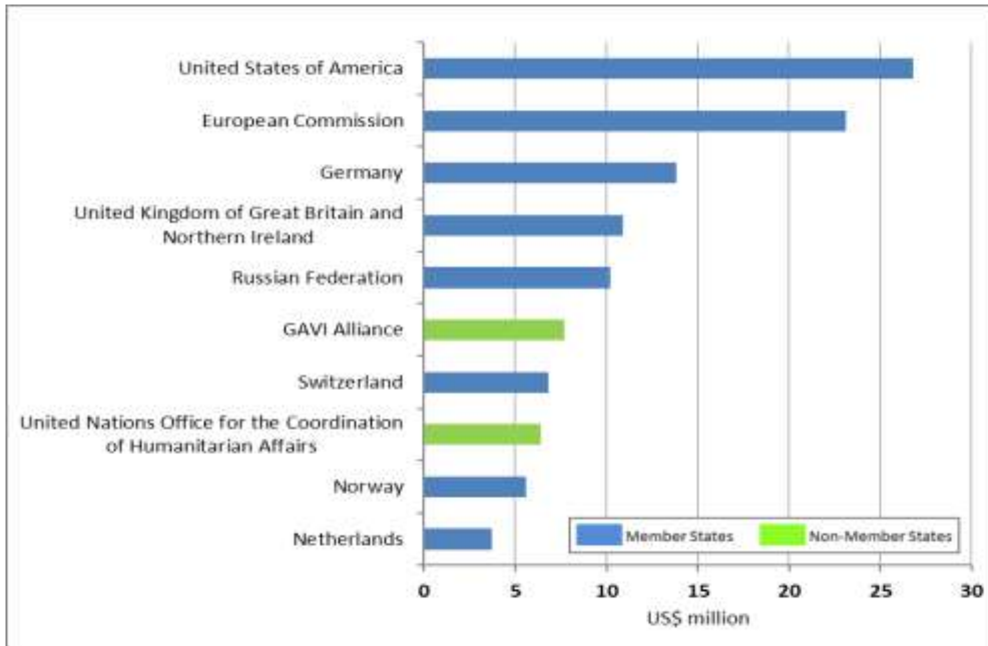
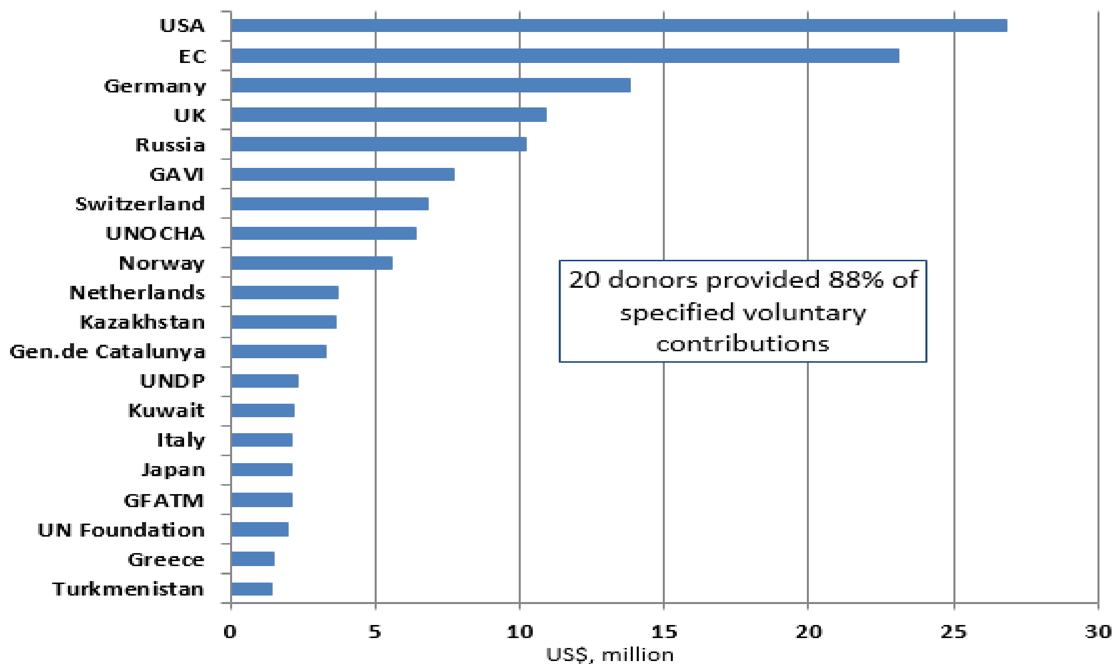
[4] See: http://open.who.int/2016-17/home.

Fig. 5. PB 2016–2017: top 10 European Region specified voluntary contribution donors



61. Fig. 6 shows the 20 top donors for the region, and the fact that, combined, they provided 88% of the specified voluntary contributions.

Fig. 6. PB 2016–2017: top 20 European Region specified voluntary contribution donors



62. A total of 24% of the Regional Office's overall funding came from EU Member States, which contributed US$ 63.6 million (in voluntary contributions), including through the European Commission. The United States and the European Commission were the largest individual donors, contributing (in voluntary contributions) a cumulative 20% of the regional overall funding.

63. The analysis shows that Regional Office budget still relies on a relatively small number of donors, showing its vulnerability. Nonetheless, progress in enlarging the donor base has been made, with, for example, Kazakhstan and Turkmenistan entering the top 20 donors in the 2016–2017 biennium. Further efforts to broaden the donor base have been made, including through additional, newly emerging donors and through strengthening collaboration with international development banks.

64. A regional resource mobilization plan has been developed to support a coherent approach, both with and complementing the global level, and reinforcing resource mobilization at the regional and country levels. The plan includes the active participation of the Region in global bilateral meetings, better communication of the results of the work at country level, and increasing the visibility of donors. It also includes increased training and capacity building, especially for country offices, to support the development of the engagement plan at country level but also in delivering and reporting results in a comprehensive and timely manner.

65. More work also needs to be done to enhance flexibility on the part of donors, such as the flexibility clause in the agreement with donors. In addition, longer-term funding provisions and more flexibility in the use of the earmarked funds (for example earmarking at a higher level for health emergencies instead of for a specific activity) would support planning and implementation.

Summary 2016–2017: achievements in countries with country offices

Albania

66. Albania's efforts to join the EU were reflected in the National Development and Integration Strategy 2016–2020, in which the health sector component was aligned both with the 2030 Agenda and with Health 2020. Moreover, and during the biennium, the National Health Strategy 2020 developed with WHO support became the formal platform for consistent policy dialogue with development partners and the official basis for resource mobilization.

67. In a continuous effort to improve health system performance and responsiveness in Albania, coordinated WHO technical support was made possible during 2016–2017 and a series of key documents was developed and/or endorsed at national level such as the Reproductive Health Strategy 2020, the NCD Control Strategy 2020, the Action Plan on Nutrition 2020 and a new Law on Infection Control.

68. Albania's successful introduction of plain packaging for cigarettes in 2016 was recognized during the Sixty-ninth World Health Assembly in 2016. Albania aligned its tobacco-control legislation with the WHO FCTC, with WHO support, and countrywide tobacco education campaigns were organized.

69. Establishing community-based mental health centres and residences, aiming at the social inclusion of recovering persons, led to substantial progress in access to mental health services in Albania. WHO played a role in promoting, catalysing and directly supporting a human rights-based concept of mental health and the implementation of the new model of mental health services in Albania, also supporting the development of the National Action Plan for the Development of Mental Health Services up to 2022.

Success story 1. Investing in mental health to improve quality of life in Albania

As part of the effort to improve the availability of medical services, Albania, with WHO support, introduced new working modalities in residential care for mental health patients.

The individual plan of care for people with mental health disorders, introduced in 2016–2017, gathers in one plan patients' rehabilitation needs and the strategies needed to gain functional independence and (re-)establish the social interactions that lead to the ultimate goal of reintegration.

Anila, living in Mimosa Residence for close to one year, benefited from such a plan: her rehabilitation needs were covered in the residence but the plan allowed her to keep in contact with her friends: initially, she was accompanied by the residence staff and but gradually she became more independent.

"I like to shop, and to visit church in the afternoon and on Sunday. I like to have coffee and cookies at the café nearby. With my friends, I play puzzles every day. I sweep and mop and clean my room. I watch TV every day, so I know what is happening in the world. I keep photos of my relatives in my room. The most exciting event for me is approaching. I will join my family in few weeks!"

70. A national study on child maltreatment conducted during the biennium with WHO support allowed the authorities to raise the findings at an intersectoral policy dialogue on prevention of child maltreatment that furthered the development of a national action plan on child protection and injury prevention.

71. In an effort to reduce environmental threats to health, Albania developed a national water protocol on small-scale water management alongside an implementation road map as a result of an intersectoral workshop held in 2016 and thanks to external expertise on national water protocols obtained with WHO support.

72. The introduction of the International Classification of Diseases during the 2016–2017 biennium facilitated Albania's reporting of essential public health indicators to WHO, enabling harmonization with other European countries and the publishing of national data in European publications such as the Mental Health Atlas 2017 and the Annual Epidemiological Report for 2017: Antimicrobial consumption. The electronic ICD-10 is now part of Albanian e-health. This critical upgrade of Albania's health information system was possible due to WHO-supported capacity-building initiatives throughout the two-year period. In addition, a health information system assessment was conducted during the same period.

73. A policy brief on health as an investment in the context of the roadmap to implement the 2030 Agenda for Sustainable Development was developed during 2017 as an input into the United Nations joint mainstreaming, acceleration and policy support (MAPS) with a focus on the EU integration process.

74. At the end of the biennium, Albania was well positioned to improve its national capacities on emergency preparedness and response. The joint external evaluation (JEE) of IHR (2005) capacities completed in 2016 showed the strengths and weaknesses of the existing health system. The recommendations provided allowed the national authorities to develop a road map to improve national capacities on emergency preparedness and response with WHO support.

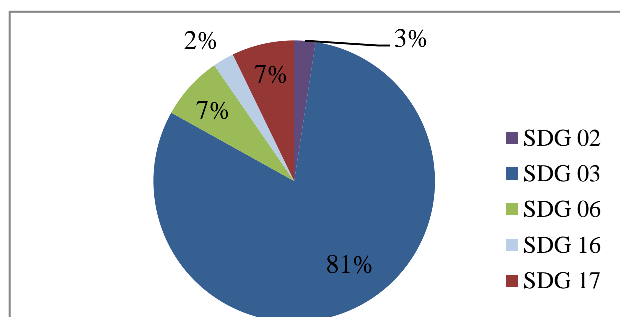
75. More details of WHO's work, funding and utilization of funds in Albania can be found at: http://open.who.int/2016-17/country/ALB.

76. In 2018–2019 Albania will continue to work with WHO, mainly focusing on the 16 priority programme areas identified through the BCA (see Box 3). The planned activities will mainly contribute to SDG 3 (See Fig. 7). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 3. Albania's priorities for 2018–2019

1. HIV and hepatitis
2. Tuberculosis
3. Vaccine-preventable diseases
4. Antimicrobial resistance
5. Noncommunicable diseases
6. Mental health and substance abuse
7. Violence and injuries
8. Nutrition
9. Reproductive, maternal, newborn, child and adolescent health
10. Health and the environment
11. National health policies, strategies and plans
12. Integrated people-centred health services
13. Access to medicines and other health technologies and strengthening regulatory capacity
14. Health systems, information and evidence
15. Infectious Hazard Management
16. Country Health Emergency Preparedness and the International Health Regulations (2005)

Fig. 7. PB 2018–2019 planned activities by SDG in Albania



Armenia

77. To increase its capacity to deliver key hepatitis interventions, Armenia developed a national strategy on viral hepatitis in line with the Action Plan for the Health Sector Response to Viral Hepatitis in the WHO European Region with support from WHO and other stakeholders.

78. Benefiting from political commitment and strong policy direction, the country successfully maintained the status of elimination of mother-to-child transmission of HIV infection, fulfilling most of the recommendations of the WHO Global Validation Committee, with a few recommendations pending completion in 2018.

Success story 2. Eliminating mother-to-child transmission of HIV in Armenia

Armenia saw one of its greatest public health achievements in 2016 with WHO certification of the elimination of mother-to-child HIV transmission, which was a recognition of the significant efforts made over the years towards the elimination of new HIV infections among children.

Building on political commitment, sound policy direction, an empowered national AIDS centre and supportive partners and civil society, the country was able to effectively steer joint efforts towards this important common goal.

WHO staff, from the Regional Office and the Country Office, strengthened national capacity through multiple consultations and championed the development of relevant policies and guidelines. Moreover, the WHO team coordinated the efforts of United Nations agencies (UNAIDS, UNICEF and UNFPA) and contributions from key public sector players (such as the Ministry of Health, Ministry of Justice, Ministry of Internal Affairs, statistical committees and others) towards the shared goal of elimination.

79. Armenia spearheaded reforms in tuberculosis models (TB) of care and their financial mechanisms during the biennium. The flagship USAID-funded, WHO-coordinated project on Sustainable TB Control in Armenia came to an end in 2016 after successfully addressing three key areas: strengthening health system capacity to control TB; improving TB infection control; and engaging civil society in addressing TB problems.

80. Armenia furthered vaccination coverage during the biennium and introduced human papillomavirus (HPV) vaccination for 13-year-old girls in December 2017. With WHO support, preparations were made to introduce the HPV vaccine into the national immunization programme schedule.

81. WHO supported Armenia in conducting a STEPwise approach to surveillance (STEPS) survey of NCD risk factors during 2016–2017 to generate the evidence needed in efforts to better prevent and manage NCDs in the country.

82. To guide efforts to increase access to interventions to improve the health of children and adolescents, Armenia developed and finalized a national child and adolescent health strategy and action plan for 2016–2020 with WHO support.

83. Armenia underwent a JEE of its IHR (2005) core capacities as part of its ongoing efforts to fulfil its IHR (2005) obligations.

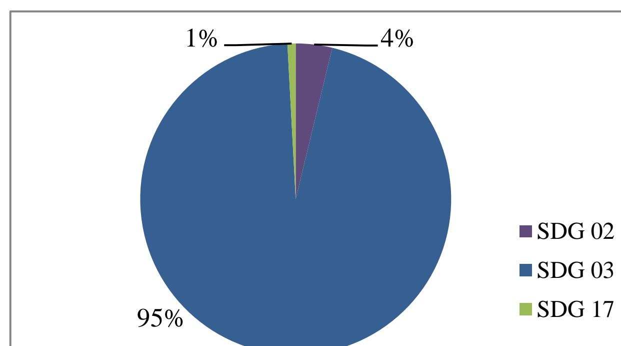
84. More details of WHO's work, funding and utilization of funds in Armenia can be found at: http://open.who.int/2016-17/country/ARM.

85. In 2018–2019 Armenia will continue to work with WHO, mainly focusing on the 16 priority programme areas identified through the BCA (see Box 4). The planned activities are primarily focused on SDG 3 (see Fig. 8). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 4. Armenia's priorities for 2018–2019

1. HIV and hepatitis
2. Tuberculosis
3. Neglected tropical diseases
4. Vaccine-preventable diseases
5. Antimicrobial resistance
6. Noncommunicable diseases
7. Mental health and substance abuse
8. Violence and injuries
9. Nutrition
10. Reproductive, maternal, newborn, child and adolescent health
11. National health policies, strategies and plans
12. Integrated people-centred health services
13. Access to medicines and other health technologies and strengthening regulatory capacity
14. Polio eradication
15. Infectious Hazard Management
16. Country Health Emergency Preparedness and the International Health Regulations (2005)

Fig. 8. PB 2018–2019 planned activities by SDG in Armenia



Azerbaijan

86. TB services were included in the basic package of mandatory health insurance and Azerbaijan's efforts to achieve universal access to quality TB care continued during the biennium. These efforts included the strengthening of capacity to address TB in prisons as well as important policy dialogues around the development of a new model of TB care as an entry point for overall health system strengthening and around financing mechanisms for TB services in the context of broader provider payment reforms in the health system.

87. At the onset of the biennium, the country obtained certification of malaria elimination, having successfully interrupted local transmission of the disease.

88. Azerbaijan's efforts to increase vaccination coverage for hard-to-reach populations and communities continued, in line with the state policy of free vaccination for all citizens in state and municipal medical facilities. Together with partners (GAVI, the vaccine Alliance, the United Nations Children's Fund (UNICEF) and the Vishnevskaya-Rostropovich Foundation), WHO provided significant support to the 2016–2017 immunization campaigns, within the national programme, and as a result Azerbaijan maintained its polio-free status; in 2016 the country was certified as having eliminated measles and rubella.

89. Building on the national NCD strategy adopted in 2015, WHO continued to support Azerbaijan to improve access to interventions to prevent and manage NCDs and their risk factors. During the biennium 2016–2017, a law on tobacco control was developed and adopted by parliament, and the country completed a nationwide STEPS survey.

90. With WHO support, Azerbaijan continued its efforts to decrease maternal mortality. The results of the first reproductive health strategy informed the drafting of a new reproductive health multisectoral strategy for 2017–2020. In addition, the country implemented a maternal and child health strategy and introduced the near miss case reviews nationwide.

91. The establishment of the State Agency for Compulsory Health Insurance during the biennium contributed to better capacity for planning, executing and monitoring health-care spending in Azerbaijan. Other noteworthy efforts were those to strengthen health human resource management, specifically through the reform of higher medical (State Medical University) and nursing education with support from the Regional Office and a WHO collaborating centre.

Success story 3. Reducing vaccine procurement costs in Azerbaijan

With graduation from GAVI funding, Azerbaijan faced budgetary constraints with regard to the procurement of vaccines for the national immunization plan.

Together with national counterparts and international partners, WHO was able to establish a direct link for vaccine procurement with the UNICEF supply division while amending the national regulation to avoid direct vaccines procurement through international organizations.

The collaboration thus established and the holistic approach to vaccine procurement ensured that Azerbaijan now has a sustainable, reliable and effective source of quality affordable vaccines through the UNICEF supply chain. Moreover, the country recorded savings of 50% against the Government budget allocation for vaccine procurement.

92. A multisectoral review, conducted with WHO support, strengthened the capacity and preparedness of the country to tackle emergency situations, and special efforts were made with regard to mass gathering events hosted in Azerbaijan during the biennium 2016–2017.

93. Advances were also made with regard to cross-border collaboration, a priority in IHR (2005) implementation. During the biennium, participants representing the Ministry of Health, the Ministry of Justice, the Border Service, WHO and the International Organization for Migration participated in the first bilateral meeting on collaborative management of communicable disease between the Islamic Republic of Iran and Azerbaijan.

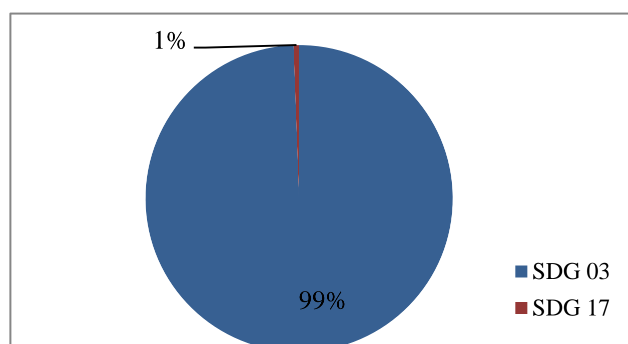
94. More details of WHO's work, funding and utilization of funds in Azerbaijan can be found at: http://open.who.int/2016-17/country/AZE.

95. In 2018–2019 Azerbaijan will continue to work with WHO, mainly focusing on the 12 priority programme areas identified through the BCA (see Box 5). The activities planned are mainly relevant to SDG 3 (see Fig. 9). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 5. Azerbaijan's priorities for 2018–2019

1. HIV and hepatitis
2. Tuberculosis
3. Vaccine-preventable diseases
4. Antimicrobial resistance
5. Noncommunicable diseases
6. Reproductive, maternal, newborn, child and adolescent health
7. Health and the environment
8. National health policies, strategies and plans
9. Integrated people-centred health services
10. Polio eradication
11. Infectious Hazard Management
12. Country Health Emergency Preparedness and the International Health Regulations (2005)

Fig. 9. PB 2018–2019 planned activities by SDG in Azerbaijan



Bosnia and Herzegovina

96. Throughout 2016–2017 Bosnia and Herzegovina continued to align its health strategies and programmes with Heath 2020 and the commitment to work on the SDGs: with WHO support, the ministers of health were among the first high-ranking officials to announce a commitment to achieving the 2030 Agenda.

97. Tailoring of immunization programmes started during the biennium, as part of the commitment by the ministries of health to overcome the worrying decreasing trend in vaccination coverage through the strengthening of vaccination programmes.

98. The main priorities of WHO collaboration in Bosnia and Herzegovina during the biennium were to increase access to integrated people-centred services and to reduce NCD risk factors. With the support of partners such as the Swiss Agency for Development and Cooperation, key achievements during the two-year period included draft tobacco-control legislation aligned with the WHO FCTC that was submitted to the parliaments, and policy dialogues on dietary health risks, physical activity, marketing and fiscal measures for effective tobacco-control.

Success story 4. Adopting a Health in All Policies approach to draft tobacco-control legislation in Bosnia and Herzegovina

The complex administrative organization of Bosnia and Herzegovina (14 mutually independent councils of ministers/governments at the state, entity/district and canton levels) poses challenges to promoting intersectoral collaboration within and across the governments on public health priorities, in the spirit of a whole-of-government/s and Health in All Policies approach.

With WHO support, during the biennium, senior civil servants (at the level of assistants to the ministers) in relevant ministries in the governments at state and entity/district level worked together on public health priorities in coordination and collaboration with the public health sector responsible coordinators from the respective ministries of/in charge of health in the Public Health Liaison Network.

As a result, both the Federation of Bosnia and Herzegovina and Republika Srpska drafted tobacco-control laws fully aligned with WHO FCTC and were supported by a strong pro-law alliance of international and national stakeholders, including civil society.

99. An effective mechanism for governmental intersectoral collaboration on public health priorities was established in 2016–2017, and the various public health policy task forces met regularly throughout the period to discuss relevant matters.

100. Following an extensive education programme covering 70% of family medicine teams in Bosnia and Herzegovina, the offer of standardized preventive cardiovascular risk assessment and management services significantly widened. This effort to strengthen the health systems, through improvements to primary health care services, contributed to a wider coverage and better management of NCDs in Bosnia and Herzegovina.

101. In an effort to improve access to services for mental health, Bosnia and Herzegovina participated in a WHO project on adults with mental disabilities living in institutions in the European Region. The findings of a survey carried out in four institutions (two in each entity), presented to the authorities, identified gaps and indicated the changes needed to address them.

102. Capacities and regulations on essential medicines were strengthened as a result of WHO support.

103. The implementation and monitoring of the IHR (2005) advanced during the biennium. WHO provided assistance to a simulation exercise on foodborne diseases at points of entry that was followed by capacity-building efforts.

104. To support Bosnia and Herzegovina in harmonizing indicators, developing a health information strategy and strengthening information flows, WHO assessed the national and subnational health information systems and e-health in April 2017.

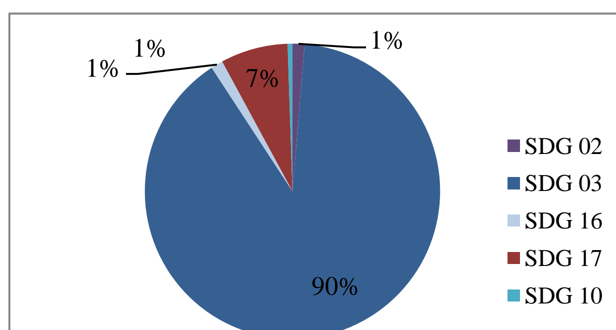
105. More details of WHO's work, funding and utilization of funds in Bosnia and Herzegovina can be found at: http://open.who.int/2016-17/country/BIH.

106. In 2018–2019 Bosnia and Herzegovina will continue to work with WHO, mainly focusing on the 14 priority programme areas identified through the BCA (see Box 6). Covering five SDGs, the planned activities will fundamentally contribute to SDG 3 (see Fig. 10). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 6. Bosnia and Herzegovina's priorities for 2018–2019

1. Vaccine-preventable diseases
2. Antimicrobial resistance
3. Noncommunicable diseases
4. Mental health and substance abuse
5. Violence and injuries
6. Nutrition
7. Reproductive, maternal, newborn, child and adolescent health
8. Health and the environment
9. Equity, social determinants, gender equality and human rights
10. Integrated people-centred health services
11. Health systems, information and evidence
12. Polio eradication
13. Infectious Hazard Management
14. Country Health Emergency Preparedness and the International Health Regulations (2005)

Fig. 10. PB 2018–2019 planned activities by SDG in Bosnia and Herzegovina



Belarus

107. During the biennium, the state programme "Healthy people and demographic security for 2016–2020" was prepared and is being implemented with WHO technical support. It is aligned and monitored in line with the SDG goals and indicators. WHO expertise was provided in the development of various health programmes, action plans and documents related to tobacco control, TB control and HIV/AIDS.

108. To continue the efforts to reduce the burden of NCDs, several initiatives took place during the biennium. Belarus set up an interministerial coordination council on NCDs in 2016 under the chairmanship of the Vice-Prime Minister to ensure an intersectoral approach.

109. A WHO STEPS survey on the prevalence of major NCD risk factors was conducted, which provided an accurate overview and formed the basis for policy development and planning of actions in the area of NCD prevention and control.

110. A pilot breast cancer screening programme was launched, which included extensive training courses and the development of normative and policy documents.

111. With the support of WHO, Belarus generated evidence to strengthen public health interventions through WHO assessments and reports on NCDs, health system performance, cancer control, performance of specialized health services (for heart attack and stroke) and economic analysis of investments in NCD prevention and control.

112. To increase the access to integrated, people-centred health services, with the support of WHO Belarus initiated the development a new model of health services delivery at primary health care level. During the biennium and as part of the model, new clinical protocols were developed, the functional duties of medical personnel at primary health care level were reviewed, and a series of training events took place.

113. To improve prevention and management of unintentional injuries and violence, Belarus strengthened the capacity of national experts using the WHO-TEACH VIP training methodology.

114. An assessment of the quality of childhood hospital care conducted in 2016–2017 formed the basis for further policy and managerial improvements.

115. In an effort to reduce the burden of communicable diseases, Belarus made considerable progress in implementing WHO recommendations on TB control in the biennium with the introduction of video-observed TB treatment, increased access to rapid molecular TB diagnosis, new clinical protocols on management of TB and its drug-resistant forms, use of new anti-TB drugs and pharmacovigilance, the launch of a pilot project to improve the provision of patient-oriented TB care, and a new model for financing of TB services.

116. Significant progress was also made with regard to reducing the burden of HIV/AIDS: in 2016, the elimination of mother-to-child transmission of both HIV and syphilis was validated by WHO, and antiretroviral therapy (ART) coverage increased from 35.4% in 2015 to 45.5% in 2017. With WHO support, Belarus adopted new HIV clinical protocols to ensure universal access to antiretrovirals for all people living with HIV; all antiretroviral regimens in the country are aligned with the 2016 WHO consolidated guidelines; and self-testing for HIV was

introduced. Belarus' share of antiretroviral drug procurement increased to 72% in 2017 and local production was established, contributing to a significant price drop in locally produced antiretrovirals and thus allowing universal access to treatment for people with HIV in Belarus.

Success story 5. Improving HIV screening and treatment coverage in Belarus

In the past there has been low HIV testing coverage in Belarus and people living with HIV/AIDS experienced low treatment success rates.

The turning point came in 2016–2017, when strong political commitment and well-coordinated partnerships (international partners and NGOs) led to the thorough review and dissemination of national clinical protocols for HIV/AIDS diagnosis and treatment.

With WHO support, Belarus introduced HIV/AIDS self-testing in May 2017. The joint efforts led to the streamlining of ART treatment regimens (from 33 in 2015 to 16 in 2017) which, together with the new and revised protocols, led to a rapid increase in ART treatment coverage (from 35.4% in 2015 to 45.5% in 2017).

117. In November 2017, a United Nations joint MAPS mission to recommend health policies and actions was carried out, with the aim of revising Belarus' development strategy and promoting accelerated action, as well as advising on monitoring of SDG indicators.

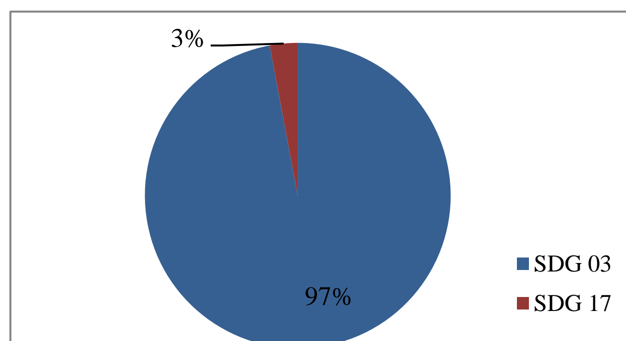
118. More details of WHO's work, funding and utilization of funds in Belarus can be found at: http://open.who.int/2016-17/country/BLR.

119. In 2018–2019 Belarus will continue to work with WHO, mainly focusing on the nine priority programme areas identified through the BCA (see Box 7). The planned activities will contribute mainly to SDG 3 (see Fig. 11). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 7. Belarus's priorities for 2018–2019

1. HIV and hepatitis
2. Tuberculosis
3. Noncommunicable diseases
4. Mental health and substance abuse
5. Violence and injuries
6. Reproductive, maternal, newborn, child and adolescent health
7. Integrated people-centred health services
8. Access to medicines and other health technologies and strengthening regulatory capacity
9. Health systems, information and evidence

Fig. 11. PB 2018–2019 planned activities by SDG in Belarus



Bulgaria

120. Bulgaria demonstrated a genuine commitment to improving its population's health, and has aligned its recently adopted national health policy 2020 with the European policy framework, Health 2020. During 2016–2017, with WHO support, Bulgaria strengthened the health system and public health through active engagement with a whole-of-governmental and whole-of-society approach, such as the WHO high-level policy dialogue on integration of the SDGs into the National Development Programme 2020 and the National Health Strategy 2020.

Success story 6. Cross-sectoral policy dialogue on achieving the SDGs in Bulgaria

With the adoption of the 2030 Agenda, the question arose of how Bulgaria could integrate the SDGs into the National Heath Strategy 2020 and the National Development Programme 2020.

WHO facilitated a policy dialogue to discuss implementation of the Bulgarian National Health Strategy 2020 geared towards achieving the targets contained in Health 2020, the policy framework for health and well-being.

Stakeholders at the workshop developed a framework for achieving the SDGs in Bulgaria through multisectoral collaboration and active engagement, that allowed the integration of the SDGs into multiple Government programmes.

Moreover, the newly developed framework further strengthens the monitoring and evaluation of the National

121. To raise awareness among key decision-makers and the public about the growing burden of NCDs, the key risk factors and the necessary interventions, as well as the issue of the high share of private household out-of-pocket payments for health, the relevant *Highlights on health and well-being* and *Profile on health and well-being* were updated and published with WHO support.

122. To improve the management of NCDs during 2016–2017, Bulgaria's National Centre of Public Health and Analysis conducted a survey among women with diabetes, based on WHO's methodology and guidance. The findings led to the development of a booklet and an educational movie distributed among women with diabetes, health clinics and the public, resulting in increased awareness of the disease by the targeted groups.

123. To increase health awareness and knowledge by young people, Bulgaria conducted activities informed by the recommendations of the Health Behaviour in School-aged Children (HBSC) survey conducted during the biennium. Highlights include the introduction of health-related activities into the curriculum of the Bulgarian school system.

124. To improve information and raise patient awareness of the responsible use of medicines, the Bulgarian Drugs Agency developed and distributed an information brochure with the technical support of WHO.

125. During the biennium, Bulgaria hosted the first multicountry meeting on strengthening national health research systems, during which the WHO European Health Research System and Strategy Initiative and participating Member States adopted the Sofia Declaration. The latter reaffirmed the commitment to strengthen the use of evidence, information and research for policy-making. Bulgaria also initiated activities on strengthening evidence-informed policy-making in collaboration with the Evidence-informed Policy Network (EVIPNet). National experts who are involved in this network organized a national evidence-informed policy stakeholder meeting.

126. During the biennium, the National Plan of the Republic of Bulgaria for Influenza Pandemic Preparedness was updated with support from WHO and the European Centre for Disease Prevention and Control (ECDC), leading to better national coordination between different sectors.

127. To further reduce the burden of communicable diseases, Bulgaria developed and endorsed the National Programme on HIV/AIDS 2016–2020 and the National TB Strategy and Action Plan with WHO support. The country also piloted the integration of TB services into primary health care with WHO's technical assistance.

128. A high-level policy dialogue on viral hepatitis, engagement with civil society on World Hepatitis Day celebrations, and other targeted guidance initiatives developed during the biennium, had a positive impact on efforts to improve control of viral hepatitis in the country. WHO supported the development of targeted recommendations to improve hepatitis prevention and care in Bulgaria.

129. During the biennium, several initiatives were undertaken to raise the profile of AMR at different national levels. The National Centre for Parasitic and Infectious Diseases, the Bulgarian Agency for Food Safety, and other multisectoral partners developed the National Strategy for AMR with technical guidance from WHO. As a result, Bulgaria is well placed to lead in this field, being responsible for AMR in the context of SEEHN.

130. To strengthen Bulgaria's health information system, WHO undertook an assessment that generated recommendations in this regard.

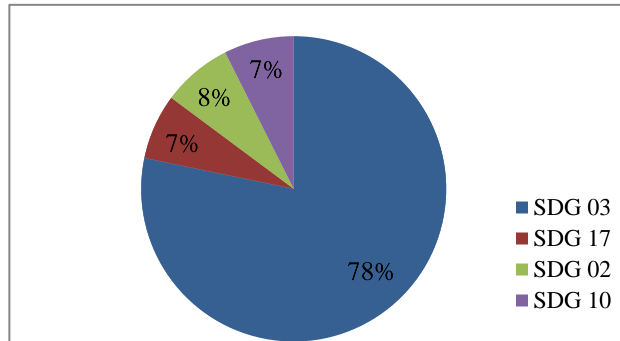
131. More details of WHO's work, funding and utilization of funds in Bulgaria can found at: http://open.who.int/2016-17/country/BGR.

132. In 2018–2019 Bulgaria will continue to work with WHO, mainly focusing on the 11 priority programme areas identified through the BCA (see Box 8). While almost 80% of the planned activities are focused on SDG 3, the work will also contribute to three other SDGs (see Fig. 12). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 8. Bulgaria's priorities for 2018–2019

1. HIV and hepatitis
2. Tuberculosis
3. Vaccine-preventable diseases
4. Antimicrobial resistance
5. Noncommunicable diseases
6. Mental health and substance abuse
7. Nutrition
8. National health policies, strategies and plans
9. Health systems, information and evidence
10. Infectious Hazard Management
11. Country Health Emergency Preparedness and the International Health Regulations (2005)

Fig. 12. PB 2018–2019 planned activities by SDG in Bulgaria



Croatia

133. In an effort to reduce the burden of communicable diseases, Croatia developed, with WHO support, a national strategy for the prevention and control of viral hepatitis to be endorsed in 2018. The surveillance and management of vector control was strengthened through capacity-building initiatives on invasive mosquitoes and (re-)emerging vector-borne diseases. In addition, awareness of the threat posed by vectors was raised through a national public health campaign aimed at stopping mosquitoes from breeding. With support from WHO and national partners, the public was informed about and empowered to take vector control measures.

Success story 7. Stopping mosquitoes breeding in Croatia

Croatia is one of the few countries in the European region in which locally transmitted dengue cases have been reported.

With an absence of effective treatment or vaccines against dengue, early detection of human cases and prevention through vector control are vital to protect vulnerable populations.

The national authorities, with WHO support, launched a national media campaign, entitled "Stop mosquitoes breeding". To improve its effectiveness, the campaign was intensified during the summer season, to coincide with the mosquito breeding season, and was targeted at the Dubrovnik region due to the important tourist influx. No human cases were detected during the biennium.

134. Work continued to improve nationwide vaccination coverage through WHO technical assistance to the national verification committee on the elimination and control of vaccine-preventable diseases.

135. To inform future policies on controlling AMR and to build evidence-based interventions, an assessment of outpatient antibiotic utilization and prescription practices was conducted, focusing on primary health care units.

136. Croatia improved health care coverage for diabetic management through several WHO-supported initiatives, such as the development of new guidelines, building on normative guidance, reviews and evaluation of existing standard operating procedures, and regional training courses at primary health care level.

137. In an effort to improve access to services for mental health, Croatia participated in a WHO-led project on adults with mental disabilities living in institutions in the European Region. The findings identified gaps, indicated required changes, and proposed gradual transition to community living to enable people with psychosocial and intellectual disabilities to live full lives.

138. To strengthen the public health response and influence policy initiatives to reverse the obesity epidemic, Croatia participated in the WHO Childhood Obesity Surveillance Initiative (COSI), which monitors trends in childhood obesity. In parallel, the development and updating of food-based dietary guidelines for children, and the national salt reduction strategy further sustained Croatia's momentum in reducing nutritional risk factors.

139. In the context of promoting the health of all members of its population, with WHO support Croatia conducted a policy review of health and employment to generate meaningful

information and awareness about vulnerable groups with health conditions affecting their ability to work and to create opportunities for participation and inclusion in employment/labour market for these vulnerable groups.

140. During the biennium, efforts were made towards increasing consumer safety. A biomonitoring survey of prenatal exposure to mercury was conducted and the results used in policy-making.

141. To contribute to the reduction of environmental threats to health, during the biennium a platform to discuss and increase awareness of the impact of climate change on health was created. This initiative led to the development of a national strategy with strengthened health-related climate change commitments and improved environmental risk mitigation efforts. With WHO's technical assistance, Croatian counterparts addressed the challenges of energy sustainability, climate change and the SDGs within the health system.

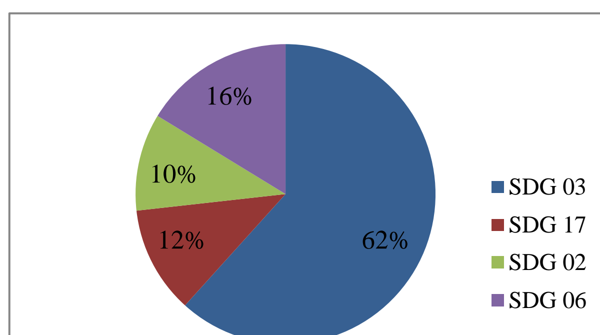
142. More details of WHO's work, funding and utilization of funds in Croatia can be found at: http://open.who.int/2016-17/country/HRV.

143. In 2018–2019 Croatia will continue to work with WHO, mainly focusing on the 11 priority programme areas identified through the BCA (see Box 9). With a clear focus on SDG 3, the planned activities will also contribute to three other SDGs (see Fig.13). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 9. Croatia's priorities for 2018-2019

1. HIV and hepatitis
2. Tuberculosis
3. Neglected tropical diseases
4. Noncommunicable diseases
5. Mental health and substance abuse
6. Nutrition
7. Food safety
8. Health and the environment
9. Integrated people-centred health services
10. Access to medicines and other health technologies and strengthening regulatory capacity
11. Country Health Emergency Preparedness and the International Health Regulations (2005)

Fig.13. PB 2018–2019 planned activities by SDG in Croatia



Czechia

144. During the biennium, Czechia continued to implement the National Strategy Health 2020, which is aligned with Health 2020, the 2030 Agenda and the SDGs.

145. To better manage NCDs and their risk factors, in implementing the National Action Plan on Health Risky Behaviour during this two-year period, the country developed a model for the treatment of dependency in children, and launched an information campaign and interventions to reduce tobacco and alcohol consumption. The May 2017 adoption and enforcement of a comprehensive Law on Protection of Health against the Harmful Effects of Addictive Substances was the result of WHO technical assistance and advocacy efforts.

146. The implementation of the Action Plan on Counteracting Obesity and the Action Plan on Nutrition and Dietary Habits continued to benefit from the knowledge of childhood obesity trends as a new COSI survey was conducted with WHO support and provided updated results.

147. To further improve access to mental health services, Czechia, with WHO technical advice and support, reformed psychiatric care and initiated the transformation of mental health care. A comprehensive quality assessment of long-stay institutions for adults with mental disabilities conducted during the biennium informed the development of the transformation plans and the drafting of the quality monitoring framework.

Success story 8. Applying WHO's QualityRights approach in mental health reform in Czechia

In common with many countries in central and eastern Europe, Czechia's mental health system is characterized by a high number of beds in long-stay institutional care settings and a low level of access to person-centred services embedded in the community.

With support from European structural and investment funds, the Government initiated the implementation of a large and ambitious programme of mental health system reform that will see a steady reduction in the number of mental hospital beds and the establishment of more than two dozen community mental health centres over the next 10 years.

WHO supported these efforts by providing strategic advice on the implementation and evaluation of key elements of the reform programme, including deinstitutionalization and stigma reduction, as well as building capacity and knowledge on institutional care standards and human rights protection via the application of WHO's QualityRights approach.

148. Increasing the proportion of older people who can maintain an independent life remained high on the agenda with the ongoing implementation of the national healthy ageing targets. With technical assistance from WHO, a concept of long-term care was prepared; a data model for the evaluation of health care in long-term care facilities was developed; and a palliative care needs assessment was conducted.

149. In an effort to reduce the risks of unintentional injuries the adoption of a graduated driver licensing system for novice drivers was promoted with WHO support by the Violence and Injury Prevention Working Group at the Ministry of Health that assessed road traffic injuries caused by young people drink-driving.

150. Violence prevention and response was strengthened with the drafting of guidelines and training materials on the provision of care to victims of domestic and gender-based violence, through a joint initiative of Ministry of Health, the Senate and WHO.

151. During the biennium, WHO collaborated with Czechia to further the implementation of the Health Impact Assessment, with a review of the current situation leading to the identification of capacity and data needs and the recommendation for further Health Impact Assessment strengthening as an intersectoral tool. Czechia also contributed to the update of the WHO Health Promoting Hospitals standards manual.

152. To advance the functioning of its health information system to support up-to-date national health policies, the national e-health strategy was endorsed during the biennium, after a lengthy discussion and negotiation process.

153. During the biennium, a subnational assessment of the national health-care information system was developed and piloted in several regions. The initial comments, suggestions and recommendations were incorporated into the final version that was disseminated across the 14 regions of Czechia in October 2016.

154. Reiterating its international commitment to reducing environment threats to health, Czechia hosted the Sixth Ministerial Conference on Environment and Health in Ostrava. This important regional event a led to the adoption of the Ostrava Declaration on better health, better environment and sustainable choices in the European Region.

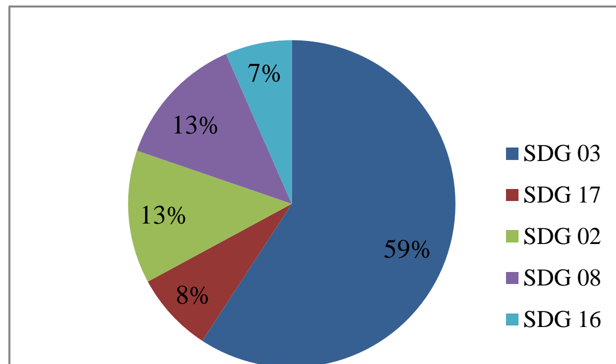
155. More details of the WHO work, funding and utilization in Czechia can be found at: http://open.who.int/2016-17/country/CZE.

156. In 2018–2019 Czechia will continue to work with WHO, mainly focusing on the 11 priority programme areas identified through the BCA (see Box 10). While close to 60% of the planned activities will contribute to SDG 3, SDG 2 and SDG 8 will also receive important attention during 2018–2019 (see Fig. 14). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 10. Czechia's priorities for 2018–2019

1. Antimicrobial resistance
2. Noncommunicable diseases
3. Mental health and substance abuse
4. Violence and injuries
5. Nutrition
6. Reproductive, maternal, newborn, child and adolescent health
7. Ageing and health
8. Health and the environment
9. National health policies, strategies and plans
10. Integrated people-centred health services
11. Health systems, information and evidence

Fig. 14. PB 2018–2019 planned activities by SDG in Czechia



Estonia

157. In an effort to improve the sustainability of health financing, the Estonian parliament approved a broadening of the health insurance revenue base through direct state budget transfers to the health insurance fund on behalf of non-working pensioners. This noteworthy decision was the result of a long-term advocacy and policy dialogue built on WHO recommendations and longstanding policy support. In addition, a reimbursement scheme to cover high pharmaceutical expenditures was implemented, which is expected to provide better financial protection.

Success story 9. Broadening the base of health insurance to move towards universal health coverage in Estonia

Estonia's heavy reliance on the working population's wage-based contributions, relatively low-level health expenditures (against comparable countries) and gaps in financial protection have been concerns for more than a decade.

WHO's long-standing policy support in Estonia through advice, advocacy, policy dialogue facilitation, and production of evidence on financial sustainability and protection, led to tangible results during 2016–2017 when policy recommendations were discussed at the highest political level.

Advocacy to improve financial protection and to introduce health financing reforms, in order to move towards universal health coverage was successful even given the country's fiscal constraints. At the end of 2017, building on the recommendations by WHO, the parliament passed legislation to broaden the revenue base of health insurance: a state budget allocation would be made on behalf of non-working pensioners; in addition, to provide better financial protection to people with high out-of-pocket expenditures on medicines, an additional compensation system was introduced.

158. The percentage of daily smokers in Estonia has decreased from 33% in 1994 to 21% in 2016. During the biennium, Estonia continued its efforts to reduce the burden of NCDs, namely by approving and implementing stricter tobacco-control measures aligned with the provisions of the WHO FCTC. Key measures implemented during the biennium included bans on displays of tobacco products at points of sale, the introduction of pictorial warnings on tobacco packaging, regulation of e-cigarettes, and measures to curb sales to minors and illegal sales. WHO supported these measures with evidence, policy advice and advocacy.

159. The reduction of NCD risk factors remained high on the health agenda during the biennium. Estonia approved restrictions on marketing and sale of alcohol products and generated evidence and normative work to support the necessary public health policies: a policy paper on nutrition and physical activity was drafted with WHO support.

160. An evidence brief for policy on reducing consumption of sugar-sweetened beverages produced under the EVIPNet initiative was followed by a high-level policy dialogue and led to the elaboration of a national tax proposal by the ministries of health and finance. The proposed tax on sugar-sweetened beverages was approved by the parliament. The tax debates were supported with evidence and technical advice provided by WHO that included modelling of tax impacts, data collection and publication of results on childhood overweight and obesity under COSI.

161. Access to services for substance abuse disorders was increased with strengthened capacity to provide opioid substitution therapies. WHO supported the training of national authorities and sharing of other country experiences. In mental health, WHO worked with partners to increase awareness of depression during World Health Day and World Mental

Health Day and on dementia at a conference on mental health and ageing. Moreover, policy advice was given on suicide prevention and a QualityRights assessment of standards and human rights was undertaken in long-term institutions for people with mental disabilities.

162. To reduce the burden of HIV, the Estonian Government adopted the National HIV Action Plan for 2017–2025 to speed up progress in tackling HIV. The Action Plan aims to meet the 90-90-90 targets set by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and WHO.

163. To continue with the work on vaccination coverage, and to prepare for the HPV vaccine launch scheduled for early 2018, WHO supported national counterparts in Estonia with the development of the relevant communication tools and materials.

164. During the biennium WHO organized a table-top exercise to identify gaps in, and the strengths of, prevention and control of health-care acquired infections, generating recommendations for policy on the subject.

165. Throughout the biennium and with WHO support, several policy dialogues took place that helped advance efforts with regard to health policies in three major areas: availability of pharmaceuticals, improving patient safety and strengthening primary care. WHO provided the recommendations and facilitated round-table discussions and provided a platform for cross-country learning at the Baltic Policy Dialogue.

166. WHO-supported training and cross-country learning led to improved national capacity to conduct health impact assessments, and to expand chemical safety.

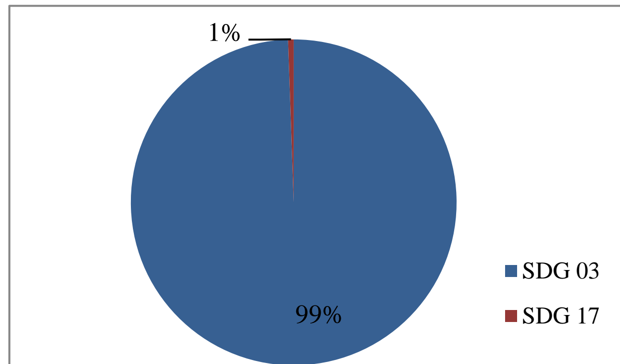
167. More details of WHO's work, funding and utilization of funds in Estonia can be found at: http://open.who.int/2016-17/country/EST.

168. In 2018–2019 Estonia will continue to work with WHO, mainly focusing on the 10 priority programme areas identified through the BCA (see Box 11). Most of the planned activities will contribute to SDG 3 (see Fig. 15). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 11. Estonia's priorities for 2018–2019

1. HIV and hepatitis
2. Vaccine-preventable diseases
3. Antimicrobial resistance
4. Noncommunicable diseases
5. Mental health and substance abuse
6. Health and the environment
7. National health policies, strategies and plans
8. Integrated people-centred health services
9. Access to medicines and other health technologies and strengthening regulatory capacity
10. Health systems, information and evidence

Fig. 15. PB 2018–2019 planned activities by SDG in Estonia



Georgia

169. To increase capacity to deliver key hepatitis interventions, Georgia endorsed the Hepatitis C Elimination Strategy 2016–2020 in 2015. Between April 2015 and February 2018 1.2 million tests were done and approximately 40 000 individuals were treated and cured, mainly during 2016–2017, thanks to the collaboration between the national authorities, WHO and two main partners: Gilead Sciences and the United States Centers for Disease Control and Prevention.

170. To reduce the burden of TB through sustainably financed TB management, Georgia continued to implement the National Strategic Plan for TB Control in Georgia 2016–2020 with WHO support. The National Strategic Plan aims to sustain universal access to diagnosis and treatment during the transition period and after the Global Fund phases out its support in this area.

171. With regard to vaccination coverage, WHO assisted Georgia in updating measles and rubella guidelines and in nationwide capacity-building efforts for all medical personnel. In addition, during the biennium, Georgia implemented GAVI transition plan activities for immunization programme strengthening and the country launched HPV vaccination free of charge for most of the population with WHO support.

172. To increase access to interventions to prevent and manage NCDs and their risk factors, Georgia conducted a knowledge, attitudes and practices survey for NCD prevention and control at primary health care centres and a STEPS survey in 2016. The results represent the initial steps in managing NCDs nationwide and led to the adoption by the Government of the National Strategy and Action Plan for NCDs 2016–2020, that clearly defines the way forward in addressing the challenges of NCDs in Georgia.

173. During the biennium, a modern tobacco-control law positioned Georgia among most advanced countries in the area of tobacco control. Among other things, the law (gradually) introduces a ban on smoking in public indoor places; a ban on advertising and promotion; and larger health warnings and plain packaging. WHO, together with the Secretariat of the WHO FCTC, provided support to the work on tobacco control.

174. To improve the health of children and adolescents in Georgia, a pilot survey on HBSC was completed, enabling the country to participate in a full HBSC survey and to generate broader evidence for policy-making.

175. The endorsement of the National Environmental Health Action Plan (NEHAP-2) and the National Strategy 2017–2021 established these multisectoral platforms on reducing the environmental threats to health in Georgia.

176. Through the Universal Health Coverage Partnership supported by WHO, the EU and Luxembourg, Georgia continued to advance towards universal health coverage. While the main impact will only be visible in the medium and longer term, the following are highlights from the biennium: implementation of the national action plan for strategic purchasing; introduction of selective contracting (delivery hospitals); assessment of Social Services Agency capacity; feasibility analysis and a diagnosis-related group (DRG) implementation plan; and drafting of patient pathways for diabetes type 2. Furthermore, WHO continued to provide assistance to Georgia in strengthening its public health services.

Success story 10. Strengthening the health system to reduce maternal and neonatal mortality in Georgia

Georgia's frail health system was hindering improvements in maternal and neonatal mortality.

WHO advocated for strong political commitment to achieving universal health coverage. Together with its national counterparts, WHO developed a system to select and contract maternity care services and defined clear selection criteria.

In addition, Ministry of Health and purchasing agency capacity to contract health care providers was improved.

The new contracting system ensures appropriate geographical distribution of providers, resulting in more equitable access to health services nationwide and better use of limited resources.

177. To advance health information and evidence for policy-making, a country profile on health and well-being was launched during the biennium and WHO assisted the authorities (running training courses and securing training materials) in strengthening the national health information system (improving the quality of registered causes of death).

178. To better meet its obligations under the IHR (2005), Georgia translated into the local language a series of key documents (e.g. *Guide to ship sanitation and Handbook for inspection of ships and issuance of ship sanitation certificates*) to be used at entry points.

179. In line with the global action plan on antimicrobial resistance, the Georgian Government endorsed the National AMR Strategy.

180. During the biennium, Georgia's polio environmental surveillance systems enabled the detection of polio-like viruses in high-risk areas.

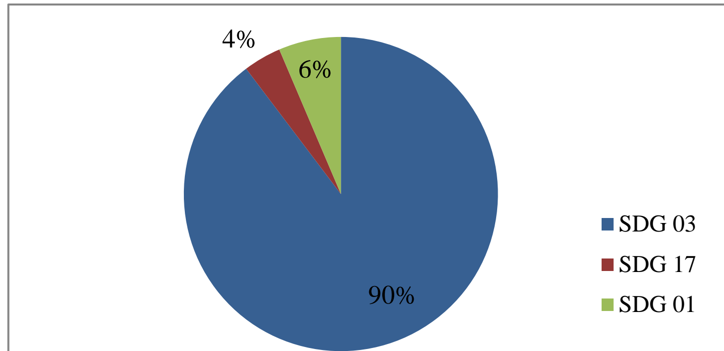
181. More details of WHO's work, funding and utilization of funds in Georgia can be found at: http://open.who.int/2016-17/country/GEO.

182. In 2018–2019 Georgia will continue to work with WHO, mainly focusing on the 14 priority programme areas identified through the BCA (see Box 12). The planned activities will contribute mainly to SDG 3 (see Fig. 16). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 12. Georgia's priorities for 2018–2019

1. HIV and hepatitis
2. Tuberculosis
3. Vaccine-preventable diseases
4. Antimicrobial resistance
5. Noncommunicable diseases
6. Reproductive, maternal, newborn, child and adolescent health
7. Health and the environment
8. National health policies, strategies and plans
9. Integrated people-centred health services
10. Access to medicines and other health technologies and strengthening regulatory capacity
11. Health systems, information and evidence
12. Polio eradication
13. Infectious Hazard Management
14. Country Health Emergency Preparedness and the International Health Regulations (2005)

Fig. 16. PB 2018–2019 planned activities by SDG in Georgia



Hungary

183. WHO support to Hungary during the biennium was instrumental in solidifying efforts to address the burden of NCDs, and risk factors such as poor nutrition and tobacco use.

184. In an effort to reduce nutritional risk factors, Hungary developed a multisectoral action plan to address childhood obesity that engaged not only the health sector but also the education, sports and finance sectors. During 2016–2017 Hungary implemented a comprehensive set of measures ranging from legislation (a ban on trans-fats) and financial acts (a public catering act) to targeted health policies (expansion of the national physical activity programme) to create the foundations for a comprehensive and sustainable framework curbing childhood obesity.

185. With WHO support the trans-fat ban was evaluated as a health-promotion measure and, subsequently, a policy dialogue was undertaken, which engaged with senior policy-makers and leading country experts, to review the policy measures needed to sustain the achievements made so far.

186. With regard to the other key risk factor – tobacco – during the biennium, Hungary developed a tobacco-control action plan on the basis of a situation analysis. The latter benefited from WHO expertise and the action plan was successfully piloted, also with WHO support, in two regions of Hungary, focusing on two components of the plan: health promotion and smoking cessation.

187. As part of a wider WHO project on adults with mental disabilities living in institutions in the European Region, two institutions in Hungary were assessed and the general findings and the Hungary-specific concerns will serve as evidence to support future policy decisions to increase access to services for mental health.

188. During the biennium, Hungary finalized and published a health system performance assessment (HSPA) with the aim of institutionalizing it as a sustainable platform for informed policy-making. WHO's guidance on HSPA methodology and coordination of other European experts were critical to the endeavour. Intense debate in the public health community and the public at large generated from the published findings of the HSPA led to WHO supporting a public perception assessment and the development of a communication plan that will inform and support policy-makers with regard to future HSPA rounds.

Success story 11. Health system performance assessment for efficient health planning in Hungary

Over the years, Hungary could not rely on structured and systematic HSPAs as the basis for national health policy decision-making.

Together with WHO, the Ministry of Health developed an HSPA framework to establish a comprehensive performance monitoring tool during 2016–2017. Furthermore, the Ministry enhanced its capacity to evaluate health systems performance and to monitor the impact of health policy interventions.

The first Hungarian HSPA report was published in 2017, presenting the findings from the assessed period (2013–2015) and several policy dialogue events were scheduled, based on the structured findings.

189. In line with the implementation of the global action plan on AMR, and with the support of EVIPNet, operating under the aegis of the WHO European Health Information Initiative,

Hungary developed an evidence policy brief on AMR. The national EVIPNet country team engaged with multiple stakeholders to identify three policy options that were presented to professionals and policy-makers at a policy dialogue envisioning the creation of sustainable capacity for AMR prevention and control in Hungary. An evidence brief for policy on AMR and a situation analysis on national evidence-informed policy processes in health research policy and systems were developed as a result.

190. Immunization coverage remained high in Hungary during the biennium. To sustain the high levels throughout the period, immunization information sheets for parents were prepared and distributed nationally within primary health care centres and among general practitioners.

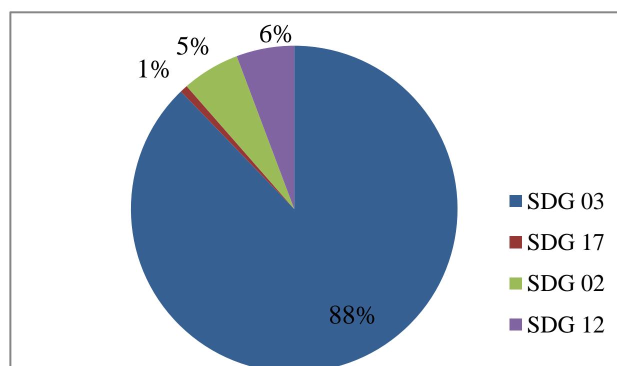
191. More details of WHO's work, funding and utilization of funds in Hungary can be found at: http://open.who.int/2016-17/country/HUN.

192. In 2018–2019 Hungary will continue to work with WHO, mainly focusing on the nine priority programme areas identified through the BCA (see Box 13). The planned activities will contribute to four SDGs although a very strong focus is given to SDG 3 with close to 90% of the planned activities (see Fig. 17). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 13. Hungary's priorities for 2018–2019

1. HIV and hepatitis
2. Noncommunicable diseases
3. Mental health and substance abuse
4. Nutrition
5. Reproductive, maternal, newborn, child and adolescent health
6. Health and the environment
7. National health policies, strategies and plans
8. Integrated people-centred health services
9. Health systems, information and evidence

Fig. 17. PB 2018–2019 planned activities by SDG in Hungary



Kazakhstan

193. During the biennium, the interdependence of health and development, as highlighted in the European health policy, Health 2020, and in the SDGs, received the highest political recognition in Kazakhstan with the adoption of the national programme on health-care development “Densaulyk” for 2016–2019. The programme has the overall goal of improving health to ensure sustainable social and economic development, and was developed with WHO support. Given the priority of strengthening intersectoral cooperation, Kazakhstan set up an interministerial council on health, reporting to the Vice-Prime Minister.

194. The national strategic documents (“Kazakhstan 2050 strategy”, “100 steps to achieve the five institutional reforms”) developed during the period are consistent with WHO policies and frameworks. Moreover, they highlighted the need to tackle risk factors for health and to strengthen primary health care as priority public health interventions.

195. Kazakhstan further strengthened the stewardship function through the adoption of a new public health concept in 2017 that is fully aligned with the WHO European Action Plan for Strengthening Public Health Capacities and Services. With the adoption of this concept, public health structures and functions were reintegrated within the Ministry of Health. Furthermore, Kazakhstan became the first central Asian country to join the WHO European Healthy Cities Network with the accreditation of the city of Almaty.

196. Kazakhstan’s capacity to address the challenge of AMR was considerably strengthened by the establishment of an interministerial commission and the development of a strategic plan on containment of antimicrobial resistance, facilitated with WHO technical support.

197. In an effort to increase access to integrated, people-centred services, Kazakhstan integrated specialized care core services into primary health care, in line with Regional Committee resolution EUR/RC66/R5.

Success story 12. Better screening to reach the multidrug-resistant TB (MDR-TB) treatment targets in Kazakhstan

For many years Kazakhstan was afflicted with a high burden of TB and MDR-TB.

During the biennium, the country benefited from intensive technical support from WHO. Working with key national and international partners, the country embarked on a comprehensive set of measures recommended by WHO.

New diagnostic and treatment regimens were introduced, health services were adapted to better address TB patients’ needs, significant investments were made in the national system and the national guidelines were reviewed.

As an outcome of the holistic approach, Kazakhstan managed to almost reach the 75% multidrug-resistant

198. Kazakhstan’s efforts to combat NCDs have been significantly strengthened with the introduction of an NCD management programme at the primary health care level, as part of the cooperation with WHO during the biennium.

199. WHO’s expertise supported Kazakhstan in the establishment of a national quality of care assurance mechanism: the integrated commission on health services.

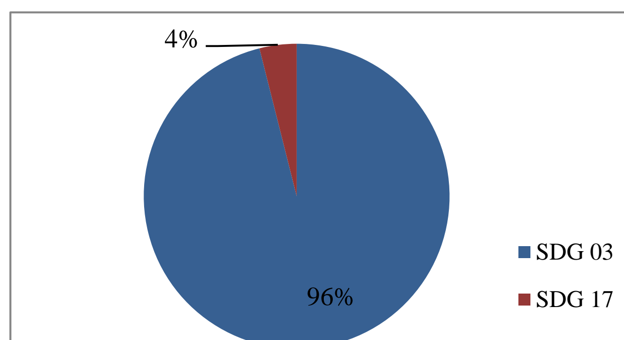
200. More details of WHO’s work, funding and utilization of funds in Kazakhstan can be found at: http://open.who.int/2016-17/country/KAZ.

201. In 2018–2019 Kazakhstan will continue to work with WHO, mainly focusing on the 15 priority programme areas identified through the BCA (see Box 14). More than 95% of the planned activities will contribute to SDG 3 while the remainder will be focused on SDG 17 (see Fig. 18). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 14. Kazakhstan's priorities for 2018–2019

1. Tuberculosis
2. Vaccine-preventable diseases
3. Antimicrobial resistance
4. Noncommunicable diseases
5. Violence and injuries
6. Food safety
7. Reproductive, maternal, newborn, child and adolescent health
8. Health and the environment
9. National health policies, strategies and plans
10. Integrated people-centred health services
11. Access to medicines and other health technologies and strengthening regulatory capacity
12. Health systems, information and evidence
13. Polio eradication
14. Infectious Hazard Management
15. Country Health Emergency Preparedness and the International Health Regulations (2005)

Fig. 18. PB 2018–2019 planned activities by SDG in Kazakhstan



Kyrgyzstan

202. Kyrgyzstan is aiming to harmonize its sectoral programmes with a new national sustainable development strategy to 2040, and with the global SDGs. With WHO support, the health sector spearheaded the adaptation of the SDGs to the national context and the development of related indicators.

203. The national development strategy, the fourth-generation health strategy and preparation of various programmes (including on hepatitis, TB control, tobacco control, alcohol control, mental health, and the public laboratory network), as well as midterm reviews of other documents, were informed by best practices and WHO normative frameworks. WHO convened development partners to support health strategy implementation and consistent policy dialogue for strategic and evidence-informed decision-making.

Success story 13. Elevating the profile of health in Kyrgyzstan's strategic agenda

In 2014 Kyrgyzstan adopted its national health policy to 2020 (Health Protection and Promotion Strategy of the Kyrgyz Republic) and established a high-level mechanism under the Vice-Prime Minister to support intersectoral cooperation and coordination, the Coordinating Council on Public Health of the Kyrgyzstan (CCPH).

Over the years, WHO has supported Kyrgyzstan to strengthen the functioning of the CCPH: reviewing the mechanisms and instruments for implementation of intersectoral action; holding a health diplomacy training course in relation to universal health coverage and an intersectoral dialogue chaired by the Minister of Health and co-hosted by the Diplomatic Academy of the Kyrgyz Ministry of Foreign Affairs; and supporting a high-level intersectoral round table and bringing together sectors from across the Government, including the Office of the President and the parliament.

These efforts helped position health and well-being prominently in national strategies and plans, and improved capacity for governance for health and well-being at the national level.

204. In 2016 WHO certified Kyrgyzstan as a malaria-free country, which was a result of comprehensive antimalarial interventions and the efforts made over the years to strengthen surveillance systems.

205. WHO provided technical assistance and capacity building through various partners, which helped reduce the prevalence of soil-transmitted helminth infections among school-aged children in Kyrgyzstan from 56% to 13.2% thanks to deworming campaigns.

206. The national immunization programme was reviewed and, in 2016, pneumococcal conjugate vaccine was introduced in Kyrgyzstan with the support of WHO to prevent severe diseases such as pneumonia and meningitis; since late 2017, seasonal influenza vaccine coverage was doubled with WHO prequalified vaccine.

207. The second edition of the WHO pocket book of management of common childhood illnesses was adapted and disseminated among health-care professionals, including as a mobile application; confidential enquiries into maternal deaths were institutionalized with WHO's support, and support to further scaling up of near-miss care reviews was provided.

208. With WHO assistance, United Nations agencies were convened to support the NCD agenda, performance reviews of primary care and specialized care were conducted to improve access to, and quality of, NCD services, and three key NCD risk factor surveys were

conducted to generate evidence for policy-making (on the urban food environment, knowledge attitudes and practices regarding tobacco and alcohol use, and alcohol taxation).

209. Following a policy dialogue on tobacco control led by WHO during the biennium, the country introduced graphic warnings on tobacco products.

210. With the second-highest road traffic mortality rate in the European Region, capacity building among various sectors and Kyrgyzstan's participation in global forums helped to increase awareness of the dangers of excessive speed and to generate measures to address these dangers.

211. WHO's high-level policy dialogue on universal health coverage led to increased awareness of the need to ensure financial protection and the importance of access to medicines. The first strategy of the Mandatory Health Insurance Fund was developed to strengthen governance and increase purchasing capacity; steps were taken to establish strategic purchasing through the revision of contracting mechanisms with hospitals.

212. In an effort to improve access to safe and effective medicines and medical products and to lighten the financial burden on citizens, Kyrgyzstan's parliament approved a regulation package during the biennium, by means of which the state can regulate the price of medicines to make them more affordable. In addition, protective mechanisms have been introduced to safeguard the market from poor-quality products, and post-marketing controls monitor the effectiveness and side-effects of drugs in the market. A review of the drug regulation agency, together with capacity building, aims to enable the national authorities to implement the regulation effectively. WHO supported the drafting of all relevant legal documents, provided evidence and supported the policy dialogue to ensure Government approval.

213. An external evaluation of IHR (2005) capacities was carried out in 2016, followed by action to improve national emergency preparedness and response capacity: 70 hospitals (half of the public facilities) were evaluated to support further infrastructure investments.

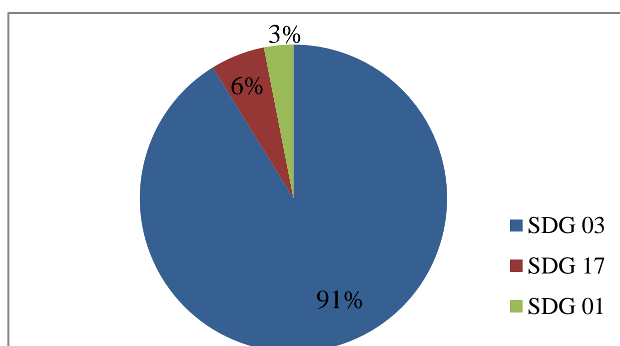
214. More details of WHO's work, funding and utilization of funds in Kyrgyzstan can be found at: http://open.who.int/2016-17/country/KGZ.

215. In 2018–2019 Kyrgyzstan will continue to work with WHO, mainly focusing on the 13 priority programme areas identified through the BCA (see Box 15). The planned activities will contribute to three SDGs, albeit SDG 3 has most of the attention (see Fig. 19). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 15. Kyrgyzstan's priorities for 2018–2019

1. Tuberculosis
2. Vaccine-preventable diseases
3. Antimicrobial resistance
4. Noncommunicable diseases
5. Food safety
6. Reproductive, maternal, newborn, child and adolescent health
7. National health policies, strategies and plans
8. Integrated people-centred health services
9. Access to medicines and other health technologies and strengthening regulatory capacity
10. Health systems, information and evidence
11. Polio eradication
12. Infectious Hazard Management
13. Country Health Emergency Preparedness and the International Health Regulations (2005)

Fig. 19. PB 2018–2019 planned activities by SDG in Kyrgyzstan



Latvia

216. Based on the health needs assessment analysis for Latvia for 2016–2017, the collaboration between Latvia and WHO during the biennium focused on developing and implementing health policies, specifically addressing NCDs, communicable diseases, mental health, nutrition, violence and injuries, health financing, health system strengthening and maternal and child health.

217. Latvia's response to communicable diseases was scaled up with the development of a new national HIV, sexually transmitted infections and hepatitis programme aimed at progressing towards WHO-recommended ART policies and practices and introducing protocols to eliminate mother-to-child transmission of HIV.

218. Latvia also made advances in its NCD agenda: owing to strong evidence, such as that provided by COSI and HBSC, for the importance of nutrition and exercise in health, a comprehensive approach to nutrition and diet-related NCDs across the life course was implemented (including providing guidelines on nutrition for pregnant women, national regulations on school meals, and a road map for physical activity in schools), through strengthened cross-sectoral cooperation. Furthermore, national capacity was strengthened through workshops on salt reduction strategies and on other selected nutrients in food products.

219. As part of a WHO project on adults with mental disabilities living in institutions in the Region, four Latvian institutions underwent a quality assessment, with the findings providing evidence for subsequent policy decisions in mental health services reform.

220. Continuing its efforts towards preventing child maltreatment, the Latvian parliament held a high-level policy dialogue engaging the government and other key stakeholders, with the dialogue being informed by the results from an Adverse Childhood Experiences (ACE) survey conducted in Latvia during the biennium, as well as a national report on child maltreatment in Latvia. Moreover, a WHO Nordic–Baltic technical workshop on child maltreatment also helped raise awareness and allowed an exchange of international experience and best practices among professionals from multiple sectors in the region.

Success story 14. Preventing interpersonal violence in Latvia

Before the biennium, rates of violence against children and women in Latvia had been among the highest in the Region.

During the biennium, together with WHO, Latvia pushed for high-level advocacy to stop violence in the country. The first national report on violence and health in Latvia was commissioned in 2017. National guidelines on a response to intimate partner violence were developed, and a capacity-building programme using WHO's TEACH-VIP curriculum was implemented in Latvia's medical schools.

In addition, a series of national programmes for the prevention of domestic violence, together with the Nordic–Baltic meeting on the prevention of child maltreatment, which was held in Riga in 2017, have set the course for an improved intersectoral response to preventing interpersonal violence in Latvia.

221. As Latvia has one of the highest levels of out-of-pocket payments in the Region, strengthening the Latvian health system with respect to health financing was another important area of focus for the Latvian Ministry of Health and WHO during the biennium.

222. Data on health financing in Latvia, collected throughout the biennium, supported a comprehensive policy-making process that culminated in the adoption of a new health financing law (which was approved by the Latvian parliament in December 2017) that stipulates that, by 2020, 4% of Latvia's GDP should be used to improve access to health services. In addition, the Scandinavian DRG system, NordDRG, was introduced in Latvian hospitals.

223. During the biennium, WHO assisted Latvia in advancing national health information systems through conducting a rapid e-health assessment, which enabled the development of a national e-health service platform by evaluating operational requirements, standardization and interoperability, and fostering a dialogue between local and international stakeholders. In addition, during the biennium, it became mandatory to use an electronic platform for the issuance of sick-leave certificates and state-compensated prescriptions.

224. To improve women's health through strengthening the cross-sectoral response to maternal mortality, confidential queries into maternal death and near-miss care reviews were made standard practice in Latvia. In addition, maternal mortality analysis was conducted for all maternal death cases during a three-year period to generate evidence to support further policy-making.

225. WHO supported Latvia's capacity to manage public health risks associated with emergencies by carrying out a JEE in 2017. The results of the evaluation led to an action plan that will help the country improve national capacities for emergency preparedness and response.

226. Advocacy activities conducted throughout the biennium, including the World Health Day celebrations, World Antibiotic Awareness Week and a seasonal influenza campaign, contributed to better health awareness in Latvia.

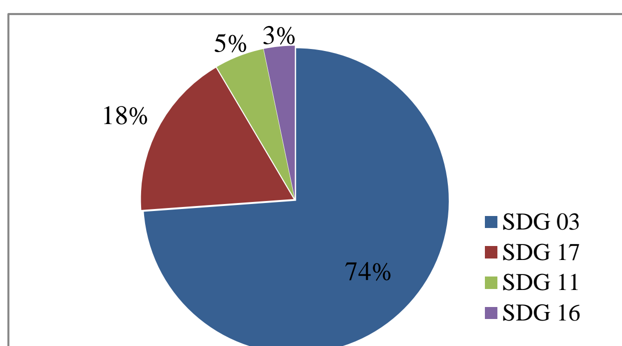
227. More details of WHO's work, funding and utilization of funds in Latvia can be found at: http://open.who.int/2016-17/country/LVA.

228. In 2018–2019 Latvia will continue to work with WHO, mainly focusing on the 12 priority programme areas identified through the BCA (see Box 16). The activities planned are mainly relevant to SDG 3 (see Fig. 20). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 16. Latvia's priorities for 2018–2019

1. Vaccine-preventable diseases
2. Antimicrobial resistance
3. Noncommunicable diseases
4. Mental health and substance abuse
5. Violence and injuries
6. Nutrition
7. Reproductive, maternal, newborn, child and adolescent health
8. Health and the environment
9. National health policies, strategies and plans
10. Integrated people-centred health services
11. Access to medicines and other health technologies and strengthening regulatory capacity
12. Health systems, information and evidence

Fig. 20. PB 2018–2019 planned activities by SDG in Latvia



Lithuania

229. During the biennium, to address the burden of communicable diseases, Lithuania's national TB programme was reviewed by a joint WHO and ECDC mission, and its findings and recommendations generated evidence for future interventions by the Lithuanian Ministry of Health.

230. Lithuania has one of the highest alcohol consumption rates in the Region; the country took a major step towards reducing this risk factor during the biennium by amending laws on alcohol control to incorporate three of the "best buys" recommended by the WHO – banning alcohol advertising, implementing marketing restrictions on alcohol, and increasing taxes on alcohol – along with taking other measures, such as raising the legal drinking age.

231. In an effort to increase access to NCD interventions during the biennium, the Lithuanian Ministry of Health and WHO organized a workshop to promote better intersectoral collaboration for improved NCD outcomes in 2017, focusing on salt reduction efforts. In addition, Lithuania ratified the Protocol to Eliminate Illicit Trade in Tobacco Products, and collaborated with WHO to support country awareness efforts (e.g. media campaigns and awareness programmes for family doctors) and to develop and manage quitlines.

232. To strengthen mental health services during the biennium, Lithuania developed a draft mental health law and a draft evidence brief for policy on the role of gatekeepers in suicide prevention under the EVIPNet initiative. In addition, the 2017 World Health Day activities dedicated to the prevention of depression sparked discussions on this topic throughout the year in Lithuania. In an effort to improve access to services for mental health and promote human rights, Lithuania also participated in a WHO project on adults with mental disabilities living in institutions in the Region; at the end of this project, findings from a survey conducted in four institutions identified gaps in care and suggested ways to address them.

233. During the biennium, injuries and violence prevention remained high on the agenda in Lithuania: a high-level multisectoral policy dialogue on promoting parenting and child-maltreatment-prevention activities was held, and a law banning corporal punishment was passed. WHO further supported Lithuania in this area by providing information on approaches used by other countries to prevent violence against children and by sponsoring the United Nations Global Road Safety Week.

234. During the biennium, Lithuania continued to monitor childhood obesity trends by participating in the fourth round of the WHO COSI survey, which led to stronger management of the nutritional risk factors responsible for this issue.

235. In addition, Lithuania continued with efforts to increase health equity by performing capacity-building activities and collecting evidence to inform future strategies for achieving SDGs on health and health equity.

236. To reduce environmental threats to health, Lithuania, with support from WHO, increased indoor pollution risk assessment capacities and completed a review of the impact of temperature changes (heat and cold) on health. Results in both areas were presented and discussed in stakeholders' meetings that took place during the biennium. Environment and health impact assessment capacities were also strengthened through a WHO workshop that incorporated the Lithuanian context and data.

237. In addition, continuous capacity-building activities on evidence-informed policy-making took place throughout the biennium in Lithuania and included participation in both national and international events and activities.

238. Influenza vaccination coverage among pregnant women increased from <0.5% (2015) to an average of 4.5% (2017), following a two-year tailoring immunization programmes for seasonal influenza (TIP FLU) pilot in Kaunas.

Success story 15. Implementing Lithuania's national vaccination campaign for seasonal influenza

Before the start of the biennium, seasonal influenza vaccination rates among vulnerable population groups, such as pregnant women, in Lithuania were low. Therefore, during the biennium, several national and local partners worked together with WHO to improve communication on this issue and disseminate evidence-based information on the vaccine.

In addition, they created a pilot TIP FLU in Kaunas; this led to an increase in vaccine uptake, which rose from less than 0.5% to 4.5%. The programme was then scaled up to the whole country by WHO and national health officials, who subsequently received the "Annual Public Health Leader Award 2017" for their efforts in this area.

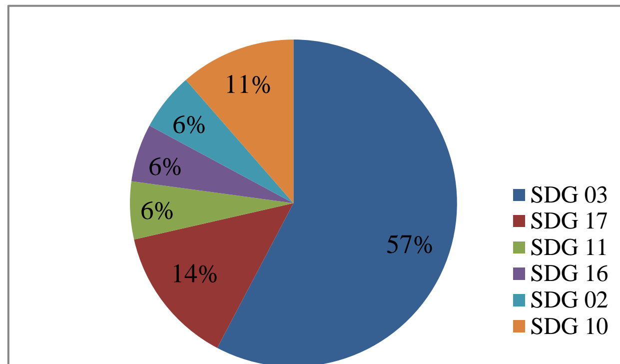
239. More details of WHO's work, funding and utilization of funds in Lithuania can be found at: http://open.who.int/2016-17/country/LTU.

240. In 2018–2019 Lithuania will continue to work with WHO, mainly focusing on the 14 priority programme areas identified through the BCA (see Box 17). The activities planned are mainly relevant to SDG 3 (see Fig. 21). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 17. Lithuania's priorities for 2018–2019

1. HIV and hepatitis
2. Tuberculosis
3. Noncommunicable diseases
4. Mental health and substance abuse
5. Violence and injuries
6. Nutrition
7. Reproductive, maternal, newborn, child and adolescent health
8. Ageing and health
9. Health and the environment
10. Equity, social determinants, gender equality and human rights
11. National health policies, strategies and plans
12. Integrated people-centred health services
13. Access to medicines and other health technologies and strengthening regulatory capacity
14. Health systems, information and evidence

Fig. 21. PB 2018–2019 planned activities by SDG in Lithuania



Montenegro

241. To increase access to interventions to prevent and manage NCDs and their risk factors, Montenegro established a national NCD council which is chaired by the prime minister, which is tasked with coordinating a national response to the NCD epidemic.

242. Throughout the biennium, Montenegro generated evidence to inform policy-making. Noteworthy accomplishments include WHO's contribution to assessments, surveys and studies, such as the investment cases on NCDs and AMR, an assessment of primary health care performance to effectively manage NCDs, and studies on air pollution and health impacts, tobacco and alcohol, obesity in adults and children, and daily salt intake.

243. With WHO assistance, several initiatives were taken to help Montenegro make progress on the agreed public health priorities. A normative framework on access to safe medicines was developed.

244. With the support of EVIPNet, operating under the aegis of the WHO European Health Information Initiative, Montenegro formed a national working group to develop an EVIPNet evidence brief for policy on AMR.

245. In addition, as part of the implementation of the draft global action plan on AMR, the country developed guidelines aimed at rational use of antibiotics as well as for the prevention of sexually transmitted infections.

246. With WHO support, a WHO-accredited national AMR reference laboratory was established in Montenegro, and capacities were built to coordinate effective, epidemiologically sound surveillance of AMR among common pathogens in the community and hospitals.

Success story 16. Tackling drug resistance fears in Montenegro

With the second-highest consumption of antibiotics per capita in the Region, Montenegro's fears of drug resistance are on the increase.

Starting with a review of national capacities for AMR, using a multisectoral approach, WHO supports the Montenegrin Ministry of Health in setting up a national strategic framework as well as strengthening AMR surveillance and monitoring capacity.

During the biennium, Montenegro approved a national strategy on AMR (aligned with the global strategy) and initiated the implementation of an operational national AMR surveillance system over five years, including the establishment of a national AMR reference laboratory.

247. In 2016, Montenegro launched its voluntary national review of SDGs and the national sustainable development strategy. The country aims to integrate global sustainable development targets and indicators in the national frameworks.

248. More details of WHO's work, funding and utilization of funds in Montenegro can be found at: http://open.who.int/2016-17/country/MNE.

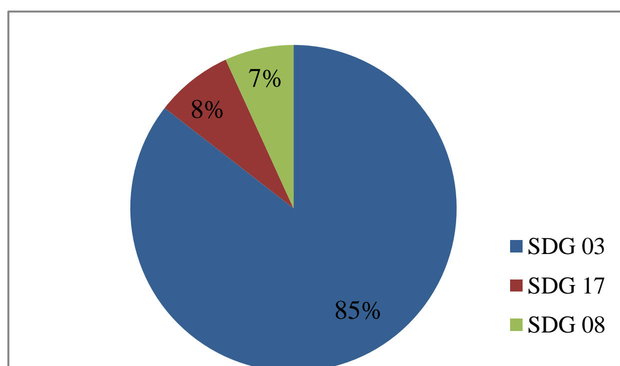
249. In 2018–2019 Montenegro will continue to work with WHO, mainly focusing on the 13 priority programme areas identified through the BCA (see Box 18). The activities planned

are mainly relevant to SDG 3 (see Fig. 22). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 18. Montenegro's priorities for 2018–2019

1. HIV and hepatitis
2. Tuberculosis
3. Vaccine-preventable diseases
4. Antimicrobial resistance
5. Noncommunicable diseases
6. Mental health and substance abuse
7. Violence and injuries
8. Disabilities and rehabilitation
9. Reproductive, maternal, newborn, child and adolescent health
10. Health and the environment
11. National health policies, strategies and plans
12. Integrated people-centred health services
13. Access to medicines and other health technologies and strengthening regulatory capacity

Fig. 22. PB 2018–2019 planned activities by SDG in Montenegro



Poland

250. During the biennium, in an effort to address the burden of NCDs, WHO extensively supported Poland with the development of national policies in the area of NCD risk factors. Particular attention was given to the growing rate of obesity among children and adults, and policy options to fight obesity and improve early nutrition were formulated in complementary reports. Furthermore, WHO continued to support Poland to generate updated epidemiological evidence through COSI.

Success story 17. Strengthening prevention to address increasing childhood obesity rates in Poland

As childhood obesity rates were rising in Poland, the Polish government deemed it necessary to review its approach to childhood obesity prevention. Therefore, with support from WHO, country-based interviews, a situation analysis and a literature review were performed to develop a guidance document containing specific recommendations for Poland.

The recommendations were tailored to the national context and called for an inclusive approach based on multisectoral collaboration, action across the life course, action to reduce inequalities, and routine monitoring.

Subsequently, Poland increased its action on obesity prevention, and school food standards were revised with updated nutritional criteria. In addition, monitoring of compliance with the International Code on the Marketing of Breastmilk Substitutes was strengthened, and WHO provided guidance on inappropriate promotion of complementary foods in order to promote optimal early life nutrition. Furthermore, Poland participated in two rounds of COSI.

251. To improve the health of children and adolescents, an ACE survey was conducted among Polish students. The survey showed that there was a significant association between adverse childhood experiences and health-harming behaviours such as suicide attempt, alcohol misuse, drug use, risky sexual behaviour and tobacco use. The findings also demonstrated the need to invest in prevention and will further the implementation of the national health programme and other social policy programmes.

252. To strengthen people-centred health systems, as part of EVIPNet and with WHO support, Poland developed a national policy to optimize the role of general practitioners in improving primary health care in Poland.

253. Building on the previous bienniums, WHO continued to support Poland in strengthening patient safety and quality of health care, with the adaptation and introduction of the WHO multi-professional patient safety curriculum guide into the national undergraduate training system.

254. During the biennium, WHO also provided extensive technical support to Poland to address social determinants of health and reduce health inequity at local and regional levels. The first report on social determinants of health at the local level in Poland, Strengthening action to reduce health inequity in Poland, was published during the biennium. It focused on good practices in service delivery that address social and economic determinants of health.

255. In 2017 Poland organized a consultative process on investment for health as part of its voluntary national report on the SDGs.

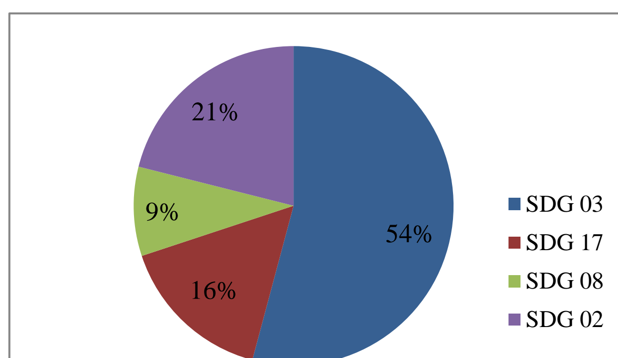
256. More details of WHO's work, funding and utilization of funds in Poland can be found at: http://open.who.int/2016-17/country/POL.

257. In 2018–2019 Poland will continue to work with WHO, mainly focusing on the five priority programme areas identified through the BCA (see Box 19). The activities planned are mainly relevant to SDG 3 (see Fig. 23). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 19. Poland's priorities for 2018–2019

1. Noncommunicable diseases
2. Nutrition
3. Equity, social determinants, gender equality and human rights
4. Integrated people-centred health services
5. Health systems, information and evidence

Fig. 23. PB 2018–2019 planned activities by SDG in Poland



Republic of Moldova

258. During the biennium, the Republic of Moldova continued to increase its capacity to deliver key hepatitis interventions; as a result, access to treatment for hepatitis C increased sevenfold in 2016 (from 500 patients to 3500 patients) and in 2017 the country neared its goal of providing universal access to treatment, with the introduction of generic direct-acting antivirals. The policy framework was further strengthened with the adoption of the National Hepatitis Control Programme 2017–2021.

259. While more needs to be done, a steady decline in TB mortality was reported from 2012 to 2016 (from 12 to 6.7 per 100 000). In addition, with support from WHO, the Republic of Moldova adopted its National Tuberculosis Control Programme 2016–2020, which is based on the global strategy and target for TB prevention, care and control.

260. The Republic of Moldova maintained a strong immunization programme, with the overall coverage for routine vaccination ranging between 88% and 97%. In partnership with GAVI and with WHO technical support, HPV vaccine was added to the national immunization programme at the end of 2017 as vaccines for the entire cohort were secured.

Success story 18. Addressing (mis)perceptions to reach high HPV vaccine coverage in the Republic of Moldova

When preparing for the introduction of the HPV vaccine, the Republic of Moldova was aware of challenges faced by other countries to reach and sustain high coverage, as well as the need to build resilience at programmatic and population level.

Rapid, formative, qualitative research on key target groups provided insights into barriers and motivators, existing knowledge and (mis)perceptions as well as preferred messages and communication channels. Understanding the health worker perspective was equally necessary when planning measures to build resilience in service provision. With this information, WHO supported development of a resilient communication and contingency plan for the introduction of the HPV vaccine.

Preliminary results were encouraging: one month into the campaign, national vaccination coverage was over 40%.

261. During the biennium, the infant mortality rate in the Republic of Moldova continued its overall downward trend, decreasing by half between 2000 and 2016 to reach 9.5 deaths per 1000 live births, owing to increased access to quality integrated services and interventions for newborns and children. In addition, service providers' capacity was strengthened through the use of approaches outlined in WHO's *Pocket book of hospital care for children* and a capacity-building workshop held in collaboration with WHO on managing mother and child health programmes; and standards and quality of care were improved with the development of seven new obstetric protocols. WHO also validated the country's elimination of mother-to-child transmission of syphilis in June 2016, and revalidated the achievement in 2017.

262. The country developed regulatory capacities and pharmaceutical sector standards for legal harmonization with EU requirements, improving access to quality medicines, and the number of generic names on the positive list of medicines was raised from 81 in 2015 to 137 in 2017. In addition, a proposal for harmonization of the pharmaceutical legal framework with the EU acquis communautaire was developed, and WHO provided advice on the rational selection and use of medicines, pricing, reimbursement, procurement and distribution.

263. Capacities for all-hazard emergency preparedness, readiness and disaster risk management for health were enhanced though the provision of emergency preparedness guidelines, a checklist on preparedness, updated emergency operational plans and increased capacity for bio-risk management and shipment of infectious substances.

264. Sixty-eight hospitals were assessed for safety in emergencies, resulting in a significant improvement in the overall safety index in comparison with the 2010 assessment; the recommendations led to comprehensive activities to strengthen hospitals safety and to improve the management of emergencies and disasters.

265. A comprehensive set of national policies, strategies and plans were introduced, such as a road map for the development of a primary health care strategy; a proposal for regionalization of hospital services; a plan for public health reform; and new evidence on financial protection. WHO supported the development of the National Development Document Moldova 2030, which addresses national development goals, Health 2020, WHO's general programme of work and the SDGs.

266. WHO supported a robust, evidence-informed policy framework for action, with initiatives, such as the new National HIV/Sexually Transmitted Infections Control Programme 2016–2020 and the HIV Sustainability Plan; multisectoral polices and plans to prevent and control NCDs (e.g. the National Diabetes Programme 2017–2021, a full ban on smoking in public places, amended alcohol laws); protocols for NCD interventions, including the National Salt Intake Survey (2017) and knowledge, attitude and practice surveys on tobacco and alcohol (2017)); the ACE survey (2017); the Donor Mapping Report (2016); and the National Programme for Implementation of the Protocol on Water and Health 2016–2025.

267. The Republic of Moldova also initiated a national development strategy with full inclusion of the health aspects of the SDGs.

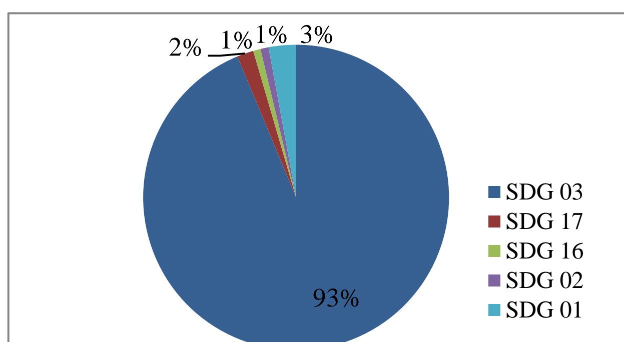
268. More details of WHO's work, funding and utilization of funds in the Republic of Moldova can be found at: http://open.who.int/2016-17/country/MDA.

269. In 2018–2019 the Republic of Moldova will continue to work with WHO, focusing on the 19 priority programme areas identified through the BCA (see Box 20). The activities planned are mainly relevant to SDG 3 (see Fig. 24). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 20. Republic of Moldova's priorities for 2018–2019

1. HIV and hepatitis
2. Tuberculosis
3. Vaccine-preventable diseases
4. Antimicrobial resistance
5. Noncommunicable diseases
6. Mental health and substance abuse
7. Violence and injuries
8. Disabilities and rehabilitation
9. Nutrition
10. Food safety
11. Reproductive, maternal, newborn, child and adolescent health
12. Health and the environment
13. National health policies, strategies and plans
14. Integrated people-centred health services
15. Access to medicines and other health technologies and strengthening regulatory capacity
16. Health systems, information and evidence
17. Polio eradication
18. Infectious Hazard Management
19. Country Health Emergency Preparedness and the International Health Regulations (2005)

Fig. 24. PB 2018–2019 planned activities by SDG in the Republic of Moldova



Romania

270. During the biennium, to further reduce the burden of hepatitis in the country, Romania drafted a national hepatitis prevention and control plan and, in 2017, with WHO support, held national multistakeholder discussions on hepatitis prevention and control.

271. Throughout the biennium, WHO supported the drafting of a new TB law, with the engagement of multistakeholders through a series of policy dialogues. The law is expected to be adopted in 2018. In the same period, WHO's technical expertise was used to develop an innovative TB care delivery model with the aim of improving the quality, cost–effectiveness and financial sustainability of TB services and to control of multidrug and extensively drug-resistant TB (M/XDR-TB).

272. Since the beginning of a measles outbreak in Romania in January 2016, WHO has supported Romania in addressing it, with the identification and immunization of susceptible individuals and those at heightened infection risk, and the development of communication plans. In addition, to inform a strategy to increase vaccination uptake, a study was conducted to describe those affected by the measles outbreak, identify factors in low vaccination uptake and determine causes of vaccine supply shortages. On the basis of this study, short-term, medium-term and long-term action points were recommended to the Romanian Ministry of Health for further policy-making.

Success story 19. Rapid strategic response to a measles outbreak in Romania

Faced with the worst outbreak of measles for decades, Romania had to control and interrupt the outbreak.

In the aftermath of the outbreak, Romania conducted a national survey on barriers to vaccination, with WHO support. The survey helped develop a rapid response plan, a vaccination strategy and a communication and advocacy plan.

A high-level event on the occasion of European Immunization Week 2017 further raised awareness.

With the analysis of vaccines shortages, the issues and underlying factors were addressed, and stronger political commitment led to resolution of supply shortages.

Additional efforts are needed to organize supplementary immunization activities, to increase vaccination coverage and prevent future outbreaks.

273. Improvement of the national cancer screening programme was assisted by WHO recommendations based on evidence-based cervical cancer prevention strategies and a review of local cervical cancer prevention activities.

274. A rapid health system performance review was performed in Romania in 2017 with WHO support. The review provided a brief overview of the main health system gaps that influence both access to and quality of health services.

275. To continue efforts to curb tobacco-associated health risks, WHO fostered closer collaboration between health stakeholders and the Romanian Ministry of Interior, through policy dialogue and evidence-exchange initiatives that took place in 2017, resulting in improvement of the enforcement of tobacco laws.

276. The Romanian food basket report, published in 2016, formed the basis for drafting national dietary recommendations that meet nutrient intake values and WHO dietary guidelines in a cost-efficient manner.

277. Furthermore, a survey of child and adolescent health and the updated COSI study established the basis for addressing child health priorities in Romania.

278. During the biennium, significant investment was made in strengthening the national health capacity in Romania. More than 500 national experts were trained in various areas ranging from better management to planning and implementation capacities. Areas covered included TB control, vaccine-preventable diseases, polio surveillance, hepatitis prevention and control, cancer prevention and screening, mental health, NCD risk factors, tobacco control, human resources for health, health system strengthening, evidence-informed policy, child and adolescent health, risk communication and long-term care.

279. In 2017, with WHO support, Romania work started work to ensure that SDG goals and targets related to health and well-being are properly reflected in national development approaches. Ongoing policy dialogues highlighted the main shortfalls and opportunities in this area.

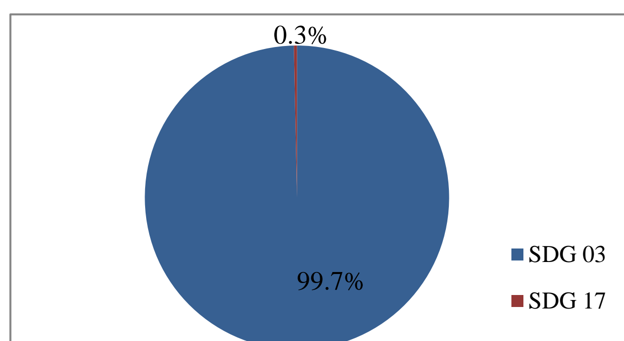
280. More details of WHO’s work, funding and utilization of funds in Romania can be found at: http://open.who.int/2016-17/country/ROU.

281. In 2018–2019 Romania will continue to work with WHO, mainly focusing on the 12 priority programme areas identified through the BCA (see Box 21). The activities planned are mainly relevant to SDG 3 (see Fig. 25). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 21. Romania’s priorities for 2018–2019

1. HIV and hepatitis
2. Tuberculosis
3. Vaccine-preventable diseases
4. Antimicrobial resistance
5. Noncommunicable diseases
6. Mental health and substance abuse
7. Reproductive, maternal, newborn, child and adolescent health
8. Health and the environment
9. National health policies, strategies and plans
10. Integrated people-centred health services
11. Access to medicines and other health technologies and strengthening regulatory capacity
12. Health systems, information and evidence

Fig. 25. PB 2018–2019 planned activities by SDG in Romania



Russian Federation

282. In 2016–2017 WHO contributed to four objectives of the collaboration strategy with the Russian Federation. With regard to increasing capacity for regional and global health collaboration, which is the overarching goal of the BCA, more than 150 national experts were involved in training courses, international missions, and experience exchanges in the fields of measles and AMR (health security), health systems performance and TB and NCD control.

283. Another objective was the creation of healthy environments throughout the life course, addressing key NCD risk factors.

284. The 21.5% reduction in smoking prevalence (Global Adult Tobacco Survey (GATS) 2016) seen in the Russian Federation during the biennium was the result of continued WHO technical and policy support for WHO FCTC implementation, which included the designation of tobacco-free public spaces, increased taxation on tobacco products, and graphic warnings on tobacco product packaging. Subsequently, tobacco control was included in priority projects funded by the Government for the next three years.

285. Total alcohol consumption in the Russian Federation dropped by 19% over five years. This contributed to effective road traffic measures, as a result of which more than 4000 lives in the Russian Federation were saved. WHO contributed to the reduction of alcohol consumption in the Russian Federation, through policy and technical interventions, and worked with national and international experts to adapt and pilot screening and a brief intervention package for alcohol problems in primary care and trauma care settings. The tool, available in the Russian language, will be used for scaling up interventions both in Russia and elsewhere in the Region.

286. Multisectoral policy and action was crucial for the creation of environments conducive to health. Consequently, the WHO European Centre for NCDs in Moscow, together with two WHO collaborating centres in Moscow, organized flagship courses for multisectoral management of NCDs. These courses were attended by more than 50 high-level officials from 17 regions in Russia. The officials who attended these courses subsequently developed subnational action plans for NCD control.

287. The third goal, to build capacities for health security by strengthening surveillance for AMR in the Russian Federation, was achieved with the adoption in 2017 of a multisectoral strategy that included indicators for monitoring antibiotic use and resistance.

288. In 2017 the European Regional Verification Committee confirmed interruption of endemic transmission of measles and rubella in the Russian Federation. The experience from high vaccination coverage and boosting laboratory capacities allowed experts from the Russian Federation to share their experiences with other countries across the region.

289. The last collaboration axis concerns the performance of the health system in the Russian Federation, targeting better coverage with high-quality care. A 2017 assessment of palliative care led to the development of a plan to strengthen palliative care capacity, increasing the number of hours on this topic in medical schools and colleges and introducing a specialty in palliative care.

290. To better plan for the cancer health services needs and capacities, an International Agency for Research on Cancer/WHO course tailored specifically to the Russian Federation was conducted for key staff in central and local cancer registries.

291. In 2017 WHO and the Ministry of Health jointly conducted an analysis of epidemiological impact of the TB epidemic (Epi-TB review), including an assessment of the national surveillance system's standards and benchmarks. The mission concluded that in the last decade TB mortality and incidence declined sharply, and that during the 2016–2017 biennium the trend was maintained: mortality and incidence continued to decline, by an annual average of 16% and 6% respectively. Compared to the decline in TB incidence, the decline in mortality is much faster, indicating that the decline is not only because of the decline in the overall TB prevalence in the population, but that it is also a result of improvements in the management of patients, resulting in a lower case fatality rate. As co-chair of the WHO–Russian Federation Ministry of Health High-Level Working Group on TB, WHO addressed key TB technical and policy issues. Courses and workshops brought together national TB experts from medical universities throughout the Russian Federation, resulting in the alignment of national guidelines and medical textbooks with WHO recommendations for MDR-TB.

Success story 20. Leaving no one behind: TB control in the Russian Federation

The Russian Federation faces a scarcity in patient organizations and NGOs that work in the area of TB.

To address this issue, WHO invited representatives of TB patients to the first ministerial conference on TB in the Russian Federation and briefed the relevant stakeholders (national and international) regarding TB control.

Having TB patients present at such a high-profile meeting helped increase the level of interest of other local civil society organizations in TB.

Furthermore, the experience reinforced the commitment to joint Ministry of Health–WHO work in tackling TB, and to empowering patient associations in driving people-centered TB services.

292. Several initiatives took place during the biennium that contributed to the improvement of health information systems to support national health priorities in the Russian Federation. The translation and implementation of ICD-10 garnered support from all three levels of WHO; a profile with highlights of health in the Russian Federation was drafted; and a workshop on digital data tools was conducted for the Ministry of Health and other health information stakeholders.

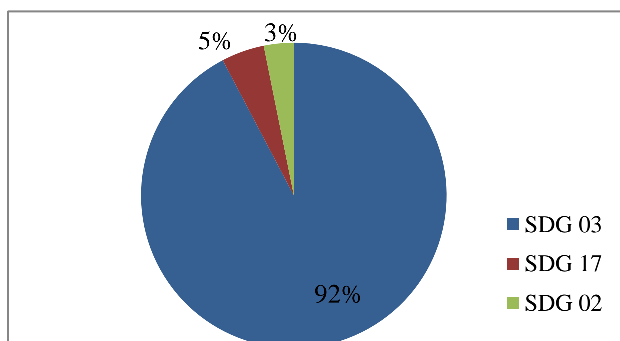
293. More details of WHO's work, funding and utilization of funds in the Russian Federation can be found at: http://open.who.int/2016-17/country/RUS.

294. In 2018–2019 the Russian Federation will continue to work with WHO, mainly focusing on the 17 priority programme areas identified through the BCA (see Box 22). The activities planned are mainly relevant to SDG 3 (see Fig. 26). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 22. Russian Federation's priorities for 2018–2019

1. HIV and hepatitis
2. Tuberculosis
3. Vaccine-preventable diseases
4. Antimicrobial resistance
5. Noncommunicable diseases
6. Mental health and substance abuse
7. Violence and injuries
8. Nutrition
9. Reproductive, maternal, newborn, child and adolescent health
10. Ageing and health
11. Health and the environment
12. National health policies, strategies and plans
13. Integrated people-centred health services
14. Access to medicines and other health technologies and strengthening regulatory capacity
15. Health systems, information and evidence
16. Infectious Hazard Management
17. Country Health Emergency Preparedness and the International Health Regulations (2005)

Fig. 26. PB 2018–2019 planned activities by SDG in the Russian Federation



Serbia

295. In order to move towards universal health coverage, Serbia developed a series of key national policy documents during the biennium that were informed by best practices and WHO normative frameworks: these include a national public health strategy, an HIV/AIDS strategy, a national AMR action plan, a national hepatitis programme and a national health emergency response plan. All of these are expected to be adopted in 2018.

296. Serbia continued to increase vaccination coverage through a TIP FLU project developed with WHO assistance. One of the highlights of this programme has been the increase in the national measles–mumps–rubella (MMR) vaccine coverage, from 81% in 2016 to 91% in 2017. Moreover, a review of the national immunization programme led to the introduction of four new vaccines in 2017: HPV, rotavirus, hepatitis A and hepatitis B.

297. With NCDs accounting for 94% of all deaths nationwide in Serbia, improving access to and the quality of NCD interventions was the focus during the biennium. With WHO assistance, the Ministry of Health reviewed two assessments supporting the NCD agenda: one on the coverage of core population interventions and another on the coverage of core individual services. The review exercise led to a set of recommendations that included the establishment of a national council on public health in Serbia.

298. In order to reduce NCD risk factors in Serbia, a global youth tobacco survey was conducted to generate evidence for policy-making. In addition, Serbia ratified the Protocol to Eliminate Illicit Trade in Tobacco Products.

299. In order to move towards better NCD outcomes, WHO supported a series of capacity-building workshops in Serbia on alcohol use and violence and injury prevention, to strengthen the knowledge of over 100 health-care professionals and 50 leading public health officials.

300. To improve the health of Serbian children, Serbia conducted a pilot HBSC survey and became a full member of the European HBSC network. An intersectoral working group then used the survey findings to develop national nutritional standards for Serbian schools.

301. To further strengthen access to mental health services, four Serbian institutions underwent a quality assessment during the biennium, as part of a wider WHO regional project on adults with mental disabilities living in institutions. The findings provided evidence and policy options for the mental health strategy that was developed and initiated during the biennium.

302. During the biennium and within the SDG framework, Serbia worked towards achieving its environment and health-related agendas, through multiple initiatives. At the onset of Serbia's tenure as Chair of the Bureau of the Protocol on Water and Health (2017–2019), an assessment of small-scale rural water supplies and sanitation was completed, with WHO support. The findings led to revised regulations promoting the adoption of a water safety plan. In addition, a detailed assessment of air quality estimated the magnitude of air pollution in Serbia and its impact on health and mortality; this will be used for future policy-making.

303. Serbia continued to effectively respond to the refugee and migrant crisis, with a coordinated health system response. With WHO support, the migrant health information system provided surveillance and monitoring, and further resources were mobilized to support the required increase in public health services and capacities. The joint efforts provided a total of 180 987 health care services in 2016, and 210 149 services in 2017, with sustained quality.

Success story 21. Reducing cultural and linguistic barriers to meet migrant health needs in Serbia

Cultural and linguistic barriers and limited resources led to unmet needs among the vulnerable migrant populations in Serbia.

Building on WHO expertise with migrant health, the Ministry of health reinforced epidemiological surveillance through partnerships and strengthened its health system response to migrant populations.

The coordinated efforts led to the establishment of a Migrant Health Information System, equipping 16 health centers in the affected areas and improving the hygiene in transit camps.

The improved partner coordination also led to successful resource mobilization initiatives.

304. Serbia improved its national capacities for emergency preparedness and response with the drafting and testing of a national health emergency response plan, and an assessment of the emergency risk communications capacity.

305. In order to facilitate the development of evidence-informed policies, Serbia joined WHO's EVIPNet initiative, to establish a national working group that prepared an in-depth situational analysis.

306. In addition, Serbia nationalized the SDG process in 2017, as a result of joint efforts conducted by WHO and other United Nations bodies. In addition, in order to implement the health-related aspects of the SDGs and the EU integration process, the Serbian parliament started a dialogue on these topics with multiple stakeholders.

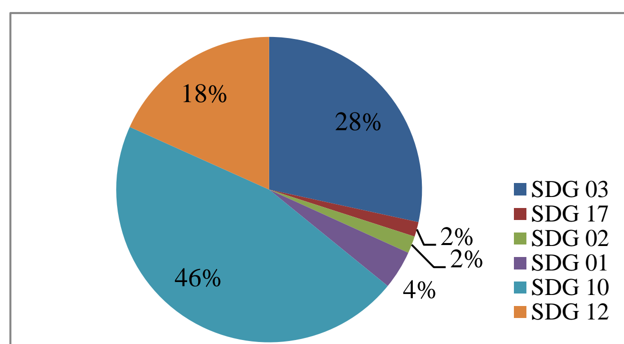
307. More details of WHO's work, funding and utilization of funds in Serbia can be found at: http://open.who.int/2016-17/country/SRB.

308. In 2018–2019 Serbia will continue to work with WHO, mainly focusing on the 13 priority programme areas identified through the BCA (see Box 23). The activities planned are relevant to six SDGs (see Fig. 27). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 23. Serbia's priorities for 2018–2019

1. Vaccine-preventable diseases
2. Antimicrobial resistance
3. Noncommunicable diseases
4. Mental health and substance abuse
5. Nutrition
6. Reproductive, maternal, newborn, child and adolescent health
7. Health and the environment
8. Equity, social determinants, gender equality and human rights
9. National health policies, strategies and plans
10. Integrated people-centred health services
11. Health systems, information and evidence
12. Infectious Hazard Management
13. Country Health Emergency Preparedness and the International Health Regulations (2005)

Fig. 27. PB 2018–2019 planned activities by SDG in Serbia



Slovakia

309. Slovakia has successfully sustained its status as a low-incidence TB country through effective implementation of WHO global and regional TB strategies. WHO supported the national community programme for socially deprived groups, in particular targeting the health and well-being of the Roma population and poor communities in Slovakia. WHO-supported training courses for Roma health activists helped general practitioners and TB specialists to monitor the situation and ensure that patients with TB observed the treatment regime. The programme has substantially contributed to prevention and control of communicable diseases, including TB. Because of its substantial achievements, Slovakia's Institute of TB and Lung Diseases will be nominated to become a WHO collaborating centre.

310. To address the burden of NCDs during the biennium, Slovakia joined COSI and collected data under the initiative for the first time. Moreover, the Slovak National Action Plan for Physical Activity was finalized and adopted, and the development of national targets, indicators and risk factors for NCD surveillance was initiated.

311. With WHO support, Slovakia established a working group to collect, analyse, disseminate and use national data on disabilities to advance policy, programming and advocacy. Moreover, Slovakia developed national guidelines to support service improvement for people with disabilities at all levels (primary care, hospital, long-term, community and home care) and within an integrated people-centred health system. Such guidelines included measures for strengthening supervision, management, accountability, quality and safety.

Success story 22. Improving long-term care for people with disabilities in Slovakia

Improving long-term care for people with disabilities is an important policy concern in Slovakia and was therefore subject to priority action during the biennium.

After a situation assessment had been conducted, round tables were held to discuss key design principles of long-term care, needs assessments, ensuring financing for long-term care, and providing integrated, person-centred long-term care.

These discussions contributed to the strengthening of inter-departmental cooperation between the Slovak Ministry of Health and the Slovak Ministry of Labour, Social Affairs and Families, as well as other stakeholders, exemplifying the intersectoral spirit of cooperation outlined in Health 2020.

In addition, emphasis was placed on the contribution of the quality of people-centred services to the quality of life of the recipients and to the contributions made by families and other unpaid care. The latter is ground-breaking for the implementation of quality measurements for long-term care services planned for 2018 (based on overall quality standards for long-term social care defined in the Slovak social care act).

312. In order to improve the quality of health-care services and contribute to the development of a Health Information System Strategy in Slovakia, during the biennium WHO supported the launch of a Slovak e-health system. In recognition of the importance of evidence-informed policies, WHO also supported the Slovak Ministry of Health in establishing a team of national EVIPNet experts, who conducted a situation analysis and developed an EVIPNet evidence brief for policy on AMR in Slovakia.

313. To reduce environmental threats to health, Slovakia strengthened its national capacities to monitor and assess the quality of water in water bodies used for recreation. These efforts were completed with the development and dissemination of specific materials that helped raise public awareness in this area.

314. A mapping and situation analysis exercise conducted in Slovakia during the biennium was instrumental in effective policy formulation as it helped identify barriers and facilitators for evidence-informed national health policies. As a result, consensus was reached among the Slovak public health authorities and institutions with regard to public health capacities and service reforms and means of cooperation.

315. To maintain Slovakia's standing capacity to address emergencies, WHO conducted a risk communications training for national authorities responsible for health emergencies in Slovakia, strengthening capacity and increasing knowledge and awareness of risk communication.

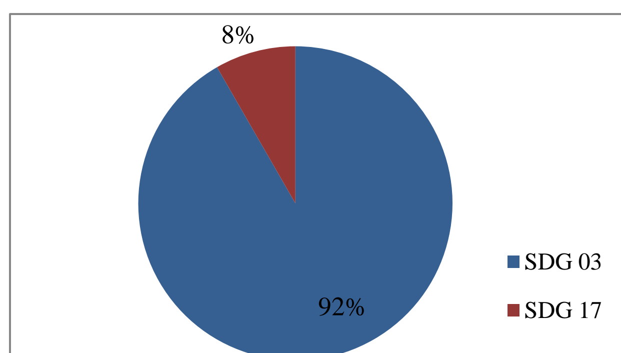
316. More details of WHO's work, funding and utilization of funds in Slovakia can be found at: http://open.who.int/2016-17/country/SVK.

317. In 2018–2019 Slovakia will continue to work with WHO, mainly focusing on the eight priority programme areas identified through the BCA (see Box 24). The activities planned are mainly relevant to SDG 3 (see Fig. 28). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 24. Slovakia's priorities for 2018–2019

1. Tuberculosis
2. Antimicrobial resistance
3. Noncommunicable diseases
4. Health and the environment
5. National health policies, strategies and plans
6. Integrated people-centred health services
7. Access to medicines and other health technologies and strengthening regulatory capacity
8. Health systems, information and evidence

Fig. 28. PB 2018–2019 planned activities by SDG in Slovakia



Slovenia

318. The health status of the population in Slovenia has improved considerably over the past decade, thanks to consistent investment in health protection, promotion and health care from the national authorities.

319. Slovenia endorsed national health targets in its first voluntary report on implementing the SDGs, highlighting cross-sectoral responsibility for contributing to health and well-being. In addition, the Slovene National Health Plan 2016–2025 established the basis for Slovenia's health development, emphasizing a whole-of-society approach and highlighting health equity, gender and human rights aspects. During the biennium, WHO supported Slovenia in the implementation of national health policies and strategies outlined in the Slovene national health plan.

320. In an effort to move towards universal health coverage, an in-depth analysis of the Slovene health system was carried out in 2016, leading to a set of recommendations, including the need for legislation to strengthen universal coverage and maintain the quality, accessibility and affordability of public health services.

321. To increase access to integrated people-centred services, with WHO support, Slovenia launched a national consultation on organizing and financing long-term care services. This consultation led to the drafting of a long-term care act and the creation of a long-term care department within the Slovene Ministry of Health.

322. Despite having well-developed close-to-client primary health care services, Slovenia requested that WHO assist the Slovene Ministry of Health and health care providers to further the integration of care and other health system segments, as well as the non-health services needed, in particular, by the elderly and patients with chronic illness.

323. At the crossroads of transformation its public health services, Slovenia requested WHO's assistance in assessing existing public health capacities and providing recommendations to develop the new 10-year public health service strategy (2018–2028).

324. As NCDs comprise the major burden of diseases in Slovenia, WHO's assistance was requested to tackle critical risk factors and other determinants of NCDs in the country. After extensive work, the Act on Restriction of Tobacco Use was endorsed in February 2017. As it was one of the strongest anti-tobacco laws in the world, the Slovene Ministry of Health was awarded a World No Tobacco Day 2017 award.

325. In response to the growing level of alcohol consumption in Slovenia, the Ministry of Health took action during the biennium to improve alcohol regulation and reduce the demand for alcohol. For example, the Ministry developed an evidence policy brief on alcohol for the Seventh European Alcohol Policy Conference, which was hosted by Slovenia in 2016. The brief subsequently led to multiple policy initiatives, which were focused in particular on strengthening the education of young people about alcohol and increasing the awareness of the public about the harmful effects of alcohol.

326. The findings of the HBSC survey, which was conducted in Slovenia with the support of WHO during the biennium, were used to draft new policies for children and adolescents, with a specific focus on mental health.

327. As one of the first countries in Europe to map and analyse health inequities among its citizens, Slovenia conducted a health inequity survey during the biennium among the elderly and patients with selected chronic diseases, with the results confirming the fact that Slovenia has a highly equitable society. WHO provided a training course in order to bridge policies and sectors for greater equity in health and well-being to stakeholders from numerous sectors.

328. During 2017 Slovenia underwent a JEE of its preparedness for health emergencies, using the WHO tool. The assessment found a fragmented and poorly communicating system of institutions with a role in emergencies, in which the Ministry of Health was not the recognized leader. Subsequently, a unit for health emergencies was established at the Slovene Ministry of Health, health workers' communication capacities were strengthened, and a Slovene national intersectoral emergency response communication plan was drafted.

Success story 23. Assessing IHR (2005) national capacities in Slovenia

In the past, Slovenia has faced consistent gaps in complying with the IHR (2005). Therefore, with WHO coordination, Slovenia underwent an IHR capacity evaluation through the JEE tool and completed a country survey, with the JEE team inspecting relevant institutions and verifying information obtained from the survey.

While the JEE concluded that the Slovene public health system was well integrated into the national health-care infrastructure, it recognized that some aspects with regard to emergency risk communication had to be addressed.

In response, Slovenia prepared a plan to strengthen its national emergency risk communication capacities and has initiated training within national institutions to overcome the identified gaps.

329. In order to produce evidence-based and evidence-informed policies, Slovenia joined EVIPNet. During the biennium, Slovene experts successfully prepared two relevant policy briefs on primary health care and AMR and published the first EVIPNet Europe situation analysis.

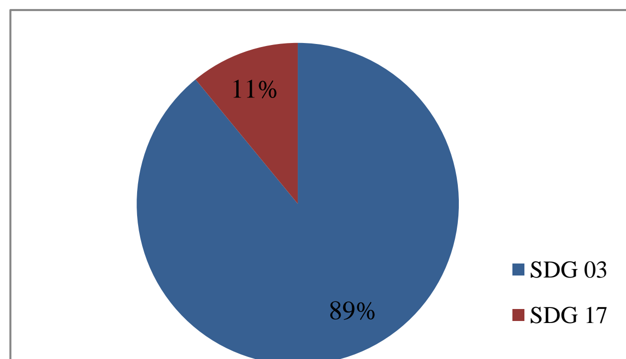
330. More details of WHO's work, funding and utilization of funds in Slovenia can be found at: http://open.who.int/2016-17/country/SVN.

331. In 2018–2019 Slovenia will continue to work with WHO, mainly focusing on the 10 priority programme areas identified through the BCA (see Box 25). The activities planned are mainly relevant to SDG 3 (see Fig. 29). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 25. Slovenia's priorities for 2018–2019

1. HIV and hepatitis
2. Antimicrobial resistance
3. Noncommunicable diseases
4. Mental health and substance abuse
5. Reproductive, maternal, newborn, child and adolescent health
6. Ageing and health
7. Equity, social determinants, gender equality and human rights
8. National health policies, strategies and plans
9. Integrated people-centred health services
10. Health systems, information and evidence

Fig. 29. PB 2018–2019 planned activities by SDG in Slovenia



Tajikistan

332. The risk of the importation of wild poliovirus in Tajikistan was mitigated through two rounds of polio campaigns facilitated by WHO during the biennium, in selected districts neighbouring Afghanistan.

333. In 2017, in response to a measles outbreak, a mass measles and rubella vaccination campaign, supported by WHO, was completed, targeting almost 2 million children aged 1–9 years and increasing vaccination coverage.

334. The country's capacity was strengthened with respect to coordination in the prevention, control and management of malaria, and the malaria-free status of Tajikistan was maintained with WHO involvement.

335. The prevalence of soil-transmitted helminths in school-age children in Tajikistan declined from 40% (2014) to 23.2% (2016) as a result of the WHO and national Government deworming campaigns conducted since 2014.

336. As a result of extensive work by WHO, a new tobacco-control law fully aligned with the WHO FCTC was endorsed by the President of Tajikistan.

337. In addition, WHO supported evidence generation through the STEPwise approach to surveillance of NCDs and their risk factors and through COSI and the FEEDCities surveys, in order to increase access to interventions to prevent and manage NCDs and their risk factors.

338. Adoption of the multisectoral National Programme on Rehabilitation of Persons with Disabilities in Tajikistan (2017–2020), which was developed with strong WHO input, facilitated an increase in Government funding for community-based rehabilitation in 2017 that will lead to expanded access to services for people with disabilities.

Success story 24. Improving the lives of persons living with disabilities in Tajikistan

With 15% of the population experiencing disabilities (including polio- and NCD-related impairments), Tajikistan was not able to provide the needed rehabilitation services.

During the biennium, the Tajik Ministry of Health and Social Protection, with WHO support, focused on strengthening the disability rehabilitation system.

Door-to-door assessments in polio-affected districts confirmed the need for a comprehensive rehabilitation plan.

Stakeholder consultations allowed Tajikistan to further develop a multisectoral national rehabilitation programme that ultimately was adopted by government (The National Programme on Rehabilitation of Persons with Disabilities (2017-2020)).

With the new policy and system, the country will be better positioned to provide the needed rehabilitation services and improve the life of those living with disabilities.

339. The WHO Global Maternal Sepsis Study revealed the situation in Tajikistan regarding preventable maternal and newborn deaths related to sepsis and will support future efforts to improve the health of women and newborns.

340. As result of improvements in nine demonstration sites, WHO Water Safety Plan recommendations were followed in a new national law on drinking water and sanitation.

341. With WHO technical support during the biennium, Tajikistan's move towards universal health coverage advanced through policy dialogue and capacity-building; adoption of the monitoring matrix to track service coverage progress and financial protection; and strengthening of the evidence base.

342. As a result of the involvement of WHO experts, in 2016 Tajikistan adopted a strategic plan for the development of family medicine-based primary health care to 2020, to optimize gains in performance and health outcomes through expanded services.

343. Capacity building of national regulatory authorities on proper pricing and reimbursement policies enabled Tajikistan to develop regulations to contain costs and enhance financial access to medicines, contributing to improvements in access to medicines, which was made possible with WHO assistance.

344. Tajikistan strengthened AMR surveillance during the biennium through training provided by WHO to over 2500 health care providers, veterinary professionals and patients in the country.

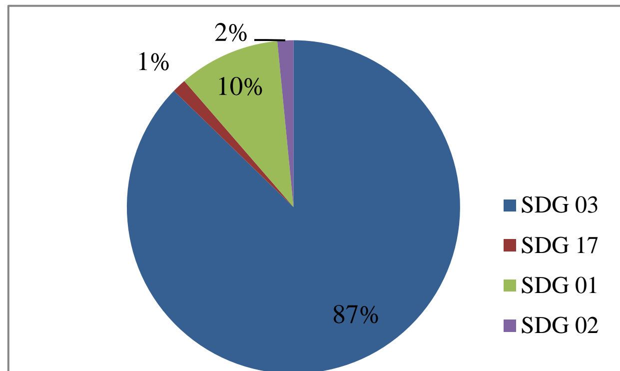
345. More details of WHO's work, funding and utilization of funds in Tajikistan can be found at: http://open.who.int/2016-17/country/TJK.

346. In 2018–2019 Tajikistan will continue to work with WHO, mainly focusing on the 18 priority programme areas identified through the BCA (see Box 26). The activities planned are mainly relevant to SDG 3 (see Fig. 30). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 26. Tajikistan's priorities for 2018–2019

1. HIV and hepatitis
2. Tuberculosis
3. Neglected tropical diseases
4. Vaccine-preventable diseases
5. Antimicrobial resistance
6. Mental health and substance abuse
7. Disabilities and rehabilitation
8. Nutrition
9. Food safety
10. Reproductive, maternal, newborn, child and adolescent health
11. Ageing and health
12. Health and the environment
13. National health policies, strategies and plans
14. Integrated people-centred health services
15. Access to medicines and other health technologies and strengthening regulatory capacity
16. Polio eradication
17. Infectious Hazard Management
18. Country Health Emergency Preparedness and the International Health Regulations (2005)

Fig. 30. PB 2018–2019 planned activities by SDG in Tajikistan



The former Yugoslav Republic of Macedonia

347. The BCA for 2016–2017 contributed to strengthened intersectoral collaboration and an all-inclusive approach to implementation of the National Health Strategy to 2020 (adopted by the Government in December 2016) in conjunction with seven action plans in the following areas: environment, public health, HIV/AIDS, NCDs, healthy ageing, AMR and nutrition.

348. In terms of policy, attention was focused on the importance of strengthening community-level and local authorities' capacities to promote health. During the biennium, a series of Health 2020 capacity-building events took place at the community level. Moreover, a joint statement on strengthening of intersectoral cooperation for health and well-being in the community announced the commitment of the participating mayors and emphasized the need to strengthen the role of the municipal public health councils.

349. Supported by the WHO, the health sector of the former Yugoslav Republic of Macedonia was one of the first to mainstream SDGs into the national health agenda and to harmonize its key health strategies and action plans with the SDGs.

350. In an effort to increase health equity by addressing the social determinants of health, the country developed a profile of the social determinants of health. The profile helped to identify the measures that needed to tackle health inequities stemming from social and economic determinants outside the health system.

351. To reduce the burden of HIV/AIDS, with WHO support, the country developed a national HIV/AIDS strategy for 2017–2021. Through a WHO-supported, inclusive process, the strategy created synergies among relevant institutions and sectors, and ensured funding continuity for NGOs and services for population groups at risk.

Success story 25. Empowering HIV/AIDS-affected communities and promoting NGOs' participation to ensure continuity of HIV/AIDS prevention and care in the former Yugoslav Republic of Macedonia

To reduce the burden of HIV/AIDS through continued prevention and care, the former Yugoslav Republic of Macedonia developed a National HIV/AIDS Strategy for 2017–2021.

Through an inclusive process, WHO engaged key partners (15 NGOs and civil society associations of people living with HIV/AIDS) to ensure that the strategy created synergies among relevant institutions and sectors and ensured funding continuity by the Government for NGOs providing services to the most affected and hard-to-reach population groups.

A significant step towards the sustainability of HIV/AIDS prevention and care, the strategy showcased the priority of the health sector in the former Yugoslav Republic of Macedonia in promoting community participation and empowering those most affected by HIV/AIDS and their families.

352. To support policy-making, the HiT report of the former Yugoslav Republic of Macedonia was published in 2017 by the European Observatory on Health Systems and Policies. It describes the health system of the former Yugoslav Republic of Macedonia and highlights recent developments in organization and governance, health financing, health care provision, health reforms and health system performance. This is the only comprehensive health system analysis available for the country.

353. In addition, a national human resources for health profile was developed to provide comprehensive data about the country's human resources for health situation and to serve as the basis for the development of the national human resources for health strategy planned for the 2018–2019 biennium.

354. National capacities for emergency preparedness and response in the former Yugoslav Republic of Macedonia were strengthened through a series of desk simulation exercises at community level, and a functional simulation exercise was organized in November 2016.

355. During the biennium, 18 health facilities (mainly the general and clinical hospitals countrywide) underwent a Hospital Safety Index assessment to better inform infrastructure investment needs. The positive experience from the assessment led to the proposal to embed the Hospital Safety Index tool criteria and requirements into the country's hospital accreditation process in the future.

356. To develop a health information system strategy, WHO supported the former Yugoslav Republic of Macedonia in convening all relevant stakeholders of the national health information system and conducting a workshop to develop a joint assessment of the national health information system. The recommendations from the assessment guided the development of the strategy.

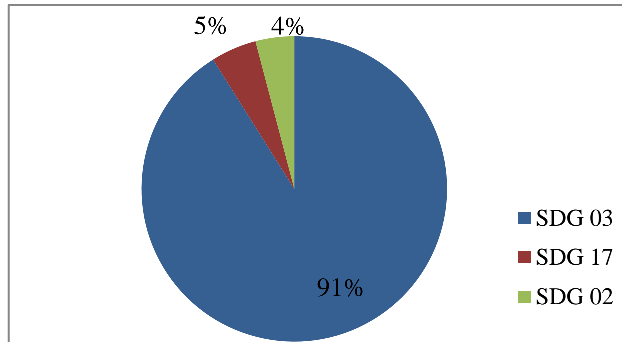
357. More details of WHO's work, funding and utilization of funds in the former Yugoslav Republic of Macedonia can be found at: http://open.who.int/2016-17/country/MKD.

358. In 2018–2019 the former Yugoslav Republic of Macedonia will continue to work with WHO, mainly focused on the 13 priority programme areas identified through the signed BCA (see Box 27). The planned activities will predominantly contribute to SDG 3 (see Fig. 31). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 27. The former Yugoslav Republic of Macedonia's priorities for 2018–2019

1. HIV and hepatitis
2. Vaccine-preventable diseases
3. Antimicrobial resistance
4. Noncommunicable diseases
5. Mental health and substance abuse
6. Nutrition
7. Ageing and health
8. Health and the environment
9. National health policies, strategies and plans
10. Integrated people-centred health services
11. Health systems, information and evidence
12. Infectious Hazard Management
13. Country Health Emergency Preparedness and the International Health Regulations (2005)

Fig. 31. PB 2018–2019 planned activities by SDG in the former Yugoslav Republic of Macedonia



Turkey

359. WHO supported Turkey during the biennium, in the development of national plans and strategies for key health and public health areas. As a result, a new strategic plan for 2018–2021 was finalized, as well as national action plans addressing NCDs, tobacco, financial protection, AMR and risk communication.

360. Evidence was produced to inform policy-making. WHO contributed to assessments, surveys and studies on health system performance, NCDs, tobacco control, alcohol and drug dependency, obesity, road safety, child maltreatment, risk factors and social determinants of health. Particular attention was given to vulnerable groups and gender.

361. NCDs and their risk factors comprised an area of focus for WHO, owing to their high share of the country's disease burden. WHO cooperated with the Turkish Ministry of Health in a multidimensional approach covering policy-making, standard setting, surveillance and advocacy, as evidenced by the resulting national action plan on NCDs, an NCD risk factors survey and pilot implementation of a package of essential NCD interventions in primary care settings.

362. As a result of Turkey's Healthy Nutrition Action Plan, a high-level policy forum on childhood obesity was organized, and WHO knowledge of evidence generation in this area was shared. In addition, WHO expertise on this topic was mobilized in close collaboration with various national and international stakeholders, to promote healthy diets and to progress towards achieving national nutrition goals.

Success story 27. Combating increasing childhood obesity through stricter marketing controls in Turkey

Turkey faces an extremely high prevalence of obesity in the country, despite having taken significant steps to combat obesity and promote a healthy diet and active lifestyle.

In 2016 the Turkish government invited WHO to assess the government's progress in tackling obesity, unhealthy diets and physical inactivity. The assessment highlighted notable achievements and identified two key areas on which interventions should be focused: (1) expanding and reinforcing measures to restrict marketing of food to children; and (2) better regulation of the sodium and trans-fat content of foods.

Since the assessment, Turkey has revised its legislation on marketing of food to children, expanding the scope of regulation in that area and including the WHO nutrient profile model as the criterion for determining which foods may not be marketed to children. In doing so, Turkey became the second country in the Region to use the model to develop legislation.

Furthermore, with WHO support, Turkey started to work on its commitment to assess the nutritional composition of packaged and fast food and use it as the basis to inform policy discussions on maximum sodium and trans-fat limit contents in foods.

363. During the biennium, WHO maintained day-to-day oversight of all emergency activities in Turkey, using the framework of WHE and thus ensuring alignment with strategies by national authorities and other partners, accountability to donors and responsibility for public information.

364. Through the coordination of partners in both northern Syrian Arab Republic and Turkey, WHO ensured an adequate response for the most vulnerable people in need of assistance.

365. Efficient management of health-related data in the context of the WHO Emergency Response Plan, with a dedicated information management function in Ankara and Gaziantep, has been maintained in both northern Syrian Arab Republic and Turkey, to ensure the promotion of data-driven decision-making among all partners.

366. WHO's work in northern Syria has focused on alleviating the health needs of millions of people through the delivery of drugs and medical supplies, provision of mental health services, immunization of children and training of a health workforce.

367. During the biennium, WHO was the coordinator of the health sector part of the Regional Refugee and Response Plan (3RP). Under this initiative and in close collaboration with the Turkish Ministry of Health, the programme framework and dedicated team worked to extend universal health coverage to the refugee population by providing linguistic and culturally sensitive health services. This was achieved by enabling Syrian doctors and nurses to serve in the Ministry's refugee health centres, providing primary health care. WHO led these efforts through designing and implementing training for Syrian health professionals, in cooperation with the Ministry.

368. WHO has ensured operational support and logistics for all activities in northern Syrian Arab Republic, ensuring the provision of medical supplies, equipment, essential medicines and support in the field.

369. Throughout the biennium, WHO supported the Ministry of Development in the design of an SDG advocacy plan and campaign strategy. Turkey's Advocacy and Campaign Strategy aims to provide an overall framework and conceptual support to the Ministry in promoting the SDGs in Turkey.

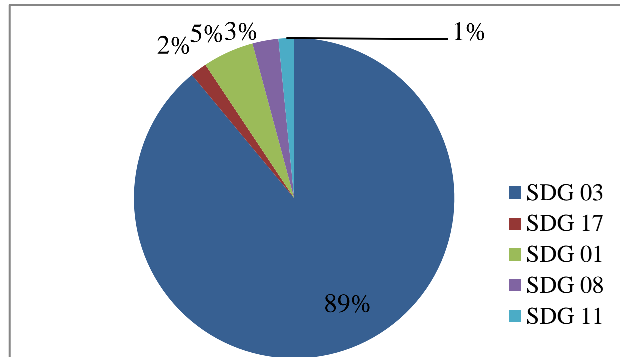
370. More details of WHO's work, funding and utilization of funds in Turkey can be found at: http://open.who.int/2016-17/country/TUR.

371. In 2018–2019 Turkey will continue to work with WHO, mainly focusing on the 14 priority programme areas identified through the BCA (see Box 29). The activities planned are mainly relevant to SDG 3 (see Fig. 33). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 29. Turkey's priorities for 2018–2019

1. HIV and hepatitis
2. Tuberculosis
3. Antimicrobial resistance
4. Noncommunicable diseases
5. Mental health and substance abuse
6. Violence and injuries
7. Reproductive, maternal, newborn, child and adolescent health
8. Health and the environment
9. National health policies, strategies and plans
10. Integrated people-centred health services
11. Health systems, information and evidence
12. Polio eradication
13. Infectious Hazard Management
14. Country Health Emergency Preparedness and the International Health Regulations (2005)

Fig. 33. PB 2018–2019 planned activities by SDG in Turkey



Turkmenistan

372. In September 2017, Turkmenistan hosted its first international sporting event (the Fifth Asian Indoor and Martial Arts Games (AIMAG)) with the participation of 65 countries from Asia and Oceania. In preparation for such a high-level event, with support from WHO, Turkmenistan developed a set of interventions to strengthen national capacity for preparedness for health-related emergencies and minimized the risks associated with international mass gathering events.

373. These initiatives included an emergency risk communications plan; conducting several simulation exercises; and evaluating seven selected hospitals with respect to the Hospital Safety Index. While addressing the preparedness for AIMAG, this evaluation also enhanced national core capacity, and the findings generated evidence for further long-term infrastructure investments.

374. Turkmenistan's proactive approach to reviewing and strengthening IHR (2005) core capacity contributed significantly to the overall success of AIMAG and significantly strengthened its capacity to manage public health risks associated with emergencies. As the first country in the Region to volunteer for a JEE assessment, Turkmenistan strengthened its national capacity for IHR (2005) monitoring and evaluation.

Success story 26. Strengthening public health planning during mass social events in Turkmenistan

Before hosting its first international sporting event, Turkmenistan felt the need to strengthen its capacity to implement the IHR (2005). Therefore, the country volunteered to be the first in the region to undergo a JEE.

On the basis of with the recommendations from the assessment, the Ministry of Health was able to effectively and in a timely manner strengthen its IHR (2005) capacity before the games.

The JEE highlighted the importance of public health planning during mass gatherings and furthered Turkmenistan's proactive approach to strengthening its IHR (2005) capacities.

375. During the biennium, Turkmenistan achieved significant results in addressing the leading risk factors for NCDs. For example, Turkmenistan's tobacco-control policy advanced with the approval of a new national programme on tobacco control (2017–2021), which was aligned with the WHO FCTC. The new programme implemented anti-tobacco policy by imposing higher tax rates on tobacco products and developing cessation services. In addition, substantial evidence for policy-making on the urban food environment, and obesity in children, was generated via the WHO FEEDCities project and COSI.

376. With the assistance of WHO, in order to boost mental health services in Turkmenistan, the mental health law was revised, and the national mental health strategy, the 2017–2021 action plan and the national guidelines on mental health for primary health care were developed.

377. During the biennium, Turkmenistan also strengthened its capacity to address AMR by improving laboratory diagnostics and strengthening its regulatory framework by approving a national strategy for the containment of AMR and a related action plan (for 2017–2025).

378. During the biennium, pandemic influenza surveillance and preparedness were also strengthened in Turkmenistan, with the introduction of best practices that led to improvements in laboratory diagnostics.

379. In 2017, Turkmenistan carried out its SDG MAPS assessment and, with WHO support, the Turkmen Ministry of Health was heavily engaged in the adaptation of the SDG agenda to the local context.

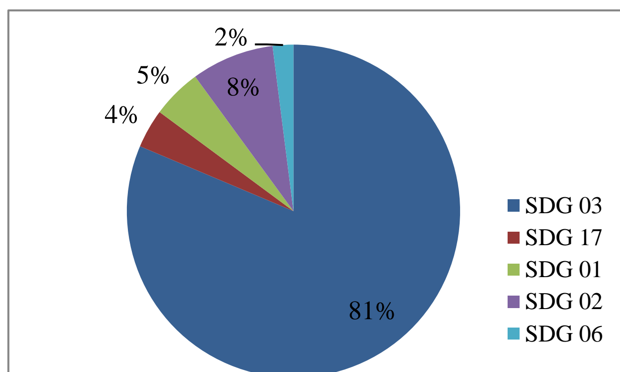
380. More details of WHO's work, funding and utilization of funds in Turkmenistan can be found at: http://open.who.int/2016-17/country/TKM.

381. In 2018–2019 Turkmenistan will continue to work with WHO, mainly focusing on the 16 priority programme areas identified through the BCA (see Box 28). The activities planned are mainly relevant to SDG 3 (see Fig. 32). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 28. Turkmenistan's priorities for 2018–2019

1. HIV and hepatitis
2. Tuberculosis
3. Antimicrobial resistance
4. Noncommunicable diseases
5. Mental health and substance abuse
6. Disabilities and rehabilitation
7. Nutrition
8. Food safety
9. Reproductive, maternal, newborn, child and adolescent health
10. Health and the environment
11. National health policies, strategies and plans
12. Integrated people-centred health services
13. Access to medicines and other health technologies and strengthening regulatory capacity
14. Health systems, information and evidence
15. Polio eradication
16. Infectious Hazard Management

Fig. 32. PB 2018–2019 planned activities by SDG in Turkmenistan



Ukraine

382. In order to improve the health outcomes of the Ukrainian population, WHO supported the Ukrainian Ministry of Health during the biennium in a series of health sector reforms and SDG alignments. As a result, concept papers on health financing, public health and mental health were adopted, supporting relevant in-country, high-level policy dialogues with stakeholders.

383. To further reduce the burden of communicable diseases, Ukraine developed a new national HIV treatment protocol in line with WHO best practices and successfully prepared a US$ 125 million application for a 2018–2020 Global Fund grant. Key documents on the treatment and prevention of HIV, TB and hepatitis were developed and a study was undertaken to gain a better understanding of the hepatitis virus circulating in the population of Ukraine.

384. During 2017 the response to a measles outbreak resulted in a doubling of the coverage rates of the first (93%) and second (91%) doses of the MMR vaccine, compared to 2016. To tackle low routine vaccination coverage, Ukraine acted in line with the European Vaccine Action Plan 2015–2020, and the system for vaccine pharmacovigilance and surveillance of adverse events following immunization was strengthened in line with a WHO-recommended global algorithm.

385. To address the burden of AMR, Ukraine adopted a national strategy on AMR and set out a road map for its implementation.

386. Ukraine stopped poliovirus circulation and maintained its polio-free status during the biennium. With WHO support and under the Global Polio Eradication Initiative (surveillance activities), Ukraine developed a national plan for polio-free status maintenance for 2017–2020 and initiated its implementation.

Success story 28. Coordinating actions to reduce maternal mortality in Ukraine

Prior to the biennium, Ukraine lacked evidence-based information to support policy-making on its stagnant maternal mortality ratio.

In order to address this issue, in 2017 the Ministry of Health, together with WHO, introduced an innovative methodology nationwide: confidential enquiries into maternal deaths (CEMD).

Strong partnerships (e.g. with UNFPA) to support joint implementation and intercountry training has allowed 25 administrative territories in Ukraine to initiate data collection for CEMD. Moreover, strong political commitment to implementation of a national CEMD commission will help further this initiative.

The data collected through CEMD will strengthen evidence-based policy-making to improve maternal mortality.

387. To further increase Ukraine's capacity to manage NCDs, during the biennium almost 8000 primary care providers underwent training on the integrated management of hypertension and diabetes. In addition, a series of key NCD-related policies were developed: the National NCD Action Plan, a draft national strategy on alcohol, and a draft national strategy and supportive legislation on reduction of salt and trans-fat intake.

388. The prevalence of tobacco smoking in Ukraine has significantly decreased, from 28.3% in 2010 to 22.8% in 2017. During the biennium, efforts to prolong this trend included the

establishment of a professional smoking cessation service with a toll-free quitline and a website: in the first six months, about 750 clients received comprehensive consultations through the quitline, and more than 7000 people visited the website.

389. Significant progress was made during the biennium towards achieving universal health coverage in Ukraine. The final draft law on public health will allow Ukraine to shift the focus from curative to preventive public health services and put in place a financial guarantee for health care provision as part of health system reform. WHO supported the overall development of the new health financing system, with the key goal being to replace unlimited constitution guarantees with clearly defined health benefits. Moreover, access to essential medicines for three priority diseases (diabetes type 2, hypertension and pulmonary asthma) was further expanded through an essential medicines reimbursement pilot scheme.

390. During the biennium, around 2.5 million people living in conflict-affected regions in eastern Ukraine were supported with essential and life-saving medicines and medical equipment needed for primary and secondary health care, such as that needed for safe deliveries, paediatric asthma prevention and care, preparedness and treatment of diarrheal diseases, life-saving surgical interventions, trauma care and psychosocial support. With WHO support, nine health facilities underwent minor repairs, and medical equipment was serviced so that it become operational again. Blood banks were upgraded, and an estimated 50 000 people received safe blood transfusions during the biennium.

391. During the biennium, mobile primary health care units provided more than 310 000 consultations in difficult-to-reach areas in Ukraine. In addition, several training opportunities, for example on laboratory quality management systems, trauma care and rehabilitative care, were provided for medical staff in conflict areas in eastern Ukraine.

392. To develop a health information strategy, WHO supported Ukraine in an assessment of the national health insurance system and e-health.

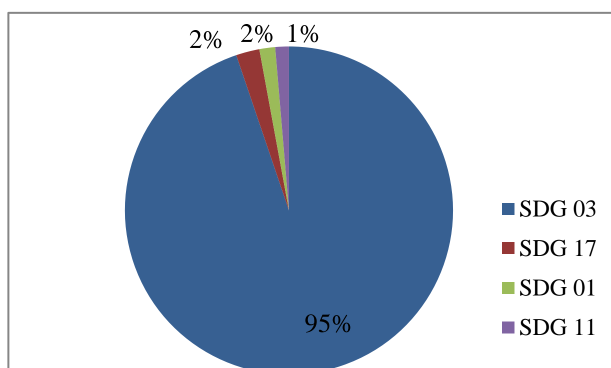
393. More details of WHO's work, funding and utilization of funds in Ukraine can be found at: http://open.who.int/2016-17/country/UKR.

394. In 2018–2019 Ukraine will continue to work with WHO, mainly focusing on the 13 priority programme areas identified through the BCA (see Box 30). The activities planned are mainly relevant to SDG 3 (see Fig. 34). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 30. Ukraine's priorities for 2018–2019

1. HIV and hepatitis
2. Tuberculosis
3. Vaccine-preventable diseases
4. Noncommunicable diseases
5. Mental health and substance abuse
6. Reproductive, maternal, newborn, child and adolescent health
7. National health policies, strategies and plans
8. Integrated people-centred health services
9. Access to medicines and other health technologies and strengthening regulatory capacity
10. Health systems, information and evidence
11. Polio eradication
12. Infectious Hazard Management
13. Country Health Emergency Preparedness and the International Health Regulations (2005)

Fig. 34. PB 2018–2019 planned activities by SDG in Ukraine



Uzbekistan

395. Uzbekistan aims to achieve the SDGs and the five action priorities of its National Development Strategy 2017–2021 through a reform process that started in February 2017, following the change of government in 2016. Under WHO leadership, the UNDAF 2016–2020 was adjusted in line with the new action priorities, the SDGs, the Health 2020 policy framework and WHO's own reforms. In addition, a Government of Uzbekistan–United Nations roadmap was developed, including development of a national health policy, a health management information system, a system of health accounts and human resources reforms.

396. With WHO involvement in policy and strategy dialogue, and using its convening power, the Government of Uzbekistan and United Nations partners, moved away from vertical project-oriented thinking and implementation towards more strategic thinking on health system strengthening.

397. During the biennium, Uzbekistan introduced shortened treatment regimens and new drugs in two pilot regions, together with an electronic registration system. Laboratories were reformed and equipped to ensure adequate patient triage. Thanks to WHO's influence and support, previously very sensitive topics like HIV and hepatitis are now higher on the agenda of the Ministry of Health and initial assessments led to a revision of the ART guidelines for HIV and the national plan for hepatitis control.

Success story 29. Maintaining poliovirus protection and preparedness following oral polio vaccine switch in Uzbekistan

In April 2016 Uzbekistan, along with many countries and territories around the world, withdrew the type 2 component of the oral polio vaccine (OPV) from routine immunization to minimize the risk of circulating vaccine-derived poliovirus (cVDPV) type 2 emergence and circulation among unvaccinated individuals. In addition, the country introduced at least one dose of inactivated polio vaccine (IPV) to ensure continuing population protection against this strain.

Global supply constraints led to the postponement of vaccine delivery in several countries considered to be at low risk until 2018. Uzbekistan, with the largest birth cohort in the WHO European Region with delayed IPV introduction, received special attention from WHO during 2016–2017 to minimize the risk of cVDPV type 2 emergence or transmission in case of importation. Supplementary immunization activities to boost type 2 immunity were implemented prior to withdrawal of the type 2 OPV component; early detection capacity was strengthened through additional investment in acute flaccid paralysis and environmental polio surveillance, and the country developed a comprehensive preparedness plan for response to a poliovirus event or outbreak, successfully testing this plan through a national polio outbreak simulation exercise in June 2017.

Uzbekistan's successful surveillance and preparedness during 2016–2017 were commended by the European Regional Certification Commission for Poliomyelitis Eradication.

398. With WHO support, a country-specific package of NCD interventions was implemented and several legislative documents related to tobacco control, nutrition issues, cancer control and NCD surveillance were revised. An integrated NCD "Healthy life" pilot project was introduced at primary health care level in two regions, with health system strengthening components; this is ready for national scale-up. WHO led a United Nations–Government multisectoral and interagency NCD task force, which developed a comprehensive NCD action plan for Uzbekistan. WHO also initiated a United Nations joint programme for comprehensive cervical cancer prevention and control.

399. The national immunization programme was reviewed and a post-introduction evaluation of pneumococcal conjugate vaccine was conducted. Best vaccine management practices were

institutionalized through strengthening of national legislation and regulatory frameworks with WHO support. Quality management system approaches in the supply chains of vaccines and other pharmaceuticals requiring a cold chain were adopted. Uzbekistan initiated the process of introducing the HPV vaccine.

400. Under the IHR (2005) agenda, the influenza programme and the Better Labs for Better Health approach, WHO led the process of development of national laboratory policy, guidelines on outbreak response and investigation, guidelines on critical care of influenza cases and supported the National Influenza Centre, which is now ready for accreditation.

401. In an effort to address AMR, WHO, with the Food and Agriculture Organization of the United Nations (FAO) and the World Organisation for Animal Health (OIE), supported the development of an intersectoral national plan of action for AMR emphasizing the "One Health" approach, involving human and veterinary medicine, agriculture, environment and other sectors. A system of data collection and analysis for antimicrobial medicines consumption was introduced.

402. A national guideline for maternal nutrition was developed with WHO support. A near perinatal death audit was conducted, which led to revised standards on supportive supervision with a focus on strengthened antenatal care, in line with WHO global recommendations.

403. Uzbekistan joined the WHO HBSC network and conducted the HBSC survey.

404. Survey results showed a very high sodium intake (6 g sodium per day = 15 g salt), equivalent to three times the WHO-recommended limit. As a result, WHO supported a series of activities: national laboratories were equipped to perform food composition analysis; the country committed to monitoring the salt content of commonly available foods as part of the WHO FEEDCities project, and primary care professionals were trained in healthy diets promotion, including salt reduction.

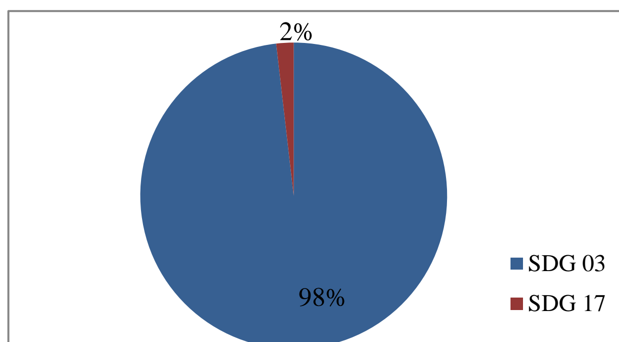
405. More details of WHO's work, funding and utilization of funds in Uzbekistan can be found at: http://open.who.int/2016-17/country/UZB.

406. In 2018–2019 Uzbekistan will continue to work with WHO, mainly focusing on the 16 priority programme areas identified through the BCA (see Box 31). The activities planned are mainly relevant to SDG 3 (see Fig. 35). This work will be further complemented by other programme areas delivered through the intercountry modality.

Box 31. Uzbekistan's priorities for 2018–2019

1. HIV and hepatitis
2. Tuberculosis
3. Malaria
4. Vaccine-preventable diseases
5. AMR
6. NCDs
7. Mental health and substance abuse
8. Reproductive, maternal, newborn, child and adolescent health
9. Health and the environment
10. National health policies, strategies and plans
11. Integrated people-centred health services
12. Access to medicines and other health technologies and strengthening regulatory capacity
13. Health systems, information and evidence
14. Polio eradication
15. Infectious hazard management
16. Country health emergency preparedness and IHR (2005)

Fig. 35. PB 2018–2019 planned activities by SDG in Uzbekistan



Summary by category

Communicable diseases

HIV and hepatitis

407. While the trend in new HIV diagnoses remained relatively stable in western Europe, in eastern Europe and central Asia it continued to increase steeply. By the end of 2016, an estimated 72% of people living with HIV had been diagnosed across the WHO European Region; 64% of those diagnosed were receiving ART; and 83% of people on ART had suppressed viral loads. However, only 28% of all people living with HIV (diagnosed and undiagnosed) in eastern European and central Asian countries were receiving ART at the end of 2016. Nevertheless, the Region as a whole has shown excellent results in terms of preventing mother-to-child transmission of HIV: 95% of HIV-positive pregnant women received ART to prevent transmission of HIV and two countries were officially certified as having eliminated it.

408. To reduce the burden of HIV and hepatitis further, the Regional Office developed, in consultation with Member States and partners, action plans for the health sector response to HIV and to viral hepatitis in the Region, both adopted by RC66 in 2016.

409. In 2017 a review of the HIV action plan showed that most of the recommendations had been integrated into national HIV strategies. Across the Region, 60% of countries had HIV strategies with integrated comprehensive packages of essential HIV services in their national health benefits packages. With WHO support, Belarus, Kyrgyzstan, the Republic of Moldova, Tajikistan, Ukraine and Uzbekistan revised their HIV treatment protocols; Kyrgyzstan, the Republic of Moldova and Tajikistan also revised their HIV testing strategies. Belarus, a pioneering country in eastern Europe and central Asia, implemented a nationally endorsed policy on the use and scale-up of self-testing in May 2017.

410. The Region contributed to the global decline in hepatitis B virus infections, reaching an estimated prevalence of 0.4% in children aged less than 5 years. During the biennium, 10 Member States adopted national action plans aligned with the regional action plan for the health sector response to viral hepatitis. Moreover, 49 of the 53 countries in the Region conducted universal hepatitis B vaccination in 2017; Norway and the United Kingdom are the latest countries to add the vaccine to their routine immunization schedules.

411. Georgia became a pioneering country with the adoption of a national strategy for the elimination of hepatitis C by 2020 at the onset of the biennium. Since the launch of the programme, almost 48 000 patients have started treatment with new antiviral medicines, of which almost 40 000 have successfully completed the treatment. Similarly, Belarus, Italy, the Republic of Moldova and Romania made great progress in improving access to antiviral medicines.

TB

412. In 2016 an estimated 290 000 incident TB cases occurred in the Region. The average annual decline in the TB incidence rate was 4.3% during 2007–2016, and during the same period the TB mortality rate fell by 57% from 6.5 to 2.8 deaths per 100 000 population; this was three times faster than the global average. At the same time, despite an impressive decline

in the TB notification rate per capita, the notification rate for rifampicin-/multidrug-resistant TB (RR/MDR-TB) rose by an average of 3% per year during 2012–2016, from 3.4 to 3.7 per 100 000 population.

413. The RR/MDR-TB case detection rate increased significantly from 33% in 2011 to 73% in 2016: the WHO European Region now has the highest detection rate in the world (the global consolidated average stands at 44%). However, it is the only region reporting an increase in new HIV infections, and TB/HIV incidence continues to rise at an annual average rate of 8.7% per year: in 2016, 12% of incident TB cases were estimated to be coinfected with HIV. In the same year 49 500 (96%) of detected RR/MDR-TB cases in the Region were enrolled in treatment, which is close to universal treatment coverage and surpasses the 90% target.

414. All Member States were supported to implement the global TB strategy through adaptation of their national action plans and guidelines in line with the Tuberculosis Action Plan for the WHO European Region 2016–2020. Intensive technical guidance was provided by WHO, with regular visits to high-priority countries in eastern Europe and central Asia (including epidemiological and programme reviews in all 12 eastern European and central Asian countries, as well as in Bosnia and Herzegovina and Romania) and daily support via country office staff. Assistance covered areas such as child and adolescent TB, management of drug-resistant TB, TB laboratory diagnosis and management of TB/HIV coinfection.

415. Policy dialogue with Member States pursued options for implementation of the strategy. For EU/European Economic Area countries, close collaboration with ECDC was maintained and TB data collection and surveillance and monitoring reports were produced yearly. Regional platforms through which Member States and partners can exchange views and experiences were established and maintained (including a workshop on cost-effective TB screening for refugees and migrants and a compendium of good practices in prevention and care of TB in correctional facilities).

Malaria

416. Following interruption of indigenous transmission of malaria in the Region in 2015, re-establishment was successfully prevented during the biennium: no indigenous malaria cases were reported in 2016 and 2017.

417. As continual importation of malaria cases from endemic regions can lead to re-establishment of transmission, the WHO Regional Office for Europe convened the first high-level consultation on preventing the reintroduction of malaria in the Region in July 2016 in Ashgabat, Turkmenistan. Following the meeting 10 countries (Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, the Russian Federation, Tajikistan, Turkey, Turkmenistan and Uzbekistan) reaffirmed their commitment to making all required efforts to maintain their malaria-free status, signing the Ashgabat Statement on preventing the re-establishment of malaria transmission in the WHO European Region. The Statement served as a new platform for planning, implementing and monitoring malaria prevention activities in the Region.

418. Along with maintaining malaria-free status, countries in the Region also invested in efforts to secure WHO malaria elimination certification. In November 2016 Kyrgyzstan was officially certified as a malaria-free country, while Uzbekistan initiated efforts to secure certification, expected to be certified by early 2018.

Neglected tropical diseases

419. In the 2016–2017 biennium WHO scaled up activities to combat the burden of neglected tropical diseases in the Region. A regional meeting on prevention and control of leishmaniasis helped identify gaps and priority areas for cooperation. A manual on case management and surveillance of leishmaniasis was published, outlining a standardized approach to the disease for the Region, and national programmes initiated revisions and development of their protocols. Georgia and Tajikistan conducted a survey of leishmaniasis and some countries received diagnosis tests and medicines for treatment of leishmaniasis from WHO.

420. Control and prevention of soil-transmitted helminths was reinforced, with development of a new framework and a set of methodological documents. Equipped with the framework, Tajikistan developed a national plan on soil-transmitted helminth control and Azerbaijan, Georgia, Kyrgyzstan and Tajikistan conducted deworming campaigns. Armenia, Azerbaijan, Kazakhstan, Kyrgyzstan, Romania and Tajikistan conducted surveys on soil-transmitted helminth prevalence.

421. A new training curriculum on invasive mosquitoes and (re-)emerging vector-borne diseases was developed to provide non-specialists with an understanding of key relevant issues and the analytical framework to improve strategic planning and implementation of activities; several training sessions took place in 2016–2017. Development of a manual for prevention of establishment and control of mosquitoes of importance to public health in the WHO European Region has been initiated and will be finalized during 2018.

Vaccine-preventable diseases

422. Progress in measles and rubella elimination was slow but evident, with fewer cases in 2016 than in any previous year on record; 37 countries have interrupted endemic transmission of one or both diseases. Countries in the Region have successfully introduced new and underutilized vaccines consistently over the biennium, and more than ever have established national immunization technical advisory groups and achieved financial sustainability.

423. As a result of competing priorities, evidence indicates that countries are challenged by a lack of financial commitment to achieving adequate immunization. Difficulties in accessing vaccines at affordable and optimum prices are compounded by global supply shortages. Further, Member States face difficulties in sustaining programme performance due to poorly researched access, hesitancy issues and the increasingly visible anti-vaccine agenda. The latter issues are particularly acute in middle-income countries.

424. WHO significantly scaled up its support to Member States to tackle these challenges by developing prominent price transparency projects and resource mobilization tools; strengthening capacity for vaccine safety management; enhancing communications to secure domestic financing of immunization programmes and of specific elements of vaccine demand; and building awareness and advocating measurement of vaccine hesitancy with proposed solutions to hesitancy and the measurement of hesitancy.

425. To promote demand for vaccination and to ensure equitable extension of vaccination services, WHO provided assistance to national immunization programmes, developing guidance tools and strengthening capacity through training activities. New guidance on how

to respond to anti-vaccine lobbyists was developed, together with a support package on vaccine safety and crisis communication. Celebrations of European Immunization Week included an international symposium and debate on measles and rubella elimination. A new "group of peers" was established to support Member States to respond to HPV vaccination hesitancy.

426. Six GAVI-supported countries remained in the vaccine sentinel surveillance network for rotavirus, while four others were part of the invasive bacterial vaccine-preventable diseases network. The Region now boasts 45 national immunization technical advisory groups, which assist national programmes with evidence-based decision-making on new vaccine introductions. Three countries introduced HPV vaccinations in 2017 with GAVI support and, with WHO support, Member States developed multi-year plans for immunization, outlining a costed plan of action.

AMR

427. Momentum for action on AMR continued to grow in the aftermath of the adoption of the global action plan on AMR in 2015; it was on the agendas of many high-level meetings such as the Seventy-first session of the United Nations General Assembly in 2016, and the G7 and G20 meetings in 2016 and 2017.

428. Countries in the Region are at different stages of development of their national action plans on AMR. During the biennium, 15 countries set up AMR intersectoral coordination mechanisms and drafted national action plans; 11 others are progressing towards the approval process; three have finalized action plans; and one country included AMR-related activities within its national health plan.

429. For the first time, AMR data were consolidated into a map covering the whole WHO European Region, with information from both the European Antimicrobial Resistance Surveillance Network (EARS-Net) and the Central Asian and Eastern European Surveillance of Antimicrobial Resistance (CAESAR) network. The scope of these networks continued to broaden: more countries introduced new approaches to stimulate routine sampling, building the foundation for national AMR surveillance; Salmonella was added to the CAESAR network's surveillance; and more laboratories participated in CAESAR external quality assessments. Furthermore, four countries provided national surveillance data to CAESAR for the first time (Bosnia and Herzegovina, Georgia, Montenegro and the Russian Federation) and two countries improved their data quality levels (Bosnia and Herzegovina and Serbia).

430. Countries in the Region celebrated World Antibiotic Awareness Week through a variety of activities and events in numerous locations, raising awareness among the public and health-care workers about the threat of AMR and what can be done to control it.

NCDs

431. Progress on NCDs in the Region continued to be a major success story. During the biennium, significant progress was achieved against the global SDG/NCD targets and NCD progress indicators, as well as the outcome indicators.

432. Premature mortality continued to decline steadily; if the trend continues, it is likely that the European Region will be the only WHO region to exceed the agreed SDG target of mortality reduction by one third between 2010 and 2030.

433. Implementation of priority actions improved steadily, and an overall increase in achievement of the 19 progress monitoring indicators (PMIs) set by WHO in 2015 was registered during 2016–2017. Full achievement of PMIs by Member States rose from 34% in 2015 to 42% in 2017, and partial achievement increased from 69% to 76% during the period.

434. Prevalence of raised blood pressure decreased and is likely to reach the 2025 target. Similarly, it is expected that alcohol per capita consumption will decrease by 9% by 2025, within the target. While the Region is unlikely to achieve the targets related tobacco use, physical activity, obesity/diabetes, or salt consumption by 2025, good examples and success stories were demonstrated at the country level.

435. To further the prevention and management of NCDs and their risk factors, the Regional Committee endorsed the Action Plan for the Prevention and Control of Noncommunicable Diseases in the WHO European Region 2016–2025 in September 2016. By the end of the biennium 35 countries had a multisectoral NCD plan (NCD progress monitor), so 66% of Member States fully achieved this indicator, up from 43% in 2015.

436. During the biennium, the proportion of countries increasing tobacco excise taxes (PMI 5a) increased to 47%, although nine countries did not reach taxes above 50% of the retail price of a packet of cigarettes. During the two-year period, six countries adopted new legislation fully aligned with the WHO FCTC; 12 countries ratified the Protocol to Eliminate the Illicit Trade in Tobacco Products and seven countries adopted plain packaging for tobacco products.

437. With regard to alcohol, only 13% of Member States fully implemented pricing policies such as excise tax increases on alcoholic beverages in 2017.

438. In contrast, 62% of countries adopted national policies that limit saturated fatty acids and virtually eliminate industrially produced trans-fatty acids in the food supply (PMI 7b) – a significant 20% increase since 2015. Two thirds of Member States implemented the WHO set of recommendations on the marketing of foods and non-alcoholic beverages to children (PMI 7c) – a 24% increase since the previous biennium.

439. Furthermore, 28 Member States established joint surveillance and monitoring mechanisms on physical inactivity as part of the implementation process of the Physical Activity Strategy for the WHO European Region 2016–2025, while others increased the number of physical education classes and/or mandated their health services to implement physical activity prescription schemes.

440. Full implementation of cardiometabolic risk assessment and management in primary health care almost doubled from 30% (2015) to 58% (2017) of countries. With WHO support, at least five high-burden Commonwealth of Independent States (CIS) countries achieved global NCD target 8 related to treatment and counselling for people at high risk of cardiovascular disease.

441. By 2017, more than two thirds (68%) of Member States in the Region had fully implemented evidence-based national guidelines for NCD management – an increase from the 45% baseline at the onset of the biennium (2015). WHO provided technical assistance to 14 high-burden countries to implement essential NCD interventions in primary health care. Tailored technical assistance for cancer screening and early diagnosis and screening was provided to six countries, while four received support in the field of cancer treatment and/or palliative care and eight participated in a workshop on cancer screening and early diagnosis.

Mental health and substance abuse

442. Across the Region, the treatment gap for people with mental and substance use disorders remains substantial, especially for the more "common" mental disorders of depression and anxiety. Raising awareness about depression and options for accessing care was an important first step to increase demand and uptake of care, which the World Health Day 2017 campaign ("Depression: let's talk") did much to enhance in the Region and beyond.

443. Policy dialogue at the national level was largely focused on increasing access to evidence-based, person-centred and community-based services, leading to policies, plans and practices that pursued this objective. At the international level, mental health was explicitly included within the SDGs, providing renewed opportunities for policy engagement and country action on the social determinants of mental health and intersectoral responses to address the access gap.

444. WHO activities and achievements contributed to the central objectives of the European and global mental health action plans, which in turn enabled structured progress to be made towards increasing access to services for mental health and substance abuse.

445. An assessment of the quality standards and human rights situation in long-term institutions for people with mental disabilities in more than 20 countries in the Region conducted during the biennium resulted in a set of country-specific reports highlighting key areas for improvement and policy-making. In addition, WHO provided technical assistance on mental health policy and service reform to Bulgaria, Estonia, Greece, Kyrgyzstan, Lithuania and Ukraine.

446. The Regional Office and 33 country offices in the Region participated in the global advocacy campaign on the theme of World Health Day 2017. Data collection for the mental health atlas 2017 was secured for all Member States in the Region with WHO coordination and support.

447. To address the Region's needs, WHO published a technical report to address comorbidity between mental disorders and major NCDs and provided advice and capacity-building on mental health and psychosocial support to countries in need (including Turkey and Ukraine).

448. To implement the evidence-based alcohol policy of using primary health care settings to identify those patients drinking at risky levels, WHO developed a training of trainers toolkit (a 1.5-day training course with manuals) to be disseminated to, and support, workers in the Region.

Violence and injuries

449. During the biennium, countries reported greater policy priority in the area of violence and injuries: developing national strategies and improving legislation for risk factors in the areas of road traffic injuries, child injuries and violence. As a result, some even reported a mortality reduction.

450. Legislative reviews, policy dialogues and capacity-building workshops were held during the period to support countries to achieve the goals of the Decade of Action for Road Safety 2011–2020 and SDG target 3.6, thus preventing and managing unintentional injuries within the Region. National data coordinators were recruited in 53 countries to contribute to the global status report on road safety, while 51 countries completed surveys and held policy dialogues on road safety. The Region supported the United Nations Global Road Safety Week actions on speed and slowing down, with strong participation by around 40 countries.

451. Evidence on child injury prevention programmes was disseminated within the Region and, with WHO support, experiences were shared among countries during a global focal point meeting in Finland. Capacity-building initiatives and policy dialogues took place in Belarus, Cyprus and Kazakhstan; Serbia conducted a situation analysis review using a global policy instrument.

452. Using the evidence from ACE surveys, six countries (Albania, Czechia, Latvia, Lithuania, the Republic of Moldova and Ukraine) conducted policy dialogues. Czechia adapted guidelines for violence against women and Latvia hosted the Nordic–Baltic workshop on the prevention of violence against children, at which countries exchanged expertise in intersectoral responses to achieve SDG target 16.2 (end abuse, exploitation, trafficking and all forms of violence and torture against children).

453. National data coordinators were identified in 48 countries for the Countdown to 2020 European status report on child maltreatment prevention, and good progress was made on data collection (50% of surveys had been completed by the end of the biennium).

Disabilities and rehabilitation

454. To improve access to services for people with disabilities in the Region, Member States increased their requests for WHO support for strategic policy development and for specific activities during the 2016–2017 biennium.

455. Six countries singled out improving services for people with disabilities as a priority for collaboration with WHO (Montenegro, Republic of Moldova, Slovakia, Slovenia, Tajikistan and Ukraine).

456. Technical assistance was provided to Slovakia and Ukraine to introduce new policies or laws on preventing disability and strengthening rehabilitation.

457. A major highlight of the programme was the maintenance and expansion of Tajikistan's rehabilitation capacity. The tools and experience gained have the potential to be used in other countries, thus improving capacity across the Region.

458. Although very successful in a small number of countries, this policy area had limited scope within the Region during the biennium, mainly owing to resource limitations.

Nutrition

459. Over the two-year period significant progress was achieved in this area by Member States in the Region. The vast majority of countries adopted measures to promote healthy diets in schools (96%), including setting standards for foods available in schools (87%).

460. Significant progress was made on lists of mandatory nutrition declarations and ingredients: 90% of countries reported nutrient declarations, 77% reported mandatory declarations on all pre-packaged food and 98% reported ingredients lists. In addition, many countries reported voluntary front-of-pack labelling (69%), although only 27% issued specific guidelines, legislation or regulations to guide such labelling. Most countries in the Region reported some activities related to food product reformulation.

461. Excellent progress was made across the WHO European Region in the introduction of measures to eliminate industrial trans-fats from the food supply. The latest data reveal that many countries in the Region took steps to limit marketing of food high in fat, sugar or salt to children. Nevertheless, many countries (44%) are yet to report any action on that front.

462. The vast majority (98%) of countries in the Region reported implementing breastfeeding counselling, mainly with regard to early initiation and continued exclusive breastfeeding to six months.

463. To reduce nutritional risk factors, initiatives for the promotion of healthy diets and the creation of healthier food and drink environments were undertaken in the Region.

464. Substantial progress was made in areas such as school food policies, food product reformulation, fiscal policies and childhood obesity surveillance. Areas where implementation lagged – such as front-of-pack labelling and comprehensive marketing restrictions – will require attention in the future. Simultaneously, other areas may also need to be reinvigorated or expanded, such as support for breastfeeding and complementary feeding counselling.

465. Member States continued to implement the WHO European Food and Nutrition Action Plan 2015–2020 and WHO supported them with development of relevant tools such as the nutrient profile model and with specific training approaches for primary health care settings.

466. Work was also undertaken to gather and generate evidence on digital marketing, price policies and trans-fat elimination. To anticipate future scenarios, obesity and salt and sugar reduction models were developed, and work was done beyond the health sector to review regulatory frameworks and food supply chain interventions.

467. The Regional Office provided technical assistance to 40 Member States in the area of nutrition, as part of bilateral country agreements, and implemented targeted support to national nutrition programmes in 23 Member States.

468. During the biennium, the COSI survey was further expanded. By the end of the biennium this unique system was measuring trends in overweight and obesity among primary school-aged children across 41 countries and covering close to half a million children in the Region.

469. Lastly, during the two-year period, a significant amount of evidence was gathered through technical and scientific reports and policy briefs to better inform policy-making in the Region.

Promoting health through the life course

Reproductive, maternal, newborn, child and adolescent health

470. The Action Plan for Sexual and Reproductive Health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind was endorsed by RC66 in September 2016. This comprehensive framework supports countries in ensuring sexual and reproductive health and well-being for all across the Region. Five countries initiated the development of sexual and reproductive health national strategies with WHO assistance since endorsement of the Action Plan.

471. A framework for improving the quality of care for reproductive, maternal, neonatal, child and adolescent health in the Region was also developed and made available to Member States in English and Russian.

472. To comply with the Action Plan for Sexual and Reproductive Health and SDG commitments, WHO assisted eastern European and central Asian countries in developing policies to implement perinatal audits that integrate confidential enquiries into maternal deaths and near-miss case reviews.

473. To improve the quality of interventions for ending preventable maternal, perinatal and newborn deaths, eight countries initiated the planning of a maternal sepsis study and Kyrgyzstan published evidence on the expansion of safe abortion services. Four countries focused their efforts on antenatal care, while another four developed or updated their national antenatal care guidelines with WHO support.

474. Country profiles for sexual and reproductive health and maternal health for all 53 Member States were developed and published through the WHO European Health Information Gateway, providing information for policy-making. In addition, 48 Member States contributed to a baseline survey on national policies and practices for child and adolescent health; the results will also be disseminated through the gateway and as a report.

475. In 2016–2017 the Regional Office developed guidance and several tools to support Member States, including a tool to develop national child and adolescent health strategies and plans, a mobile application to improve quality of care, a near-miss case review manual, a new module for the effective perinatal care training package and a revised antenatal care module.

476. To further improve the health of children and lay the foundation for the next generation of the WHO Integrated Management of Childhood Illness strategy, a review of the European Region’s experience was undertaken in 16 countries. A subsequent consultation exercise on “child health redesign” led to the development of recommendations for WHO guidelines in this area.

477. To counter the lack of attention to newborn health, following a July 2017 intercountry meeting on accelerating progress in maternal and newborn health in central Asia and the Caucasus in the context of the SDGs, seven countries drafted national roadmaps to improve

newborn care. In addition, further early childhood development work, preparatory work on guidelines, referral pathways and a framework for nurturing care were completed during the biennium.

478. A report on the HBSC survey was launched midway through the biennium and the 2017–2018 school year survey was launched after a review of survey protocols and data analysis approaches. The survey results guided country feedback and implementation of the survey on child and adolescent health strategy, and further documented relevant adolescent health policies.

479. With the support of WHO collaborating centres, school health approaches were developed throughout the Region to expand access to and improve the quality of effective preventive interventions for children and adolescents. In a cross-cutting collaboration, water and sanitation for health was introduced within the sexual health education approaches developed in the Region.

Ageing and health

480. During the biennium, efforts continued to increase the proportion of older people who can maintain an independent life. The Region has 20 countries with at least one city/community member of the Global Network of Age-friendly Cities and Communities, and more than 230 member cities. A handbook and a comprehensive set of tools published for local and regional governments will further support the growth of age-friendly environments across the Region, in cooperation with the European Healthy Cities Network.

481. At the end of 2017, 29 Member States had a national programme on ageing, including substantial policies, strategies or actions on healthy ageing. Furthermore, with WHO support, two additional countries developed national policies (Tajikistan and the former Yugoslav Republic of Macedonia) on healthy ageing and seven countries developed multisectoral policies on ageing and health (Lithuania, the Republic of Moldova, Slovakia, Slovenia, the former Yugoslav Republic of Macedonia, Turkey and Ukraine), with a focus on long-term care.

482. Demand from Member States in this policy area continued to grow, as reflected in the increased 2016–2017 regional budget (versus 2014–2015) and in the approved 2018–2019 budget. Furthermore, the Regional Office saw an increase in the number of ad hoc requests for technical and policy support from Member States.

483. Separately, cooperation within WHO's programme areas was also strengthened and efforts converged to address common goals, such as through the country review of integrated long-term care delivery, as well as policies on long-term care for universal health coverage under the SDGs, vaccination, nutrition and the draft European strategy on men's health.

484. The Regional Office for Europe reviewed and analysed national reports and policy documents to provide a regional perspective for the midterm review of progress in implementing the global action plan on ageing and health.

Gender, equity and human rights mainstreaming

485. 2016–2017 was an important biennium for this area of work in the Region, with several documented successes – the most significant being the adoption by RC66 of the Strategy on

Women's Health and Well-being in the WHO European Region and the launch of the flagship report *Women's health and well-being in Europe: beyond the mortality advantage*.

486. An assessment of the health system response to NCDs in Kazakhstan included a strong component on gender and encouraged further work to address the gender impact on health-care access and health system responses. This work supported the development of the Strategy on Women's Health and Well-being and raised awareness of the impact of masculinities on health, integrated into the development of the draft European strategy on men's health.

487. After the adoption of the Strategy on Women's Health and Well-being, the Regional Office developed cross-divisional packages on gender and rights-based approaches to support its implementation at the country level and a framework for monitoring implementation. Building on this experience, the Regional Office initiated the development of a men's health and well-being report and strategy from a gender and human rights perspective.

488. The biennium also saw increased partnership coordination on gender equality at regional levels through the United Nations Issue-based Coalition on Gender.

Social determinants of health

489. Member States placed increasing emphasis on social determinants of health and inequities in the Region. Firmly anchored in the Health 2020 policy framework, a new roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020, was adopted during RC67 in 2017, to strengthen SDG implementation at the national and subnational levels within the Region.

490. Major investments were made to increase practical support to cross-sectoral policy-making, including the launch of a flagship course on Health in All Policies (attended by representatives of one third of the countries in the Region); knowledge products and communication tools on the investment case for health equity and well-being; and best practice policy exchanges, such as the Nordic–Baltic Health 2020 Social Determinants and Health Equity Collaboration.

491. In Croatia, a country policy review was used to strengthen dialogue and work between the health, employment and social sectors. The effectiveness and impact of occupational services and policies for vulnerable populations increased thanks to improved collaboration between the three sectors tackling poor health, social exclusion and employment.

492. A policy review in Tajikistan to improve early years outcomes generated evidence on the best available options for cross-sectoral policies to support the Ministry of Health and Social Protection in developing a new national child and adolescent health strategy, with an intersectoral focus and addressing health determinants.

493. During the biennium, a large number of refugees, asylum seekers and migrants continued to flow through Hungary, making it both a receiving and a transit country. The 2015 report on the health authorities' assessment of the health system's capacity to respond to large-scale migration (using the WHO toolkit) was published in 2016 and identified gaps in preparedness and health system capacity, developed informed health interventions and promoted intersectoral collaboration in the development and implementation of a health sector response.

494. The refugee and migration crisis increased Member States' activities and requests for WHO support. The strong response from the Regional Office had an impact within and beyond the Region through various high-level events conducted during the period, including two courses on refugee and migrant health.

495. To improve migrant health and reduce health inequities, within a migration and health project supported by the United Nations High Commissioner for Refugees and the International Organization for Migration, WHO developed the first toolkit to assess health system capacity to respond to large-scale migration and to support national and subnational health authorities leading multisectoral collaboration when managing large influxes of refugees, asylum seekers and migrants.

496. The effective network of WHO collaborating centres and high-level external experts, together with WHO support to country offices, led to several innovations (including the European Health Equity Status Report and further investment for health approaches). A united approach from the Regional Office and proactive collaboration across the various technical areas have increased momentum in terms of demand and WHO support for strengthened intersectoral policies and actions to increase health equity by addressing social determinants of health.

497. The successes of the Regions for Health Network and the small countries initiative coordinated by the Office for Investment for Health and Development in Venice, Italy, have also contributed strongly to very positive feedback from Member States.

Health and the environment

498. In Tajikistan, the Ministry of Health and Social Protection and a high-level multisectoral steering group led a large-scale intervention on water safety planning and water quality surveillance, with WHO support and funding from the Finnish Ministry of Foreign Affairs. This joint project led to a major policy achievement: WHO-recommended water and sanitation safety planning approaches were incorporated into a draft law on drinking water and sanitation – a milestone for the country and the Region. Through the project and during the biennium, a national team of water safety trainers was established and sector capacity for water safety planning and risk-based drinking water quality surveillance was strengthened, with a focus on vulnerable rural areas and small-scale water supplies. Furthermore, national laboratory capacity for analysing core drinking water quality parameters was strengthened and closely monitored pilot projects led to the building of local experience and knowledge that will support scale-up of water safety planning in the country.

499. To reduce environmental threats to health, the Regional Office continued work on norm and standard setting and guideline development for environmental and occupational health risks and benefits. Highlights for 2016–2017 include the updating of the WHO global air quality guidelines, a review of the environmental noise guidelines for the Region, the launch of a new tool to estimate the health impacts of air pollution, the publication of an action brief and an evidence review on urban green spaces, and a review of the evidence on environmentally sustainable health systems.

500. Significant progress was made in enhancing country capacity to monitor environmental health SDG-related indicators with the roll-out of WHO-led global monitoring instruments and the strong participation of Member States in the Region in the WHO/UNICEF Joint

Monitoring Programme to monitor SDG targets 6.1 and 6.2 and in the United Nations Water Global Analysis and Assessment of Sanitation and Drinking-water to monitor targets 6.a and 6.b.

501. Moreover, the Region's efforts towards implementation of the Minamata Convention advanced, with the Global Review of Mercury Monitoring Networks.

502. The European Environment and Health Process and the Sixth Ministerial Conference on Environment and Health in 2017 resulted in the adoption of the Ostrava Declaration. This links the work on environment and health to the implementation of the 2030 Sustainable Development Agenda, emphasizes the role of cities and regions, and commits Member States to developing national portfolios for action on environment and health by 2018. Complemented by an implementation plan and a new institutional framework for the Process, the Ostrava Declaration was endorsed by RC67 in 2017.

503. Within the framework of the Transport, Health and Environment Pan-European Programme, a new report on cycling and green jobs and a new version of the health economic assessment tool for walking and cycling were launched in 2017. As part of the joint secretariat of the Protocol on Water and Health, WHO organized the governing body meetings, including the fourth session of the Meeting of the Parties.

504. The Joint WHO/United Nations Economic Commission for Europe Convention Task Force on Health Aspects of Long-range Transboundary Air Pollution met and agreed a new workplan for 2018–2019. During the biennium, WHO served as an observer at the meeting of the Parties to the Convention on Environmental Impact Assessment in a Transboundary Context but will be included in the development of advanced guidance on health in strategic environmental assessments in 2017–2020.

Health systems

National health policies, strategies and plans

505. During the biennium, several countries introduced new policies for improved population coverage and financial protection. Significant progress towards universal health coverage was registered in Estonia, Georgia, Kyrgyzstan, the Republic of Moldova and Ukraine.

506. In Montenegro, strong scientific evidence was gathered about the short- and long-term health and social consequences of adverse childhood experiences. The 2012 ACE survey data, coupled with subsequent technical consultations with WHO, influenced policy-makers to move forward with the development of a strategic response to address the issue; the country is one of a handful in the Region to do so. With WHO support, an intersectoral working group from the health, education, welfare and justice sectors, as well as ombuds, police and NGOs, drafted a strategy that was presented during a high-level policy dialogue and led to the adoption of the national strategy on protection of children from violence. Subsequent technical assistance resulted in a medical faculty curriculum review to include child maltreatment-prevention modules.

507. Longstanding policy support in Estonia produced tangible results in the biennium. Building on the WHO recommendations to improve the financial sustainability of the health system and to strengthen financial protection, the government introduced coverage policy

measures to reduce the burden of out-of-pocket payments for medicines and dental care. Estonia is the first country to act upon the new evidence on financial protection produced using the Regional Office's approach to monitoring universal health coverage, which is suited to high-income countries and supports pro-poor policy actions. The government will gradually increase budget transfers to the health insurance fund to improve sustainability of financing for improved coverage policies.

508. Excellent progress was made with the support of the Regional Office on all of the three health financing streams: policy support and dialogue on universal health coverage at the country and regional levels, with particular success in Estonia, Georgia and Ukraine; improved methodology in monitoring financial protection among Member States in the Region; and capacity-building, primarily through Barcelona-based courses on health financing for universal health coverage and health systems strengthening, with a focus on NCDs and TB.

509. In the area of health financing, one of the most relevant achievements was the production of new evidence on financial protection for 25 countries in the Region, supporting country-level policy dialogue and development of policies to make progress towards universal health coverage. This also served as a baseline for SDG monitoring.

Integrated people-centred health services

510. In September 2016, RC66 endorsed Strengthening people-centred health systems in the WHO European Region: framework for action on integrated health services delivery. Several Member States subsequently requested WHO support to develop new national health strategies and policies to operationalize integration of services from prevention and promotion to palliative care in different settings, from the community level to tertiary specialized services.

511. Overall, integrated services based on renewed primary health care remained high on health ministry agendas in the Region. Countries showed progress either by supporting integration along one of the three avenues (integration of primary care with hospitals, with social services or with public health) or by renewing commitment to strengthening primary health care: increasing the overall resolutive capacity of the first contact, particularly for NCDs.

512. Across the Region WHO conducted many service delivery assessments in areas such as public health operations, ambulatory care-sensitive conditions and primary care in a multitude of countries yielding to policy recommendations later followed up by countries to ensure implementation.

513. WHO continued to support Member States in reviewing models of care, working towards people-centred services to tackle the NCD burden, ageing, multimorbidity and other areas.

514. The Regional Office pioneered an approach to strengthening the health system response to TB in 11 countries through the TB Regional Eastern Europe and Central Asia Project (TB-REP) on Strengthening Health Systems for Effective Tuberculosis and Drug-Resistant Tuberculosis Control.

515. RC66 in 2016 also considered the midterm progress report on implementation of the European Action Plan for Strengthening Public Health Capacities and Services. This led to the launch of the Coalition of Partners to strengthen public health capacities and services in the Region, bringing together public health experts and practitioners from Member States, international organizations and networks, civil society and academia. The highly participatory and action-oriented approach from all the Member States led to the development of several shared tools and resources that will be piloted at the country level in the 2018–2019 biennium.

516. The response to the conclusions of the Midterm progress report also led to an increased focus on the enabler Essential Public Health Operations (EPHOs): human and financial resources for public health services; public health law; and organization and governance of public health services. The Regional Office supported Member States with EPHO self-assessments and introduced tools to facilitate and standardize the self-assessment. The experiences and lessons learned in seven countries from conducting EPHO self-assessments were assessed. In a CIS-wide meeting, these seven Member States shared their experiences of implementing actions arising from the self-assessments.

517. To strengthen the health system response to NCDs, WHO led a series of country assessments and convened an interregional meeting on health systems, the IHR (2005) and EHPOs.

518. To accelerate the Region's efforts in achieving a sustainable health workforce in September 2017, RC67 endorsed the framework for action, Towards a sustainable health workforce in the WHO European Region; WHO developed and launched a toolkit for its implementation. Evidence on human resources for health was generated and published.

519. The Regional Office also contributed to global WHO initiatives during the biennium, such as the Global Strategy on Human Resources for Health: Workforce 2030, the Health Workforce Accounts and the United Nations High-level Commission on Health Employment and Economic Growth.

520. Significant efforts were made in the preparation of high-level events planned for early 2018, with an emphasis on health systems responses to NCDs, as well as the 10th anniversary of the Tallinn Charter and the Declaration of Alma-Ata 40th anniversary celebration.

521. Greek health reform efforts during the biennium contributed to the improvement of health and health equity in Greece, especially among the most vulnerable in the crisis-affected population. The WHO-led project helped the Greek authorities to move towards universal coverage and to strengthen the effectiveness, efficiency and resilience of their health system.

522. A major milestone in Greek health reform was reached at the end of 2017 with the inauguration of three local health units, with the aim of reducing inequalities and barriers to accessing quality health services. These units, the first of their kind in the country, are part of the Government's broader efforts towards establishing modern, people-centred primary health care services in Greece. Key elements of the newly designed primary health care system, the units serve as the first points of contact and the main coordinators of care for people in the area. Multidisciplinary teams (general practitioners/family doctors, paediatricians, nurses, health visitors and social workers) provide health care for people in a continuous manner, looking at disease prevention, health promotion, diagnosis, treatment, monitoring and care. With clear referral mechanisms, the units are a major change from the previously fragmented

network of public and private health providers, primarily specialists, providing care upon request and with little coordination.

Access to medicines and other health technologies and strengthening regulatory capacity

523. To improve access to medicines and technologies, Estonia, Greece, Kyrgyzstan, Lithuania, the Republic of Moldova and Ukraine further developed their national pharmaceutical policies, with support from the Regional Office.

524. Kyrgyzstan and the Republic of Moldova reviewed their medicines selections with WHO support.

525. During the biennium, Member States shared best practices in pricing and reimbursement policies through yearly Pharmaceutical Pricing and Reimbursement Policies network meetings and summer schools organized by the Regional Office in collaboration with the WHO Collaborating Centre for Pharmaceutical Pricing and Reimbursement Policies, Vienna, Austria. In addition, workshops were held on strategic procurement, facilitated learning and information sharing between Member States.

526. The Greek authorities conducted a review of the national medicine reimbursement committee and introduced health technology assessment principles to the decision-making process, with WHO support.

527. During Malta's EU presidency in 2017, the Regional Office developed a policy brief on access to medicines to improve the situation across the Region; this led to Member States adopting a decision on access to medicines during RC67.

528. To generate evidence for policy-making, the Regional Office analysed and disseminated data on access to and use of medicines and other health technologies, including antimicrobials, using agreed methodologies and processes. Furthermore, WHO supported Member States in developing/adapting policies, strategies and technical guidelines to promote access to and evidence-based selection and rational use of medicines, vaccines and other health technologies, including creating essential medicine/technology lists.

529. The biennium saw the publication of the report *Antimicrobial Medicines Consumption (AMC) Network: AMC data 2011–2014* (2017) and AMC Network consultations. Regional reports on trends related to availability, prices and financial mechanisms for essential medicines were also published.

Health systems information and evidence

530. Several initiatives contributed to well-functioning health information and research systems to support national health priorities, with support from the Regional Office, during the biennium.

531. In Estonia, the EVIPNet team developed and published a policy brief on taxation of sugar-sweetened beverages that led to a parliamentary decision to implement a sugar tax.

532. The Government of Czechia endorsed a national e-health strategy in November 2016 after a long negotiation process.

533. A new health research network was established in the aftermath of a multicountry meeting on health research systems and strategies held in Bulgaria in late 2017. At the meeting Member States adopted the Sofia Declaration, in which they renewed the commitment to the use of evidence, information and research in policy-making as set out in the Action Plan to Strengthen the Use of Evidence, Information and Research for Policy-making in the WHO European Region, endorsed by RC66.

534. During the biennium, Bulgaria, Georgia and the Republic of Moldova each developed and launched their respective *Highlights on health and well-being* and *Profile on health and well-being* publications.

535. The Republic of Moldova furthered efforts towards comprehensive monitoring of the global, regional and national health situation, trends, inequalities and determinants, introducing global standards (including data collection and analysis) to address data gaps and assess system performance.

536. With WHO support, Slovenia, an EVIPNet pilot country, started to create evidence briefs and decided to establish a national country team within the Ministry of Health.

537. In 2016–2017 Turkmenistan initiated a national health research system assessment; the findings and recommendations fed into a draft national health research strategy being developed with WHO support.

538. To strengthen the capacity of national officers to register causes of death, the Regional Office conducted an autumn school on health information and evidence for policy-making in Georgia in 2017, following a 2016 autumn school addressing the full cycle of public health monitoring and reporting.

539. To complement the three existing networks and sharing of experiences, four new health information networks were established within the Region: the Small Countries Network, the Burden of Disease Network and the Health Research and Health Literacy Network. Furthermore, EVIPNet Europe continued to grow, with 21 countries registered as members at the end of 2017.

540. The Regional Office launched the Health for All explorer tool on the European Health Information Gateway, while the joint monitoring framework for reporting on indicators for the SDGs, Health 2020 and the Global Action Plan for the Prevention and Control of NCDs was approved by Member States. The gold-standard European Health for All database was also updated continuously with data submitted by Member States.

541. Since 2015 the Regional Office has published *Public Health Panorama*, a quarterly, peer-reviewed, bilingual (English and Russian), open-access, fee-free journal. This publication aims to disseminate good practices and new insights in public health from the 53 Member States in the Region. By publishing in both English and Russian, the journal allows different parts of the Region to share their knowledge and experience. In 2016–2017, eight issues were published; each of these was the result of close interdivisional collaboration.

WHE

Infectious hazard management

542. Efforts in the Region to improve risk mitigation strategies for pandemic influenza continued. During the biennium, three additional countries revised their national pandemic preparedness plans, bringing the total number of countries with published revised plans in the Region to 16.

543. An analysis of seven seasons of influenza vaccination uptake data since 2008 showed that there was an increased uptake in several eastern European countries. However, overall, uptake remained low in the Region and declined in the western part of the EU. The period saw an increase in uptake of seasonal influenza vaccine in WHO-recommended risk groups in six countries, with Lithuania using TIP FLU and the other five countries benefiting from Partnership for Influenza Vaccine Introduction donations.

544. During 2016–2017, national influenza centres in 42 countries maintained recognition by WHO and the recognition of Montenegro's influenza centre increased the number of countries with a WHO-recognized centre in the Region to 43; 49 of 50 countries, including four of the five countries supported by the Pandemic Influenza Preparedness (PIP) framework, provided data to Flu News Europe and global influenza updates; 47 of 50 countries, including three of the five countries supported by the PIP framework, shared influenza viruses with WHO.

545. Under the Better Labs for Better Health initiative, 16 national reference laboratories in nine countries improved the quality of their laboratories through the mentoring programme. In addition, Kyrgyzstan implemented its national laboratory strategy, equipping and funding 10 maternal and child health hospital laboratories to implement quality management systems.

546. The Region became better equipped to mitigate risks from high-threat infectious hazards via knowledge transfer as a result of training carried out by the Regional Office. During the biennium, at least 39 countries and more than 560 experts were trained in outbreak investigation and response, clinical management of severe influenza, laboratory quality and biosafety, shipment of infectious substances, influenza virological techniques, burden of disease estimations, influenza vaccine delivery, influenza bulletin development and surveillance evaluation. Courses included training of trainers, blended learning and co-implementation with partners (CDC, WHO Collaborating Centre for Reference and Research on Influenza, Francis Crick Institute, London, United Kingdom, and Robert Koch Institute, Vienna, Austria).

547. The biennium saw the onset of the identification of needs pertaining to laboratory networks for preparedness and response to high-threat pathogens, infection control and prevention, and clinical management of Crimean-Congo haemorrhagic fever and influenza.

548. Five countries (Armenia, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan) revised national guidelines for influenza surveillance, for outbreak investigation and for the critical care of patients with severe respiratory infections through the PIP framework. Two countries (Germany and Iceland) published revised national pandemic preparedness plans and one country (Bulgaria) initiated a review of its national plan.

Country health emergency preparedness and the IHR (2005)

549. During 2016–2017, countries core IHR (2005) capacities were further strengthened through training and networking with national IHR focal points and particularly through the JEEs conducted in 10 countries (Albania, Armenia, Belgium, Finland, Latvia, Lichtenstein, Kyrgyzstan, Slovenia, Switzerland and Turkmenistan); their recommendations were considered very useful by the assessed countries. As a follow-up to the JEEs, five countries (Belgium, Finland, Kyrgyzstan, Latvia and Turkmenistan) continued with the development of national action plans for health security.

550. Simulation exercises of various kinds were much requested by Member States. During the biennium, the Regional Office tailored these simulations to high risks (mainly earthquakes or floods combined with outbreaks of disease) and focused on priority countries.

551. Most countries responded positively to WHO's strong advocacy of the four IHR (2005) monitoring and evaluation instruments, the mandatory State Party self-assessment annual reporting and the three voluntary components simulation exercises. After action reviews and JEEs were used to assess and address critical gaps in preparedness for health emergencies both under the IHR (2005) and for all-hazard health emergency risk management. Further work needs to be done on intersectoral approaches, as the health sector alone cannot solve the tasks at hand.

552. The Regional Office presented priorities for IHR (2005) implementation in the Region at RC67 in September 2017. It was agreed that the document should serve as the basis for development of an action plan to improve public health preparedness and response in the WHO European Region, aligned with the five-year global strategic plan.

553. National capacities were also strengthened through assessments of health system preparedness for crisis management. WHO supported several countries to prepare their national health emergency preparedness plans, with the development of a general template.

554. During the biennium, 225 hospitals in 14 countries were assessed with the revised Hospital Safety Index to identify weaknesses, to strengthen resilience in case of disasters and to enable them to function better in times of highest need.

555. The Republic of Moldova was the first European country to apply the Hospital Safety Index to all public and some private hospitals in the country (68 hospitals). The resulting action plan was approved by the Ministry of Health; the main parts of the assessment recommendations became mandatory for the construction of new hospitals or the retrofitting of existing hospitals. This workflow was also followed by Georgia and Kyrgyzstan.

556. Mass casualty management capacity was strengthened during the biennium. A training package on providing medical support to countries during and after such events is under development. With regard to preparedness for mass gatherings in the Region, training, workshops on legacy and simulation exercises were provided to seven countries that hosted cultural or sporting events during 2016–2017.

557. Furthermore, contingency planning and risk assessments continued throughout the biennium to enable Member States to assess the main risks and develop contingency plans, as part of overall operational readiness efforts and emergency preparedness.

558. Emergency risk communication was scaled up in the Region, with 10 countries (Armenia, Estonia, Kyrgyzstan, Romania, Serbia, Slovakia, Slovenia, Sweden, Turkey and Turkmenistan) participating in the five-step capacity-building package at various levels.

Health emergency information and risk assessment

559. During 2016–2017, all significant public health events of potential international concern were detected in the Region. The official IHR (2005) communications and continuous event-based surveillance conducted by the Regional Office, with backup from WHO headquarters and key partners (especially ECDC), led to the assessment and recording of 94 potentially serious public health events from the approximately 20 000 signals analysed per year.

560. A global internal rapid risk assessment tool was launched in early 2017 and applied to six events in the European Region during the remainder of the biennium. Significant public health events in the Region were shared through the IHR Event Information Site (EIS) (26 postings/announcements), reaching all 196 States Parties to the IHR (2005) globally. These allowed countries to take the required precautionary measures and actions to prevent, detect and control international spread as early as possible.

561. During the biennium, 21 new IHR EIS postings and six EIS announcements were published for the Regional Office. There were 19 disease outbreak news postings for events in Europe, and a news item was posted on the Regional Office's public website for each.

562. To further strengthen communication and to explore new interactions and learning opportunities for the IHR (2005) national focal points from across the Region and the IHR regional contact point for Europe, an IHR (2005) focal points workshop was conducted by the Regional Office in Copenhagen, Denmark, in October 2017. It helped prioritize the work of the Regional Office Health Information Management programme (HIM) to better address the focal points' needs during the upcoming biennium.

563. To ensure that health events are detected and that risks are assessed and communicated to enable appropriate action to be taken, efforts were made during the biennium to improve the response to Zika virus in the Region. After participation in the global incident management system for a Zika virus response, the Regional Office conducted and published a Zika virus risk assessment for the Region, followed by a technical consultation and several capacity-building workshops for national focal points. WHO Regional Office for Europe-HIM expertise was also used during joint in-country assessments of other relevant priority public health issues, including to countries outside Europe (such as a visit to assess travel-associated Legionnaires' disease in Dubai, United Arab Emirates, in April 2017).

Emergency operations

564. During the biennium, efforts were made to ensure that the populations affected by health emergencies had access to essential life-saving health services and public health interventions. Strengthened partnerships such as the Global Health Cluster (GHC), Global Outbreak Alert and Response Network (GOARN), emergency medical teams (EMTs), collaborating centres and networks were paramount.

565. Emergency operations units, both at WHO headquarters and at the regional level, continued to provide leadership, coordination, technical support, capacity building, resource mobilization, partnership strengthening and day-to-day guidance to the teams responding to

the protracted emergencies in Turkey and Ukraine. This included guidance to the health cluster under the "whole-of-Syria" initiative, with its 61 partners in Gaziantep, Turkey, to the health and nutrition cluster, with its 36 partners, in Kyiv, Ukraine, and four field clusters.

566. Preparation and verification of EMTs in the Region were intensified, bringing the total number of verified EMTs in the Region to eight by the end of the biennium.

567. To increase the number of EMTs and strengthen national preparedness, two capacity-building workshops were conducted in Kazakhstan and Israel in 2017, with participants from 14 Member States. A training course for emergency response experts on the coordination of EMTs, as part of an international response to a sudden-onset disaster, was conducted in Italy in June 2017.

568. The first meeting of the GOARN partners in the European Region was held in Saint Petersburg, Russian Federation, on October 2016. It set the stage for widening the network to include eastern European and Russian-speaking countries. Furthermore, WHO conducted extensive training of 24 GOARN public health experts from 22 countries to improve rapid and effective field response to outbreaks and health emergencies, in Lisbon and Évora, Portugal, in July 2017. Information exchange between WHO headquarters, regional offices, country offices and partners on GOARN in Europe was facilitated and enhanced through weekly teleconferences with key alert and response network partners. Information on stand-by partners and international NGOs active in the European Region was collated ahead of planning the first consultation in 2018.

569. In response to the floods in Albania, kits were delivered through WHO to the affected populations. Moreover, the Regional Office provided kits, consumables, non-consumables and full logistic support to countries facing emergencies and those at high risk.

Emergency core services

570. During the biennium, significant efforts were made to ensure the transition from category 5 of the GPW 12 results framework endorsed during the 2015 World Health Assembly to the 2016-approved WHE results framework across all WHO country offices in the Region: from planning and preparing new workplans to reviewing budgets and finance and handling the alignment of human resources. As of January 2017, WHE within the Regional Office was fully operational under the new global WHE structure due to the effective and timely implementation of the transition.

571. Continuous support was provided to the two priority countries (Turkey and Ukraine) in all areas covered by the programme, although grant management continued to be the area with further needs for stronger capacity.

572. New emergency standard operating procedures and a revised delegation of authority were developed and disseminated to WHO staff at the Regional Office and country offices through training courses and briefings. Efforts in this area will continue into 2018–2019 to ensure that the required level of knowledge and skills is harmonized among WHO staff across the Region.

573. To ensure that national emergency programmes across the Region are supported by a well-resourced and efficient WHE, the Regional Office further strengthened its coordination

with regional partner organizations (such as ECDC and UNICEF), thus setting the scene for scaled-up, coordinated approaches to harmonized communications, advocacy and risk communication. Common plans were developed, including activities and products on preparedness and response communications, and advocacy at the country level. Stronger links to resource mobilization were foreseen as a strategic approach for 2018–2019.

Polio eradication

574. During the biennium, the Global Polio Eradication Initiative, the Polio Eradication and Endgame Strategic Plan 2013–2018 and the European Vaccine Action Plan 2015–2020 provided the basis for core polio eradication activities throughout the WHO European Region – from poliovirus detection and response to outbreak preparedness, risk assessment and risk mitigation.

575. The Region remained polio-free in 2016 and 2017, as verified by the European Regional Certification Commission for Poliomyelitis Eradication (EURCCPE), which met in 2016 and 2017 to review the annual status reports prepared by the national certification committees. From the data provided in the reports, EURCCPE reviewed polio immunization coverage, polio surveillance and outbreak preparedness, and assigned each Member State a composite score for risk of importation and circulation of polioviruses and/or emergence of vaccine-derived polioviruses. Bosnia and Herzegovina, Romania and Ukraine were identified as being at the highest risk in the Region. As such, WHO engaged directly with these countries to enhance preparedness and conduct risk mitigation activities.

576. Member States were supported in mitigation activities based on the conclusions and recommendations of the EURCCPE. To improve preparedness, the Regional Office conducted polio outbreak simulation exercises at both the regional (for Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan) and national levels (Azerbaijan, Georgia, Montenegro, Tajikistan and Uzbekistan).

577. Following the eradication of type 2 wild poliovirus in 2015, the synchronized global withdrawal of the type 2 component of OPV came to effect in April 2016. The WHO European Region completed and verified this withdrawal in all 20 Member States that that were using OPV and switched to IPV vaccine by May 2016. Although these 20 Member States were expected to introduce a dose of IPV, global IPV supplies were unable to support the introduction in five countries (Kyrgyzstan, Republic of Moldova, Tajikistan, Turkmenistan and Uzbekistan), resulting in several cohorts of children without protection against type 2 polioviruses. During the interim period, the Regional Office worked with these Member States to maintain and enhanced polio surveillance and to plan and implement catch-up activities once inactivated poliovirus vaccine supplies become available (introduction planned in the first half of 2018).

578. The global and regional programmes prioritized and accelerated containment activities, particularly after the withdrawal of type 2 polioviruses, as outlined in the WHO Global Action Plan for Poliovirus Containment. Within the European Region, countries retaining polioviruses received WHO support to fulfil the global containment requirements: establishing national authorities for containment and poliovirus essential facilities. WHO also supported countries not retaining polioviruses to destroy and dispose of them. Globally, the European Region (compared to the other five WHO regions) will retain the majority of wild polio and vaccine viruses held globally, with 37 poliovirus essential facilities in 12 countries.

579. In 2017 a containment breach of wild poliovirus occurred in the Netherlands from a vaccine manufacturer, two years after the previous containment breach of wild poliovirus in Belgium from a vaccine manufacturer. Containment activities represented an important stream of work for the Regional Office during 2016–2017.

580. Surveillance was sustained throughout the biennium. WHO provided technical and financial support to Member States: 12 countries conducted acute flaccid paralysis (AFP) surveillance exclusively for the detection of polioviruses; an additional 30 countries conducted AFP surveillance with supplementary surveillance (including environmental surveillance and/or enterovirus surveillance); and 10 countries conducted exclusively supplementary surveillance. Only one country in the Region (Luxembourg) does not conduct any formal poliovirus surveillance; however, public health authorities in the country provided assurances that, based on population size and the health infrastructure, any case of AFP would be detected rapidly.

581. The WHO European Polio Laboratory Network is an integral part of polio surveillance and the largest within the Global Polio Laboratory Network: it includes 48 laboratories in 37 countries, all fully accredited during the 2016–2017 biennium.

582. The ongoing emergency in the Syrian Arab Republic and accessibility challenges in northern Syrian Arab Republic determined the maintenance of an office in Gaziantep, Turkey, throughout the biennium. This office, among others, supported polio surveillance and immunization activities and played a vital role in the response to the cVDPV type 2 outbreak in 2017, in close coordination with the WHO Regional Office for the Eastern Mediterranean. The Turkish national laboratory in Ankara, and the regional reference laboratory in Bilthoven, Netherlands, tested the AFP surveillance specimens collected in northern Syrian Arab Republic and were important for the detection of and response to the 2017 cVDPV outbreaks in Deir-ez Zor, Syrian Arab Republic, as they were for the 2013 wild poliovirus outbreak. To ensure continued high performance of the network, these laboratories were monitored throughout 2016–2017. The European Polio Laboratory Network also provided support for specimen testing in the occupied Palestinian territory via the national Israeli laboratory in Tel Aviv in 2016 and 2017.

Corporate services and enabling functions

Leadership and governance

583. The European Region continued to promote greater coherence in global health, with WHO taking the lead in enabling different actors to play an active and effective role in contributing to the health of all people as a result of the strong leadership of the Regional Director, dedicated heads of country offices and the active engagement of the Regional Office’s executive management.

584. During the biennium, two Regional Committee sessions and 10 Standing Committee of the Regional Committee sessions were held. At RC66 in 2016, representatives of Member States discussed 27 documents and adopted 13 resolutions; at RC67 in 2017, representatives discussed 19 documents and adopted eight resolutions and one decision. In addition, the Regional Office provided support to Member States at global governance sessions (Executive Board and World Health Assembly) in different formats.

585. To address past timeliness and length challenges, the Regional Office established a new process for the production and translation of governing body documents, which was successfully piloted the last Standing Committee session in 2016. The new procedures simplified the Regional Committee documentation production process, resulting in cost and staff time savings during RC67.

586. Effective leadership at the country level was strengthened through increased interaction and knowledge exchange between the WHO representatives and heads of WHO offices. Moreover, during the biennium nine country offices (Albania, Armenia, Belarus, Bulgaria, Georgia, the former Yugoslav Republic of Macedonia, Serbia, Slovenia, Slovakia) changed to an internationally recruited head of WHO country office in place of a nationally recruited officer; formal agreements were made to open two new country offices (Israel and Greece) and three countries (Malta, Belgium and Italy) signed country cooperation strategies.

587. As a platform to discuss priorities for the Region and to strengthen collaboration for public health and promote an intersectoral approach, 18 ministerial visits to the Regional Office were organized. In addition, the Regional Director visited 28 Member States.

588. To ensure successful implementation of the 28 signed BCAs for 2016–2017 and coherence with current national and organizational priorities and cost–efficiency, three retreats for heads of country offices, two subregional global health diplomacy courses and a subregional SEEHN ministerial forum were organized during the biennium.

589. In 2016–2017, WHO support to national counterparts and national technical focal points led to increased cohesion across the Region and better alignment of the Regional Office's assistance to national efforts.

590. The Regional Office continued to work closely with many partners at both the county and regional levels. Collaboration with the United Nations family is key to implementation of the SDG agenda and the Regional Office played a leading role in bringing the United Nations and partners together on key issues related to the implementation of SDG 3 through issue-based coalitions on health as well as through active participation in the United Nations country team and United Nations Development Group.

591. Collaboration with the European Commission continued, working in line with the 2015 publication *The objectives, principles and modalities for continued cooperation between the European Commission and the WHO Regional Office for Europe*. The work of the WHO Office at the EU in Brussels, Belgium, also strengthened WHO collaboration at the global level, and the Regional Office and the European Committee of the Regions signed a memorandum of understanding in 2016.

592. Following the adoption of the Framework of Engagement with Non-State Actors by the World Health Assembly in 2016, the Regional Office introduced an interim process to ensure immediate implementation. An internal system was created to conduct due diligence and to document details of the non-State actors, to keep accurate and complete records and monitor the volume of engagements with non-State actors.

593. In addition, RC67 endorsed a procedure to accredit regional non-State actors not in official relations with WHO to participate in meetings of the Regional Committee (document EUR/RC67/17 Rev.1 and Resolution EUR/RC67/R7). Accreditation is a privilege that the

Regional Committee may grant to regional NGOs, international business associations and philanthropic foundations. It includes an invitation to participate, without the right to vote, in meetings of the Regional Committee and the possibility to submit written and/or oral statements through the Regional Office.

594. The Regional Office's work with the CIS Interparliamentary Assembly and with the Eurasian Economic Union was further strengthened during 2016–2017.

595. To advance the SDG agenda in the European Region, planning for the 2018–2019 biennium fostered alignment with national SDG implementation plans.

Transparency, accountability and risk management

596. To continue to operate in an accountable and transparent manner and to improve its risk management and evaluation frameworks, the Division of Administration and Finance of the Regional Office underwent an internal reorganization and established a new compliance monitoring and reporting function. The Division underwent an operational audit by the Office of Internal Oversight Services (IOS), achieving a satisfactory classification and currently implementing the recommendations.

597. The Region initiated its third cycle in the corporate risk register early in 2017 across all budget centres, and the internal control framework self-assessment checklist for 2017 was submitted by all Regional Office budget centres at biennial closure.

598. During the biennium, the 2015–2016 the Regional Office Division of Administration and Finance and the Russian Federation country office audits were closed, with all the recommendations implemented by the end of 2017. In addition, the Regional Office provided assistance to the IOS's integrated audit of the Turkey Country Office and emergency field office that took place during 2017.

599. The Regional Office contributed to the global corporate evaluation, reviewing corporate evaluation reports, supporting evaluations and participating in the evaluation management group.

600. Throughout the biennium the constructive staff–management dialogue continued, with active participation in the Global Staff Management Council by both staff and management.

Strategic planning, resource coordination and reporting

601. During the reporting period, several initiatives took place to ensure that finance and resource allocation was aligned with the priorities and health needs of Member States, within WHO's results-based management framework, for both 2016–2017 biennium implementation and 2018–2019 biennium planning.

602. The strategic directions from both the regional and country perspectives for 2018–2019 and for the longer term were shared and discussed during a face-to-face planning retreat for selected country offices at the end of 2017, where synergies for interdivisional work were identified and country–regional level discussions advanced.

603. The Regional Office monthly EX dashboard for PB implementation, a regular management monitoring initiative of the Regional Office, was deemed good practice by the internal audit.

604. In 2016–2017 the Regional Office continued to follow a comprehensive donor proposal/agreement tracking system, strengthening compliance with the global coordinated resource mobilization processes and alignment with the PB. The process is coordinated by the Strategic Partnerships and Resource Mobilization unit in cooperation with teams involved in clearing donor proposals and agreements, such as administration and finance, legal services, programme and resource management, human resources and country relations, as well as the respective technical divisions. Since the introduction of the system in 2014 and until the end of 2017, approximately 230 proposals, agreements and no-cost extensions were initiated by programmes and country offices and were reviewed.

Management and administration

605. In an effort to continue to establish effective and efficient management and administration consistently across the Organization, several initiatives were implemented during 2016–2017. These helped to optimize processes and strengthen compliance with financial rules and regulations.

606. In addition to regular monthly reviews, a new mechanism was introduced for a more detailed in-depth review of financial practices across the various budget centres, with all 91 imprest accounts reviewed based on a 40-point checklist.

607. The successful roll-out of supplier invoice processing automation in the Regional Office in 2016–2017 was complemented with training sessions for staff in both country offices and technical units.

608. Thorough follow-up during the biennium resulted in a significant reduction in the value of committed contributions from donors that were overdue by more than 360 days: from US$ 1.8 million at the beginning of 2017 to less than US$ 40 000 at the close of the biennium. Similarly, close follow-ups with the relevant budget centres were undertaken to ensure timely donor reporting.

609. During the biennium, efforts were made to streamline processes and shorten the lead time from the signing of donor agreements to actual award implementation, capping it at one month.

610. The successful launch of the Staff Health Insurance online system (a self-service portal allowing staff to submit and track their insurance claims online) led to improved efficiency and greater transparency to staff.

611. The Regional Office continued to support the planning and implementation of the regional human resources plan and the global human resources policy and strategy. Extensive support was given to the newly approved WHE during the second half of the biennium.

612. The male/female ratio of staff in the professional and higher categories holding long-term appointments in the European Region remained close to the 50:50 target. At the end of 2017, it was 48:52, which represented a small change from the 47:53 found at the end of 2015.

613. The number of staff in the professional and higher categories holding long-term appointments that moved from a duty station in the European Region to another duty station within or outside the Region was 24 in 2016 and 26 in 2017. These 50 moves represented close to 14% of the 362 moves which took place across WHO during the biennium. Of the 50 staff moving, 32 moved to another duty station within the Region; the rest moved to headquarters (12) or to other regions (6). In addition, another 24 staff moved to the European Region during the period. The majority (18) came from headquarters and the rest (8) from other regions.

614. The Regional Office achieved full compliance with information and communication technology (ICT) organizational standards during the biennium. A comprehensive review and analysis of the status of ICT in the country offices and geographically dispersed offices was conducted. The gaps identified led to the development of new solutions for small and standard offices. The solution for small offices was fully implemented in all targeted locations, while the standard office solutions were managed centrally by the Regional Office.

615. Data centre servers and storage at the Regional Office were replaced to ensure reliable operations and sufficient hosting capacity, and a new service desk system was further enhanced to support new procedures.

616. Since 2013 the Regional Office has been located in the United Nations common premises (“UN City”) in Copenhagen, Denmark, with other United Nations agencies. In this setting, WHO provides a number of services to the other agencies, on a cost-recovery basis. During 2016–2017, the Regional Office continued to provide ICT services to UN City, with all supported agencies reporting high availability and no major issues registered. New services were also introduced, such as videoconferencing units, enhanced IT security and expanded wireless access.

617. In addition, conference services, including audiovisual, web streaming and logistics support were provided effectively to 21 high-level conferences and two sessions of the Regional Committee. Daily conference support was also provided for over 1000 conferences and meetings at UN City. Furthermore, managed multifunction printing/photocopying and print production services were provided effectively for UN City, including measures taken to reduce costs and carbon footprint.

618. With regard to operational and logistics support, procurement, infrastructure maintenance and asset management and secure environment, several initiatives were implemented to optimize processes, strengthen compliance with rules and regulations and provide high-quality services.

619. Assessment support and additional financial resources were provided to several country offices in connection with office moves and office expansions, to ensure that office premises in the countries offer a safe and secure working environment, matching the size and nature of country presence and operations.

620. The Regional Office achieved full International Public Sector Accounting Standards compliance in 2017 with regard to fixed asset management, following significant work and efforts to ensure timely recording and updating of the fixed assets register, systematic tracking and monitoring of assets, and provision of advice and support to country offices and

geographically dispersed offices. Support and training were also provided to staff in country offices and technical units in the Region in the area of travel policy and procedures.

621. The Regional Office supported the gradual implementation of WHO's global procurement strategy. Among other things, this included the introduction of new tender templates, including a new online e-tendering facility and publication of high-value tenders (above US$ 200 000) on the United Nations Global Marketplace website in order to attract more vendors and to add focus to supplier performance evaluation.

622. Three other notable initiatives and developments contributed to the strengthening of the administrative capacity in the Region: the creation and filling of internationally recruited administrative officer positions in selected country offices; the reintroduction of regional induction training for newcomers (covering many aspects of working for WHO, including introduction to key administrative areas of work); and annual network meetings bringing together administrative assistants and administrative officers from the Regional Office, country offices and geographically dispersed offices. These network meetings served as platforms for training in selected administrative areas and for sharing of best practices.

Strategic communications

623. During 2016–2017 efforts continued to improve public and stakeholder understanding of the work of WHO in the European Region.

624. Regular and timely dissemination of information led to enhanced visibility of organizational priorities, work in countries and the activities of the Regional Director. Implementation of the Regional Office's communications strategy for 2016–2020 was complemented by a comprehensive review of tasks and platforms, and an adjustment to the workflows resulted in a more strategic and participatory approach and in substantial progress in reaching and influencing targeted audiences.

625. As guided by the newly approved communications strategy, stronger outreach – making effective use of traditional and digital platforms – and collaboration with WHO networks, Member States and partners allowed the Regional Office to extend the reach of its public health messages.

626. Engagement with key audiences increased with the use of qualitative and quantitative evidence, the use of "real-life" stories and experiences, and the use of innovative, visually compelling ways (including video, photos and personal interviews) of sharing information and perspectives. These approaches helped to emphasize WHO's work and the impact of health interventions on people's health.

627. Throughout the biennium, communications campaigns for regional events (RC66 and RC67), corporate celebrations (World Health Day 2016 and 2017, World Antibiotic Awareness Week) and Region-specific events (a high-level conference in Paris on working together for better health and well-being, European Immunization Week and the Sixth Ministerial Conference on Environment and Health) provided opportunities for strong, aligned campaigns, with partners, on health priorities in countries across the Region.

628. Nevertheless, limited resources allocated for communication activities prevented the Regional Office from reaching its full potential as regards visibility and impact in major

health campaigns, its media outreach and leveraging of its strong position in United Nations networks.

629. WHO messages also reached key national audiences through the efforts of country offices. Four country offices (in Bosnia and Herzegovina, Belarus, Kyrgyzstan and Uzbekistan) ensured that WHO maintained a strong role in One-United Nations health communications through active participation in United Nations communications groups, contributions to the country office social media presence, targeted outreach to national media and a stronger presence on the Regional Office website.

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